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CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO:

TELEPHONE 223-4700

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

Illustrative Material

- A. Questionnaire for Deaths
- B. Code Sheet
- C. Selected Material from Provisional Report for First Year

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

Confidential

Death - page 1

1. Name of child _____ 2. Serial no. _____

3. Date of birth _____ 4. Date of death _____ 5. Sex _____ 6. Age at death ____ yrs. ____ mos. ____ days ____ hrs.

7. Address _____ Sector or division _____

HOUSING

8. Neighbor-hood _____ 9. Type of housing _____ 10. Number of rooms _____

11. Water: Piped water _____ Other _____
 Inside Outside

12. Toilet: Flush _____ Other _____ None _____

13. HOUSEHOLD ROSTER

Ind. no.	Name	Relation to head	Date of birth*	Age	Sex	Marital status	Education		Length of residence	
							Total years	Last Type	In community	Last 5 years
									Urban	Rural
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

*Enter date of birth for children under 6 years.

14. OCCUPATION

Ind. no.	Name	Currently employed	Occupation	Kind of business	Time in occupation

15. DEATHS IN HOUSEHOLD IN PAST YEAR

Name of deceased	Age	Sex	Date	Home	Hosp.	Name of hospital	Other

16. PREGNANCY HISTORY OF MOTHER

Order	Date pregnancy ended	Abortion?	Stillbirth?	Live births			
				Name of child	Sex	Living now?	Age at death
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

17. Pregnant now? Yes No Unknown 18. Remarks: _____

19. Source of _____ Ind. _____ Date _____ Interviewer _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

Confidential

Death - page 2

Name of child _____ Serial no. _____

Date of birth	Date of death	Sex	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
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20. DATA ON PARENTS

Ind. no.	Name	Live here?	Date of birth	Age	Marital status	Education	Employed now?	Occupation	Business
	Father								
	Mother								

21. Was the mother of this child seen by physician, or in a clinic or hospital during pregnancy? Yes No Unknown
 If yes, name of physician, clinic or hospital _____ Dates _____

Reason _____

Months pregnant at first visit? _____ Number of visits _____

22. Length of pregnancy _____ months Unknown

23. Were there complications during pregnancy? No Yes If yes, check below. Unknown

Edema Convulsions Threatened abortion Hemorrhage
 Trauma Operation Specify _____

Infectious disease Specify _____

24. Where born? Home Hospital Name and address _____ Other

25. Who attended birth? Doctor Midwife Other Certificate no. _____

26. Was the delivery spontaneous? No Yes Unknown Were instruments used? No Yes Unknown

Was anesthesia given? No Yes Was sedation given? No Yes Cesarean? No Yes

27. Was the general aspect of child good at birth? No Yes

If not good, what did you notice? _____

28. Birth weight _____ Unknown

29. Did you breast feed the child? Yes When did you start weaning? Age _____ months Reason _____
 When did you finish weaning? Age _____ months

No Why not? _____ Unknown

30. Was other milk used? No Yes At what age? _____ months or _____ days Times per day _____

Composition: Milk _____ Water _____ Was use of milk continued? _____

31. Was other weaning food used? _____ Was weaning food continued? _____

32. Give age in months when foods were added:	JUICES: _____ mos. Times per week _____	CEREALS: _____ mos. Times per week _____	PULSES: _____ mos. Times per week _____	ROOTS, TUBERS: _____ mos. Times per week _____
LEAFY VEGETABLES: _____ mos. Times per week _____	EGGS: _____ mos. Times per week _____	POULTRY: _____ mos. Times per week _____	MEAT: _____ mos. Times per week _____	FISH: _____ mos. Times per week _____

33. At what age (in months) did child do the following: a) raise head? _____ b) seat self? _____ c) stand alone? _____
 d) walk alone? _____ e) control bladder? _____ f) control bowels? _____ g) feed self? _____

