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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the 15th Congress of the
Confederation of the Medical Associations of Asia and Oceania

Bangkok
2 December 1987

Accelerating the Mementum for Child Survival and Development:
Gathering Alliances



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**ACCELERATING THE MOMENTUM
FOR CHILD SURVIVAL AND
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Remarks by James P. Grant at the opening ceremony

Mr. Prime Minister;
distinguished participants:

I join in the greetings as we open this Congress of the Confederation of the Medical Associations of Asia and Oceania.

Today as we meet, 23,000 young children will die in Asia alone, and some 38,000 will die worldwide. The same was true yesterday; the same will be true tomorrow. In the *four days* of discussion here in Bangkok on the "Challenge to Health for All", the world death toll of young children will far exceed the 120,000 lives lost at Hiroshima. 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 which they would easily survive if they were in *your care*. Tens of thousands of child lives will be lost unnecessarily this week, for example, to the dehydration associated with diarrhoea.

We know that the scientific and technical knowledge already exists in *your hands* to prevent and to cure the major killers of children everywhere on our planet. You have this knowledge and these skills; you or your close colleagues employ them daily. How do we ensure that that knowledge gets into the hands of those whom you will *never* see in your practice - into the hands of women and families for whom it will make the life-or-death difference?

The stakes are huge. If child mortality rates of 1985 continued to the year 2,000, the total number of deaths in Asia, due largely to these preventable causes, would add up to 125 million - equal to more than the combined populations of Malaysia, the Philippines and Thailand. But if levels of progress of the first half of this decade could be maintained until the end of the century, this would reduce the death toll to 102 million, meaning that the lives of 23 million Asian children had been saved. The prospect of even maintaining these levels does present somewhat of a challenge, since, in many countries, past progress is in jeopardy from global economic difficulties - as we were so sharply reminded by the stock market in recent weeks.

The United Nations set an even more ambitious goal than maintaining past rates, however. In 1980, it called for *all countries to halve their child mortality rates by the year 2000 - or to reduce them to 50 to 1000 births*, whichever was less. To achieve this goal would mean that child deaths would be reduced to 96 million in Asia by the target date, which would translate to 29 million young Asian lives saved by the end of this century.

You are gathered here, in part, to improve your skills as physicians to save the lives and improve the health of those in your care. But I know that you are here for a larger purpose as well, because you physicians gathered here are assembled with the health and well-being of all people in mind, as is clearly evidenced in the theme of this Congress and in the tremendous advances in public health, including in child survival and development, which so many of you in this room have already helped to pioneer.

I will argue later today that this more ambitious goal set by the United Nations in 1980 *can* be achieved - and that, as a result, the lives of 3.5 million young Asian children can be saved, and the crippling of a comparable number avoided, annually by the year 2000. But this historic possibility will become a reality *if*, and only if, physicians and other leaders in the health field *make it happen*.

For most countries, this will mean achieving more progress in child survival annually than was experienced even before the economic recession of the 1980s. But this decade has brought vast stores of untapped resources. We are armed with the unprecedented potential of the Child Survival and Development Revolution (CSDR), and we have, furthermore, begun to discover means of protecting the health and welfare of children and their mothers despite severe economic conditions - the approach of "adjustment with a human face."

The very fact that this Congress is meeting in Thailand offers a sign of hope, because Thailand is one of the world's success stories in *bringing maternal and child health* to all. In the past 25 years our host country has brought its child death rate down by twice the world's average - by some 4 percent annually. It is one of a handful of low-income countries who have demonstrated that child survival and development activities can always be accelerated, even during times of economic retrenchment.

You physicians, both in your Medical Associations and in your *individual roles with your national leaders* and institutions, can greatly accelerate the success of this battle for life.

I leave you with this thought, as a preface to our discussion later today and to your deliberations throughout this important congress, and, most of all, as a challenge to you to seize the historic opportunity presented by the potential of the CSDR, for the children - and the future - of the world.

Address by James P. Grant to the Congress

I am pleased, indeed, to address this Congress. There are many familiar faces in this room today - several distinguished veterans of successful struggles to improve the health and well-being of children from throughout Asia and Oceania.

We meet at an important time for those of us committed to the improved health and survival of the world's children. 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 70,000 young children dying every day; by 1980 that toll had been reduced to 43,000 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. You doctors should take pride in the major contributions of your profession to this historic advance.

The 1980s have seen mutually opposing new influences to the world situation which had 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 plunge reminds us that, for the global economy, the worst may still lie ahead.

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. While AIDS is not yet a major manifest health problem in Asia, its spread is such that no corner of the globe should expect to escape its scourge. As Director of the AIDS Treatment and Research Unit at the Prince Henry Hospital in Sydney, Australia, Dr. John Dwyer, told the First International Congress on AIDS in Asia, held in Manila, last week:

"I do not believe Asians are any more or less resistant to the disease than anybody else... It is a time bomb we are sitting on".