34. Who cared for child most of day: Mother Grandmother Sibling (15 yrs.+) Sibling (-15 yrs.)
 Other relative Maid Day care Other

35. Has your child been vaccinated? Yes No Unknown If yes, which vaccinations _____

36. At what age in months did child have following: a) German measles? _____ b) measles? _____ c) chickenpox? _____
 d) whooping cough? _____ e) mumps? _____

37. Remarks: _____

38. Source of information: Mother Father Other _____

Date _____

Interviewer _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

Confidential

Death - page 3

Name of child _____ Serial no. _____

Date of birth	Date of death	Sex	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
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39. During the past year, has this child been attended by a physician or in a clinic or hospital? Yes No Unknown

Name of physician, clinic or hospital	Type*	Dates	Days in hospital	Reason	Number of visits

*Indicate whether clinic (health center or hospital) C, in-patient in hospital H, practicing physician P, emergency E.

40. Did the child receive medical attention before the past year? Yes No Unknown

Name of physician, clinic or hospital	Type*	Dates	Days in hospital	Reason	Number of visits

*Indicate whether clinic (health center or hospital) C, in-patient in hospital H, practicing physician P, emergency E.

41. Disease a) How long was the child ill? _____ b) How did illness start? _____
 c) What disease do you think caused the child's death? _____

42. Description of the disease by the mother _____

43. Home treatment _____

44. Prescriptions _____

45. Who prescribed? _____

46. Did the mother see signs of malnutrition? (edema, loss of weight, changes in hair or skin) _____

47. To doctor a) Was child taken to doctor? No Yes b) How many days after onset of illness? _____
 c) What was condition of child? Slightly ill Moderately ill Very ill

48. Where did child die? Home Hospital Name _____ Other

49. Death certificate number _____

50. Source of information: Mother Father Other
 Date _____ Interviewer _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

Confidential

Death - page 4

Name of child _____

Serial no. _____

Date of birth	Date of death	Sex	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
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DATA OBTAINED FROM HOSPITAL, CLINIC OR PHYSICIAN

51. Abnormal conditions of pregnancy	None <input type="checkbox"/>	Edema <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Albuminuria <input type="checkbox"/>	Convulsions <input type="checkbox"/>	Hyperemesis <input type="checkbox"/>	Anemia <input type="checkbox"/>	Threatened abortion <input type="checkbox"/>	Placenta previa <input type="checkbox"/>	Other, specify _____
52. Conditions unrelated to pregnancy	None <input type="checkbox"/>	German measles <input type="checkbox"/>	T b c pulm. <input type="checkbox"/>	Syphilis <input type="checkbox"/>	Operation: reason, findings _____			Trauma, specify _____		Other, specify _____
53. Delivery	Spontaneous <input type="checkbox"/>	Manipulation <input type="checkbox"/>	Forceps <input type="checkbox"/>	Cesarian <input type="checkbox"/>	Anesthesia <input type="checkbox"/>	Sedation <input type="checkbox"/>	Other, specify _____		54. Length of gestation _____	55. Single or multiple birth _____

DATA ON CHILD (age in completed months in first line)

56. Age	At birth									
57. Weight										
58. Nutritional status										

59. DATA ON NEWBORN FROM RECORD

General state: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>	Genitals: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Activity: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Extremities: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
First cry _____ min. First breathing _____ min.	Skin, color _____
Movements: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Cyanosis: General <input type="checkbox"/> Extremities <input type="checkbox"/>
Muscular tone: Increased <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/>	Jaundice: Yes <input type="checkbox"/> No <input type="checkbox"/> Time _____
Head - Size: Increased <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/>	Hemorrhagic signs: Yes <input type="checkbox"/> No <input type="checkbox"/>
Shape: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	Infection signs: _____
Cephalohematoma <input type="checkbox"/> Lacerations <input type="checkbox"/>	Lacerations: Yes <input type="checkbox"/> No <input type="checkbox"/>
Eyes, nose, ears, mouth _____	Edema _____
Neck - Rigidity: Yes <input type="checkbox"/> No <input type="checkbox"/> Masses <input type="checkbox"/>	Breathing: Normal <input type="checkbox"/> Irregular <input type="checkbox"/>
Chest: _____	Secretion _____
First voiding _____ hrs. First bowel movement _____ hrs.	Abdominal: Masses <input type="checkbox"/> Hernia <input type="checkbox"/>
First feeding _____ hrs. Type _____	Congenital anomalies: _____
Acceptance <input type="checkbox"/> Rejection <input type="checkbox"/>	