A revolution for children

Fortunately, the 1980s has also brought good news. As those of us gathered at this Congress 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:

- immunizing their children against the six main child-killing diseases which last year took the lives of more than 3.5 million children and crippled or disabled-for-life a comparable number;
- using sanitary practices to prevent, and low-cost oral therapies to combat, diarrhoeal disease which last year took the lives of another 4.5 million children;
- maintaining exclusive breast-feeding in the early months to promote healthy growth, and applying new knowledge about when and how to introduce other foods;
- recognizing and acting early on the danger signs of acute respiratory infection;
- better spacing of births to promote safe motherhood and healthier infants;
- monitoring the growth of children to provide early warning of impending malnutrition;
- improving female literacy; and
- providing food supplementation, including low-cost iron, Vitamin A, and iodine, when necessary.

In a development even more recent than the advent of the CSDR, we also know that we can significantly reduce the number of new-born children infected with the AIDS virus by educating men and women of reproductive age to change their behaviour with regard to safe and unsafe practices, screening blood products, and sterilizing injection equipment.

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 medical and self-health knowledge and these techniques at the disposal of the great majority 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 groups, 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. The challenge is to mobilize all these channels of communication to empower parents with the knowledge - and the will - for child survival and development.

First articulated in late 1982, just five years ago, the Child Survival and Development Revolution had rapidly 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 1983. 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.

The primary 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. Furthermore, the encouraging progress of past decades which has reduced the child mortality rate to this still-unacceptable level could conceivably become threatened by the effects of the AIDS pandemic. We know now what is required to prevent the tragic waste of young child lives to preventable causes; 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?

We must advance on two fronts.

Adjustment with a human face

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 too 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. That is, we must ensure, for example, the continued provision of primary health care, basic education, nutritional supplements for those in need, etc. Second, and of equal if not greater importance - (especially 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."

Gathering alliances

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 physicians have. The medical knowledge and techniques to prevent these deaths is already available; physicians have them in hand and employ them every day to improve the health and save the lives of millions of children. The greater challenge has become 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 millions of 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 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, 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 the revolution in child survival and development.

It is worth noting that the alliances which are gathering for child survival will be indispensable in combatting the AIDS pandemic, whether we look forward to arresting its spread through a vaccine or through a massive educational campaign to change peoples' behaviour. Unfortunately, this is quite likely to be all-too-relevant to Asians in the near future. Asian countries have a vital advantage over regions where the pandemic has already taken a serious hold. If I may quote Dr. Dwyer again from his comments in Manila last week, "If we could have had this same conversation 10 years ago in Africa, we could have done something about it."

In Asia, you can do something about it. We know now that we are not defenseless against this disease. Our only weapon against AIDS is a powerful one, despite its simplicity - it is *knowledge*. An international education and social mobilization campaign to disseminate information about AIDS, to support those who are at risk or who have contracted the virus, and to change life-endangering behaviour could dramatically slow the spread of this disease. As Dr. Jonathan Mann, Director of the Special Programme on AIDS of the World Health Organization (WHO), stated in his briefing in October to the United Nations General Assembly;

"AIDS spreads through specific, identifiable human actions, all subject to human influence and control; thus, AIDS is controllable and preventable. Sexual behaviour can be modified, blood for transfusions can be screened, blood products can be treated to destroy the virus, and needles and syringes can be sterilized... AIDS should be seen as a disease spread by and controllable through, conscious human behaviour".

The task of accomplishing such a massive mobilization is so immense, however, that if it is mounted for AIDS alone, there may well be unsurpassable obstacles to achieving the critical mass necessary. If, however, the initiative is undertaken in conjunction with, for example, helping a government save the lives of several thousands of its children each year, the politics of the overall effort can be expected to maintain broad and consistent appeal.

Today such comprehensive efforts are underway in the child survival and development revolution. Both the networks which have been formed and the lessons which have been learned can be applied to this new dilemma. As physicians, many of you can pride yourselves in being among the pioneers of the CSDR, and of this health movement.

Much has been accomplished in the CSDR, and yet the grim reality of 23,000 Asian children dying each day and the daily crippling of a comparable number remind us that much remains to be done. We must now ask: *What are the next steps?* As I ask this question in this forum, 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.

Planning the survival and development of children

As you map the next steps of this effort, I urge you to consider the goal which I spoke of with you 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 per 1000 births*, whichever is smaller. In the Asian 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 in such countries as Bangladesh, India, Nepal and Pakistan. Thus, in India for example, where the target IMR by 2000 is 50, infant mortality rates decreased by an average of 2.31 per cent between 1980 and 1985 instead of the 3.4 per cent average required. In order to meet its year-2000 goal, India will have to achieve an annual reduction rate of 4.83 per cent until the end of the century. The Philippines has achieved a reduction rate slightly higher than half the rate they must attain to reach the goal. With a target IMR of 27, between 1980 and 1985 the annual rate decreased by 1.96 per cent. For the rest of the century the Philippines must achieve an annual reduction rate of 3.88 per cent in order to meet the goal. This clearly will require redoubled efforts.

Asia also holds some examples of infant and child mortality reduction which have been ahead of or close to target rate, and which serve as models in the prioritizing of health care despite limited resources. Sri Lanka, for example, has a target IMR of 22 per 1000 by the year 2000. Having achieved a reduction rate of 3.93 for the first 5 years of this decade, Sri Lanka will reach its target by attaining an annual reduction of 3.23 until the end of the century. Hong Kong, Kampuchea (albeit, they started from an inordinately high level in 1980), and Singapore have also been ahead of schedule during 1980-1985. Both Thailand and the Republic of Korea have been very close to the rate necessary to reach the year-2000 goal.

I should add parenthetically here that success in achieving this goal for reduced child mortality can be expected to reduce births by an even greater number. As we have seen recently in many countries, as infant mortality drops below 80 or so, largely because of much greater parental involvement, births drop even faster. Thailand offers a good example of this relationship - since 1960 the crude death rate dropped 7 points per 1000 from 15 to 8, while the crude birth rate dropped by double that amount, 15, from 39 to 24.

I have attached to the distribution copy of my remarks today a chart which lists the rate of past progress in improving child survival for every Asian 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. I urge each of you to look at the situation in your own country - from the number of child deaths each year to the rate at which these deaths are now being reduced each year. And I urge you to discuss and explore how the increase in these reduction rates might be accelerated.

Alliances 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 individual physicians and in your medical associations throughout Asia and Oceania, can accomplish.

- 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;
- 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;
- Support the empowerment** of women and families which is gained through experience and success with self-health techniques.
- Bring others into the Grand Alliances for Children. It is you who have by far the greatest ability to draw in and involve other doctors, nurses, and midwives. Vigorously **spread the word** and educate others on the situation and the historic opportunity for change on a vast scale.
- Explore the applicability of the CSDR and its social mobilization and participatory approach not only to AIDS, but to other diseases as well, 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 in 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 physician. 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 in the health field, 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?

In fact, recent experience in many Asian countries - exemplified by Thailand's progress toward achieving universal child immunization - indicates that a breakthrough in child-health and in the well-being of the world's poorest, which seemed like wishful thinking only a short time ago, is quite realistic. Indeed, there is a miracle in the making, and we are participating in it together. Already the lives of more than one million young Asian

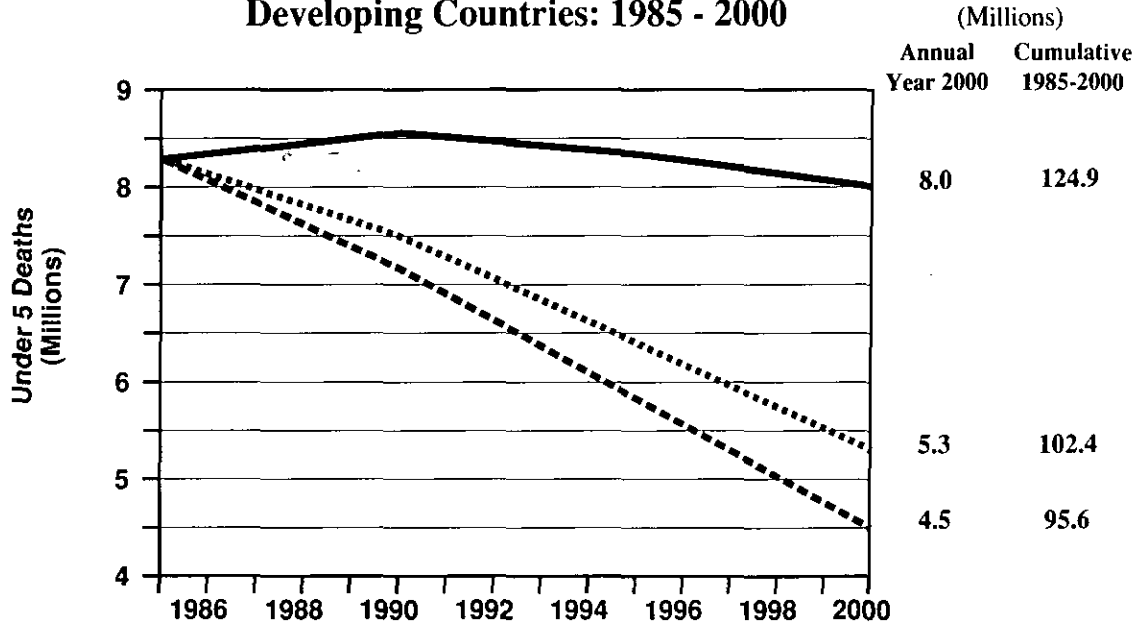
Infant and Child Mortality In The Asian Regions: Targets for 2000