Progress: _____

60. PRINCIPAL FINDINGS IN HOSPITAL AND CLINICS, PRIOR TO ILLNESS LEADING TO DEATH

61. Source of information:	Hospital <input type="checkbox"/>	Clinic <input type="checkbox"/>	Private M. D. <input type="checkbox"/>	Other <input type="checkbox"/>	Date _____	Interviewer _____
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Death - page 5

Name of child _____ Serial no. _____

Date of birth _____	Date of death _____	Sex _____	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
---------------------	---------------------	-----------	--

PRESENT ILLNESS - EVENTS THAT LED TO DEATH OF THE CHILD

62. Date disease started _____ 63. How disease started _____

64. Main symptoms _____

65. Description of disease _____

PHYSICAL EXAMINATION (at admission to hospital or first outpatient or house visit)

66. Date _____ 67. Height _____ 68. Weight and arm circumference: Wt. _____ Arm circumference _____

69. Nutritional status _____

70. Relevant physical findings _____

71. Evolution and treatment _____

72. Source of information:	Hospital <input type="checkbox"/>	Clinic <input type="checkbox"/>	Private M. D. <input type="checkbox"/>	Other <input type="checkbox"/>
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Date _____ Interviewer _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

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Death - page 6

Name of child _____ Serial no. _____

Date of birth	Date of death	Sex	Age at death
			_____ yrs. _____ mos. _____ days _____ hrs.

DATA OBTAINED FROM HOSPITAL, OUTPATIENT SERVICE OR PHYSICIAN

73. Relevant laboratory findings _____

74. X-rays: Site _____ Date _____ Results _____

75. Other auxiliary examinations _____

76. Surgical procedures and findings _____

77. Cytology _____ 78. Biopsy _____

79. CLINICAL DIAGNOSES _____

80. Autopsy? No Yes Date _____

81. Date hospitalized	82. Date discharged	83. Where died?	Home <input type="checkbox"/>	Outpatient service <input type="checkbox"/>	Hospital less than 48 hours <input type="checkbox"/>	Hospital 48 hours or more <input type="checkbox"/>	Other <input type="checkbox"/>
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84. Source of information	Hospital <input type="checkbox"/>	Clinic <input type="checkbox"/>	Private M. D. <input type="checkbox"/>	Other <input type="checkbox"/>	Date	Interviewer
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DATA OBTAINED BY HOME VISIT OF MEDICAL INTERVIEWER

85. Date disease started _____ 86. How disease started _____

87. Main symptoms _____

88. Description of disease _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

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Death - page 7

Name of child _____

Serial no. _____

Date of birth	Date of death	Sex	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
---------------	---------------	-----	--

DATA OBTAINED BY MEDICAL INTERVIEWER IN HOME

89. Disease	a) How long was the child ill? _____	b) How did illness start? _____
	c) What do you think caused death? _____	d) Did someone else have same disease? _____
90. Fever	a) Did the child have fever? No <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Very high <input type="checkbox"/>	b) How long? _____
	c) Did you take the temperature? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) What was it? _____
91. Respiration	a) How was the respiration? Slow <input type="checkbox"/> Normal <input type="checkbox"/> Rapid <input type="checkbox"/> Difficult <input type="checkbox"/>	b) Did the sides of nose move in breathing? Yes <input type="checkbox"/> No <input type="checkbox"/>
	c) Noise? _____	
92. Cough	a) Did the child cough? No <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/>	
	b) Expectoration? No <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/>	
	c) Color of expectoration? White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> With blood <input type="checkbox"/>	
93. Vomiting	a) Did the child vomit? No <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
	b) What did he vomit? Solid <input type="checkbox"/> Liquid <input type="checkbox"/> Everything <input type="checkbox"/>	
	c) How long did he vomit? _____ days	d) Did he lose appetite? _____
94. Feces	a) How were the feces? Very hard <input type="checkbox"/> Hard <input type="checkbox"/> Normal <input type="checkbox"/> Loose <input type="checkbox"/> Liquid <input type="checkbox"/>	
	b) Color of the feces? Yellow <input type="checkbox"/> Brown <input type="checkbox"/> Green <input type="checkbox"/> Red <input type="checkbox"/> Black <input type="checkbox"/>	
	c) How many times per day? _____	d) How many days? _____ e) Were worms seen? _____
95. Urine	a) Difficulty in urination? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) Retention of urine? No <input type="checkbox"/> Yes <input type="checkbox"/>
	c) Did urine diminish? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Eliminated calculi? No <input type="checkbox"/> Yes <input type="checkbox"/>
	e) Color of urine? Dark <input type="checkbox"/> Red <input type="checkbox"/> Dirty <input type="checkbox"/>	
96. Weight	a) Did the child lose weight? No <input type="checkbox"/> A little <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
	b) Did the arms get thinner? No <input type="checkbox"/> Yes <input type="checkbox"/>	c) Legs? No <input type="checkbox"/> Yes <input type="checkbox"/>
	e) Could ribs be seen under skin? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Face? No <input type="checkbox"/> Yes <input type="checkbox"/>
97. Edema	a) Did the child have swollen legs? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) Swollen abdomen? No <input type="checkbox"/> Yes <input type="checkbox"/>
	c) Face? No <input type="checkbox"/> Yes <input type="checkbox"/>	
98. Skin	a) Did you see anything on skin? No <input type="checkbox"/> Yes <input type="checkbox"/>	
	b) Appearance? Yellow <input type="checkbox"/> Rash <input type="checkbox"/> Pustule <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/>	
	Blemishes <input type="checkbox"/> Depigmentation <input type="checkbox"/> Dryness <input type="checkbox"/>	
99. Hair	a) Did the child have much hair? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) Pull out easily? No <input type="checkbox"/> Yes <input type="checkbox"/>
	c) Change of color? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Glossy? No <input type="checkbox"/> Yes <input type="checkbox"/>
100. Neuromuscular activity	a) Did the child move actively? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) All parts of body? No <input type="checkbox"/> Yes <input type="checkbox"/>
	c) Delay in movement? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Since when _____
	e) Convulsions? No <input type="checkbox"/> Yes <input type="checkbox"/>	
101. Pain	a) Did the child have pain? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) How long? _____
	c) Continuous? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Associated with what? _____
102. Accident	a) Did the child have a fall? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) Injury? _____
	c) Other accident? No <input type="checkbox"/> Yes <input type="checkbox"/>	d) Explain _____
103. Other	What other symptoms? _____	
104. Observation	Provide data regarding these items before final illness.	
105. To doctor	a) Did you take child to doctor? No <input type="checkbox"/> Yes <input type="checkbox"/>	b) How soon after onset of illness? _____
	c) What was condition of child? Slightly ill <input type="checkbox"/> Moderately ill <input type="checkbox"/> Very ill <input type="checkbox"/>	
106. Source of information	Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	Date _____ Interviewer _____

INTER-AMERICAN INVESTIGATION OF MORTALITY IN CHILDHOOD

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Death - page 8

Name of child _____ Serial no. _____

Date of birth _____	Date of death _____	Sex _____	Age at death _____ yrs. _____ mos. _____ days _____ hrs.
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AUTOPSY REPORT