Country	Under 5 Mortality Rate								Infant Mortality Rate								GNP per capita		Total Fertility Rate			Annual no. of births / infant and child deaths (0-4) (thousands)
	1960	1980	1985	Target 2000	Annual reduction rate			1960	1980	1985	Target 2000	Annual reduction rate			growth rate		1960	1986	80 - 86	1986		
					60 - 80	80 - 85	85 - 2000					60 - 80	80 - 85	85 - 2000	65 - 80	80 - 85					Average annual reduction rate	
Afghanistan	380	340	329	87	0.55%	0.66%	8.48%	215	194	189	50	0.51%	0.52%	8.48%			7.0	6.7	0.16%	863/280		
Bangladesh	262	212	196	79	1.05%	1.56%	5.88%	156	132	124	50	0.83%	1.24%	5.88%	0.4	0.9	6.7	5.7	0.60%	4428/854		
Bhutan	297	223	206	77	1.42%	1.57%	6.36%	206	143	134	50	1.81%	1.29%	6.36%			5.9	5.4	0.36%	54/11		
Burma	229	101	91	49	4.01%	2.06%	4.06%	153	72	67	36	3.70%	1.43%	4.06%	2.4	3.3				1192/106		
China	202	56	50	28	6.21%	2.24%	3.84%	150	40	36	20	6.40%	2.09%	3.84%	4.8	8.6	5.9	2.2	3.75%	19914/942		
Hong Kong	65	14	11	7	7.39%	4.71%	3.35%	44	12	10	6	6.29%	3.58%	3.35%	6.1	4.4	5.3	1.9	3.90%	94/1		
India	282	183	158	75	2.14%	2.90%	4.83%	165	118	105	50	1.66%	2.31%	4.83%	1.7	3.1	5.8	3.9	1.55%	22477/3455		
Indonesia	235	145	126	72	2.39%	2.77%	3.68%	139	90	79	45	2.15%	2.57%	3.68%	4.8	2.3	5.4	3.7	1.49%	5020/614		
Iran	254	172	162	73	1.93%	1.19%	5.18%	169	118	111	50	1.78%	1.22%	5.18%		7.1	8.1	5.3	1.60%	1801/286		
Kampuchea	218	313	216	74	-1.82%	7.15%	6.85%	146	212	145	50	-1.88%	7.32%	6.85%						318/66		
Korea, Dem.	120	44	35	21	4.89%	4.47%	3.43%	85	32	27	16	4.77%	3.34%	3.43%			5.6	3.7	1.53%	615/21		
Korea, Rep.	120	44	35	21	4.89%	4.47%	3.43%	85	32	27	16	4.77%	3.34%	3.43%	6.6	6.3	5.4	2.5	2.85%	975/33		
Laos	232	190	170	73	0.99%	2.20%	5.51%	155	128	117	50	0.95%	1.78%	5.51%						165/27		
Malaysia	106	43	38	22	4.41%	2.44%	3.66%	73	32	28	16	4.04%	2.64%	3.66%	4.4	1.8	6.7	3.5	2.48%	448/16		
Mongolia	158	77	64	38	3.53%	3.63%	3.44%	109	58	49	29	3.11%	3.32%	3.44%			5.7	4.9	0.59%	69/4		
Nepal	297	222	206	77	1.44%	1.48%	6.36%	206	143	134	50	1.81%	1.29%	6.36%	0.1	0.8	5.9	6.0	-0.07%	677/137		
Pakistan	277	191	174	76	1.84%	1.85%	5.40%	163	125	115	50	1.32%	1.65%	5.40%	2.6	2.8	7.2	5.5	1.02%	4211/716		
Philippines	135	86	78	43	2.23%	1.93%	3.88%	80	53	48	27	2.04%	1.96%	3.88%	2.3	-3.4				1757/132		
Singapore	50	14	12	7	6.17%	3.04%	3.35%	36	12	10	6	5.34%	3.58%	3.35%	7.6	6.4	4.9	1.7	4.05%	43/1		
Sri Lanka	113	55	48	29	3.54%	2.69%	3.23%	70	44	36	22	2.29%	3.93%	3.23%	2.9	3.2	5.1	3.0	2.01%	417/19		
Thailand	149	68	55	33	3.85%	4.15%	3.45%	103	52	44	26	3.36%	3.29%	3.45%	4.0	2.6	6.4	3.0	2.93%	1290/68		
Vietnam	233	119	98	56	-3.30%	3.81%	3.61%	156	83	72	42	3.11%	2.80%	3.61%			7.0	3.9	2.26%	1835/175		
Weighted Average Excluding Arab countries	232	134	119	56	2.71%	2.31%	4.88%	151	88	80	38	2.68%	1.93%	4.84%								

Target Mortality Rates are based on U.N. goal set in 1980 to either halve infant mortality rates by the year 2000 in every country or to reduce them to 50 per 1000 births, whichever is less.

children are being saved annually as a result of this peaceful revolution for children. And it is well within our grasp to, by the turn of the century, save the lives of another 2.5 million Asian children annually. This historic possibility will become reality, however, *if* - and only if - we *work together* even more actively, for the children - and the future - of Asia and the world.

Deaths of Children under 5 in Asia Developing Countries: 1985 - 2000

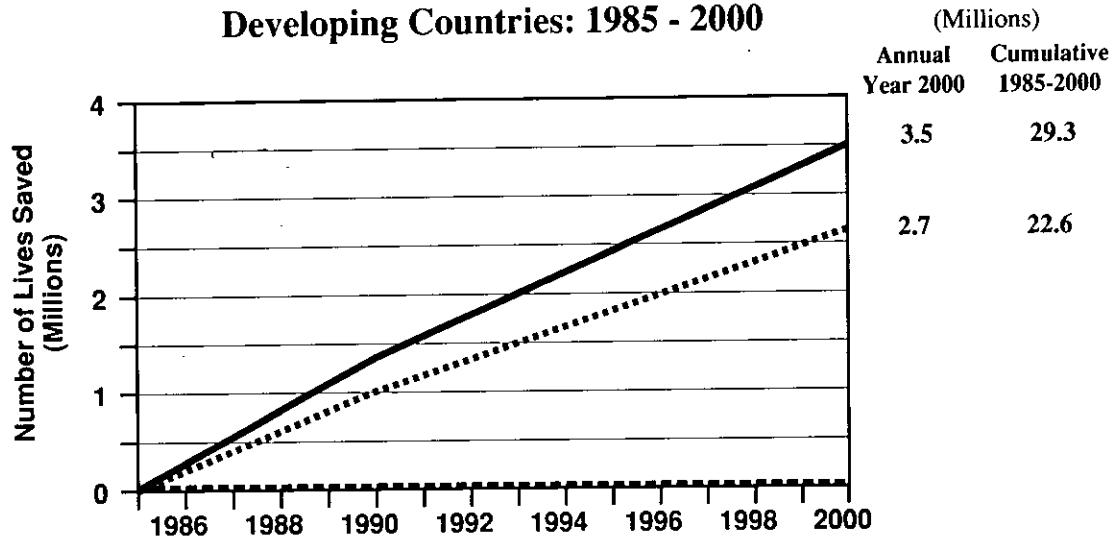


Model A
The 1985 under five mortality rates remain constant to the year 2000.

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

Model C
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 the rate.

Lives of Children Saved in Asia Developing Countries: 1985 - 2000



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

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

Model C
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 U5MR of less than 140 in 1980 will halve the rate.

Projections of Deaths and Lives Saved of Children Under Five in Asia

	1985	By 1990	By 1995	(Millions) By 2000
Model A				
Annual number of deaths	8.3	8.5	8.3	8.0
Annual number of lives saved	-	-	-	-
Cumulative number of deaths	-	42.2	84.3	124.9
Cumulative number of lives saved	-	-	-	-
Model B				
Annual number of deaths	8.3	7.5	6.5	5.3
Annual number of lives saved	-	1.0	1.9	2.7
Cumulative number of deaths	-	39.2	73.6	102.4
Cumulative number of lives saved	-	3.0	10.7	22.6
Model C				
Annual number of deaths	8.3	7.2	5.9	4.5
Annual number of lives saved	-	1.3	2.4	3.5
Cumulative number of deaths	-	38.3	70.3	95.6
Cumulative number of lives saved	-	4.0	13.9	29.3

For explanations of Models see graphs

The Child Survival Index ie. the 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 reduction of the Under 5 mortality rate			GNP per capita growth rate		Total Fertility Rate			Annual no. of birth/infant and child deaths (0-4) (thousands) 1986
	1960	1986	1960 - 86	60-80	80-85	Target * 85-2000	65-80	80-85	1960	1986	Average annual reduction rate 60-86	
Afghanistan	62.0	67.5	14.6	0.55	0.66	8.44			7.0	6.7	0.16%	863/280
Mali	63.0	70.3	19.6	0.66	1.40	7.96	1.4	-3.0	6.5	6.7	-0.14%	421/125
Sierra Leone	60.3	70.3	25.1	1.01	1.40	7.96	1.1	-0.2	6.1	6.1	-0.01%	174/52
Malawi	63.6	73.0	25.8	1.00	1.59	7.34	1.5	-0.6	6.9	7.0	-0.08%	384/104
Ethiopia	70.6	74.5	13.3	0.57	0.38	7.15	0.2	-2.0	6.7	6.7	-0.00%	2228/568
Guinea	65.4	74.5	26.3	1.07	1.48	7.19	0.8	-1.4	6.4	6.2	0.12%	292/74
Somalia	70.6	74.5	13.3	0.57	0.38	7.15	-0.7	0.6	6.6	6.6	-0.00%	226/58
Mozambique	69.8	75.3	18.1	0.52	1.52	6.95		-13.6	5.7	6.1	-0.25%	651/161
Burkina Faso	61.2	75.9	38.0	1.98	1.18	6.86	1.3	-1.3	6.5	6.5	-0.00%	342/82
Angola	65.4	76.2	31.3	1.40	1.50	6.76		0.1	6.4	6.4	-0.01%	427/101
Niger	68.0	76.7	27.1	1.11	1.53	6.67	-2.1	-6.7	7.1	7.1	-0.02%	324/76
Chad	67.4	77.2	29.9	1.30	1.56	6.49	-2.3	1.8	6.0	5.9	0.07%	228/52
Guinea-Bissau	68.5	77.2	27.5	1.13	1.56	6.49	-1.5	1.9	5.1	5.4	-0.24%	37/8
C. African Rep.	69.2	77.2	25.9	1.20	0.84	6.55	-0.2	-1.5	5.7	5.9	-0.15%	117/27
Senegal	68.7	77.3	27.3	1.12	1.57	6.49	-0.6	0.0	6.7	6.5	0.09%	309/70
Mauritania	69.0	77.5	27.5	1.23	1.62	6.26	0.1	-0.7	6.9	6.9	-0.02%	98/21
Liberia	69.7	78.9	30.2	1.30	1.60	6.04	-1.4	-6.4	6.3	6.9	-0.37%	110/23
Rwanda	75.2	79.0	15.2	0.38	1.43	6.00	1.8	-1.5	6.8	7.4	-0.30%	323/68
Kampuchea	70.2	79.4	5.5	-1.82	7.15	6.91			6.3	4.8	1.01%	318/66
Yemen	62.2	79.6	46.0	2.33	2.31	5.99	5.3	0.9	7.0	6.9	0.03%	339/69
Yemen, Dem.	62.2	79.6	46.0	2.33	2.31	5.99			7.0	6.6	0.20%	104/21
Bhutan	70.3	79.8	32.1	1.42	1.57	6.27		3.4	5.9	5.4	0.36%	54/11
Nepal	70.3	79.8	32.1	1.42	1.57	6.27	0.1	0.8	5.9	6.0	-0.07%	677/137
Burundi	74.2	80.4	23.9	0.93	1.34	5.60	1.9	-0.8	5.7	6.4	-0.46%	225/44
Bangladesh	73.8	80.7	26.4	1.05	1.56	5.78	0.4	0.9	6.7	5.7	0.60%	4428/854
Benin	69.0	81.1	38.9	1.91	1.77	5.36	0.2	0.1	6.8	7.0	-0.11%	213/40
Sudan	70.7	81.8	37.9	1.68	2.20	5.17	()	-4.2	6.7	6.4	0.14%	996/181
Tanzania	75.2	82.1	27.7	1.05	1.86	5.08	()	-3.1	6.9	7.1	-0.13%	1184/212
Bolivia	71.8	82.1	36.6	1.49	2.52	5.42	-0.2	-7.0	6.6	6.1	0.30%	284/51
Nigeria	68.2	82.2	43.9	2.29	1.87	5.02	2.2	-7.3	6.9	7.1	-0.13%	5015/895
Haiti	70.6	82.4	40.2	1.96	1.89	5.76	0.7	-2.5	6.2	5.6	0.35%	278/49
Gabon	71.2	82.6	39.5	1.91	1.91	4.90	1.5	-1.2	4.1	4.9	-0.76%	43/7
Uganda	77.6	82.6	22.3	0.87	1.09	4.94	-2.6	2.2	6.9	6.9	0.01%	810/141
Pakistan	72.3	83.0	38.6	1.84	1.85	5.34	2.6	2.8	7.2	5.5	1.02%	4211/716
Zaire	74.9	83.4	33.8	1.46	1.89	4.63	-2.1	-3.8	5.9	6.1	-0.10%	1394/232
Laos	76.8	83.4	28.4	0.99	2.20	5.38			5.7	5.5	0.10%	165/27
Oman	62.2	83.4	56.2	3.08	3.16	4.96	5.7	0.5	7.2	6.9	0.13%	58/10
Iran	74.6	84.1	37.4	1.93	1.19	5.19		7.1	8.1	5.3	1.60%	1801/286
Cameroon	72.5	84.2	42.5	2.15	1.87	4.35	3.6	4.5	5.7	5.8	-0.07%	435/69
Togo	69.5	84.3	48.6	2.68	2.00	4.24	0.3	-5.6	6.2	6.1	0.04%	138/22
India	71.8	84.6	45.5	2.14	2.90	4.63	1.7	3.1	5.8	3.9	1.55%	22477/3455
Côte d'Ivoire	68.0	84.7	52.2	2.97	2.15	4.77	0.9	-5.2	6.6	6.6	-0.01%	463/71
Ghana	77.6	85.0	33.1	1.52	1.50	4.03	-2.2	-3.9	6.5	6.5	-0.01%	663/99
Lesotho	79.2	86.0	32.6	1.30	2.09	4.84	6.5	3.4	5.8	5.8	0.01%	65/9
Zambia	77.2	86.9	42.3	2.14	1.82	3.93	-1.6	-4.1	6.6	6.8	-0.08%	333/44
Egypt	70.0	86.9	56.3	2.89	4.02	3.81	3.1	1.3	7.1	4.5	1.76%	1629/214
Peru	76.7	87.2	44.9	2.21	2.25	3.92	0.2	-4.2	6.9	4.6	1.50%	708/91
Libya	73.2	87.5	53.3	2.52	4.19	3.27	-1.3	-9.1	7.2	7.0	0.11%	167/21
Morocco	73.5	87.5	52.8	2.71	3.21	3.73	2.2	0.1	7.2	4.6	1.72%	755/95
Indonesia	76.5	87.8	47.9	2.39	2.77	3.62	4.8	2.3	5.4	3.7	1.49%	5020/614
Congo	75.9	88.1	50.5	2.93	1.71	3.96	3.8	4.9	5.9	6.0	-0.08%	80/10
Kenya	79.2	88.3	43.5	2.10	2.31	3.77	1.9	-1.7	8.2	8.0	0.05%	1182/139
Zimbabwe	81.8	88.3	35.4	1.52	2.02	3.86	1.6	0.0	6.6	6.6	0.01%	431/51
Honduras	76.8	88.8	51.7	2.64	3.13	3.50	0.4	-2.6	7.4	5.9	0.87%	184/21
Algeria	73.0	88.8	58.6	2.99	4.46	3.05	3.6	1.7	7.4	6.5	0.48%	938/105
Tunisia	74.5	89.4	58.6	3.06	4.30	3.11	4.0	1.4	7.2	4.3	1.93%	226/24

The Child Survival Index ie. the 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 reduction of the Under 5 mortality rate			GNP per capita growth rate		Total Fertility Rate			Annual no. of birth/infant and child deaths (0-4) (thousands) 1986
	1960	1986		1960 - 86	60-80	80-85	Target * 85-2000	65-80	80-85	1960	1986	
Guatemala	77.0	89.5	54.5	2.89	3.16	3.49	1.7	-4.3	6.9	5.9	0.59%	340/36
Saudi Arabia	70.8	89.5	64.2	3.86	3.90	3.24	5.3	-7.3	7.3	6.9	0.18%	495/52
South Africa	80.8	89.9	47.5	2.28	2.98	3.55	1.1	-1.6	5.6	5.0	0.46%	1272/128
Nicaragua	79.0	90.0	52.6	2.48	3.92	3.24	-2.1	-3.1	7.3	5.6	1.01%	145/14
Turkey	74.2	90.1	61.7	3.12	5.36	3.12	2.6	2.1	6.0	3.7	1.80%	1486/147
Iraq	77.8	90.2	55.9	3.36	2.24	3.79			7.2	6.2	0.54%	689/67
Botswana	82.6	90.4	44.7	2.22	2.26	3.78	8.3	7.4	6.4	6.5	-0.05%	57/5
Viet Nam	76.7	90.5	59.1	3.30	3.81	3.27			7.0	3.9	2.26%	1835/175
Madagascar	81.9	90.6	48.0	2.37	2.83	3.60	-1.9	-6.1	5.8	6.1	-0.19%	458/43
Ecuador	81.7	91.0	51.0	2.69	2.79	3.61	3.5	-2.4	6.9	4.8	1.43%	347/31
Papua NG	75.3	91.0	63.7	3.88	3.44	3.39	0.4	-1.6	6.3	5.4	0.58%	132/12
Brazil	84.0	91.1	44.4	2.23	2.26	3.79	4.3	-1.5	6.2	3.6	2.08%	4039/359
Burmn	77.1	91.1	61.3	4.01	2.06	3.85	2.4	3.3	5.9	3.8	1.69%	1192/106
El Salvador	79.4	91.2	57.2	3.27	3.01	3.54	-0.2	-3.1	6.9	5.2	1.03%	222/20
Dominican Rep.	80.0	91.4	57.2	3.31	2.91	3.57	2.9	-0.8	7.3	3.8	2.49%	201/17
Philippines	86.5	92.5	44.2	2.23	1.93	3.89	2.3	-3.4	6.6	4.1	1.83%	1757/132
Mexico	86.0	92.9	49.5	2.64	2.30	3.77	2.7	-2.1	6.7	4.2	1.83%	2587/183
Colombia	85.2	93.0	52.6	3.09	1.84	3.92	2.9	-0.5	6.7	3.7	2.28%	693/49
Syria	78.2	93.2	68.9	4.71	3.07	3.52	4.0	-2.1	7.5	6.9	0.28%	502/34
Paraguay	86.6	93.7	53.1	3.13	2.05	3.85	3.9	-1.9	6.6	4.6	1.40%	132/8
Mongolia	84.2	93.8	61.0	3.53	3.63	3.33			5.7	4.9	0.59%	69/4
Jordan	78.2	93.9	71.8	4.89	4.07	3.18	5.8	1.5	7.2	7.3	-0.07%	170/10
Lebanon	90.8	94.7	42.5	1.95	2.02	3.87			6.4	3.5	2.26%	80/4
Thailand	85.1	94.7	64.7	3.85	4.15	3.16	4.0	2.6	6.4	3.0	2.93%	1290/68
Albania	83.6	95.0	69.5	4.90	2.82	3.60			5.7	3.4	1.99%	84/4
China	79.8	95.3	76.6	6.13	2.59	3.68	4.8	8.6	5.9	2.2	3.75%	19914/942
Sri Lanka	88.7	95.4	59.6	3.54	2.69	3.65	2.9	3.2	5.1	3.0	2.01%	417/19
Venezuela	88.6	95.6	61.2	3.94	2.47	3.72	0.5	-5.4	6.5	3.9	1.95%	558/25
U.A.E.	76.1	95.9	83.0	7.25	4.10	3.18			6.9	5.6	0.79%	35/1
Guyana	90.6	96.1	58.1	2.73	5.36	2.75	-0.2	-7.3	6.0	2.9	2.76%	26/1
Argentina	92.5	96.1	47.7	2.52	2.33	3.76	0.2	-3.9	3.1	3.3	-0.26%	733/29
Malaysia	89.4	96.3	65.3	4.41	2.44	3.73	4.4	1.8	6.7	3.5	2.48%	448/16
Panama	89.5	96.6	67.4	4.48	3.58	3.35	2.5	-0.2	5.9	3.2	2.30%	60/2
Korea, Dem.	88.0	96.7	72.2	4.89	4.47	3.05			5.6	3.7	1.53%	615/21
Korea, Rep.	88.0	96.7	72.2	4.89	4.47	3.05	6.6	6.3	5.4	2.5	2.85%	975/33
Uruguay	94.4	96.9	44.3	1.43	5.29	2.77	1.4	-6.0	2.9	2.7	0.33%	58/2
Mauritius	89.6	97.0	70.8	4.43	5.29	2.77	2.7	2.3	5.7	2.5	3.08%	26/1
Romania	91.8	97.0	63.7	4.03	2.95	3.56			2.0	2.4	-0.66%	396/12
Yugoslavia	88.7	97.1	73.9	5.43	3.48	3.38	4.1	-0.5	2.7	2.0	1.12%	362/11
USSR	94.7	97.2	46.8	2.20	3.13	3.50			2.5	2.4	0.22%	5207/147
Chile	85.8	97.5	82.3	6.14	8.25	1.73	-0.2	-3.9	5.1	2.5	2.66%	272/7
Trinidad & T	93.3	97.6	63.4	3.94	2.82	3.60	2.3	-6.0	5.0	2.7	2.30%	30/1
Jamaica	91.2	97.6	72.5	5.40	2.92	3.57	-0.7	-3.1	5.5	3.0	2.25%	63/2
Kuwait	87.2	97.6	81.1	6.28	6.51	2.35	-0.3	-0.8	7.4	5.9	0.88%	68/2
Costa Rica	87.9	97.7	81.3	7.06	2.24	3.79	1.4	-2.7	7.0	3.3	2.79%	78/2
Portugal	88.8	97.9	81.1	6.37	6.01	2.52	3.3	-0.5	3.1	2.1	1.41%	172/4
Bulgaria	93.8	98.0	67.9	4.44	3.43	3.40			2.2	2.2	-0.02%	138/3
Hungary	94.3	98.0	65.1	3.85	4.18	3.15	5.8	1.7	1.8	1.8	0.06%	132/3
Poland	93.0	98.0	71.6	5.21	2.64	3.66			2.7	2.2	0.70%	637/13
Cuba	91.3	98.1	78.2	6.24	4.56	3.02			4.7	2.0	3.27%	181/3
Greece	93.6	98.3	73.6	4.99	4.78	2.94			2.2	2.1	0.17%	145/2
Czechoslovakia	96.8	98.3	48.1	2.32	3.20	3.48	3.6	-0.3	2.4	2.1	0.51%	232/4
Israel	96.0	98.4	60.0	3.91	2.33	3.76	2.5	-0.7	3.9	2.9	1.06%	94/2
New Zealand	97.3	98.7	52.2	2.58	2.64	3.66	1.4	1.8	3.8	1.9	2.70%	60/1
USA	97.0	98.7	57.3	3.41	2.82	3.60	1.7	1.4	3.3	1.9	2.14%	3789/48
Austria	95.7	98.7	70.7	4.82	4.07	3.18	3.5	1.7	2.8	1.6	2.06%	93/1
Belgium	96.5	98.7	64.0	4.15	2.82	3.60	2.8	0.6	2.7	1.6	1.90%	122/2

The Child Survival Index ie. the 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 reduction of the Under 5 mortality rate			GNP per capita growth rate		Total Fertility Rate			Annual no. of birth/infant and child deaths (0-4) (thousands) 1986
	1960	1986	1960 - 86	60-80	80-85	Target *	65-80	80-85	1960	1986	Average annual reduction rate 60-86	
German Dem.	95.6	98.7	71.4	5.24	2.82	3.60			2.5	1.9	0.97%	240/3
Italy	95.0	98.7	74.8	5.25	5.22	2.79	2.6	0.4	2.6	1.6	1.78%	658/8
Singapore	95.0	98.8	76.0	6.17	3.04	3.53	7.6	8.4	4.9	1.7	4.05%	43/1
Germany, Fed.	96.2	98.8	69.5	4.23	5.59	2.67	2.7	1.2	2.5	1.4	2.19%	636/7
Ireland	96.4	98.8	67.8	4.28	4.36	3.08	2.2	-0.3	4.0	3.0	1.09%	79/1
Spain	94.4	98.9	79.8	6.37	4.36	3.08	2.6	0.9	2.9	2.1	1.19%	580/7
United Kingdom	97.3	98.9	58.1	3.23	3.04	3.53	1.6	2.1	2.8	1.8	1.69%	743/8
Australia	97.5	98.9	57.6	2.86	4.71	2.97	2.0	0.9	3.3	1.9	2.00%	249/3
Hong Kong	93.5	98.9	83.7	7.39	4.71	2.97	6.1	4.4	5.3	1.9	3.90%	94/1
France	96.6	99.0	69.7	4.69	3.29	3.45	2.8	0.3	2.9	1.9	1.63%	765/8
Canada	96.7	99.0	70.9	4.55	5.11	2.83	2.4	0.8	3.6	1.7	2.87%	384/4
Denmark	97.5	99.1	62.8	4.02	1.89	3.91	1.8	2.0	2.6	1.5	2.15%	56/1
Japan	96.0	99.1	76.8	6.70	2.09	3.84	4.7	3.5	2.0	1.8	0.42%	1522/14
Netherlands	97.8	99.1	57.7	3.41	1.89	3.91	2.0	0.3	3.1	1.5	2.89%	173/2
Switzerland	97.3	99.1	68.1	4.39	3.93	3.23	1.4	1.3	2.5	1.5	2.04%	70/1
Norway	97.7	99.2	63.9	3.62	1.89	3.91	3.3	3.2	2.9	1.6	2.23%	49/0
Finland	97.2	99.3	73.9	5.52	2.33	3.76	3.3	2.1	2.6	1.6	1.71%	63/0
Sweden	98.0	99.3	63.5	3.91	2.33	3.76	1.8	1.5	2.3	1.5	1.64%	87/1

* Target Mortality Rates are based on the U.N. goal set in 1980 to either halve infant mortality rates by the year 2000 in every country or to reduce them to 50 per 1000 births, whichever is less.