107. Autopsy number _____ 108. Interval from death to initiation of autopsy _____

109. Weight _____ 110. Arm circumference _____

111. Other anthropometric measurements _____

112. Description of cadaver (note all positive findings, especially on nutrition) _____

113. Macroscopic examination of cavities and segments (positive findings of head, thorax, abdomen, pelvis, neck, limbs) _____

114. Macroscopic examination of organs (positive findings of appearance, surface, weight, color, consistency, etc.) _____

115. Microscopic examination of organs and tissues (positive findings of organs macroscopically abnormal and of those requested) _____

116. Positive laboratory findings from autopsy _____

117. Final diagnoses from autopsy: Direct cause of death: _____

Principal diagnosis (underlying cause): _____

Secondary diagnoses (associated causes): _____

118. Associated diagnoses not related with underlying cause: _____

119. Type of autopsy	Hospital <input type="checkbox"/>	Verification of death <input type="checkbox"/>	Medico-legal <input type="checkbox"/>	Complete <input type="checkbox"/>	Partial <input type="checkbox"/>	Incomplete <input type="checkbox"/>
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Date _____ Interviewer _____

Selected Material from Provisional Report for First Year

I. QUALITY OF VITAL STATISTICS

a) Deficiency in registration and in hospital records and procedures.

Figure 2

DEATHS UNDER 5 YEARS WITHOUT REGISTRATION IN 9 PROJECTS,
FIRST YEAR OF INVESTIGATION

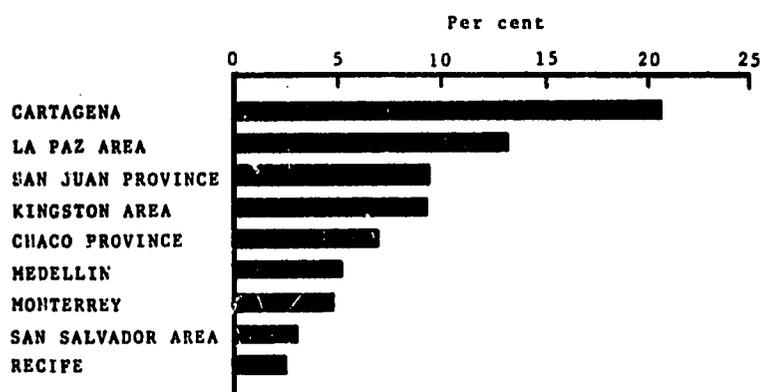
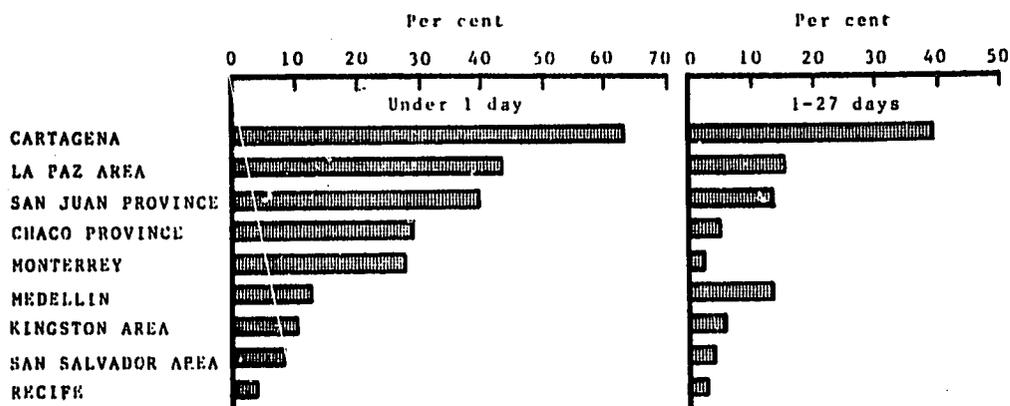


Figure 3

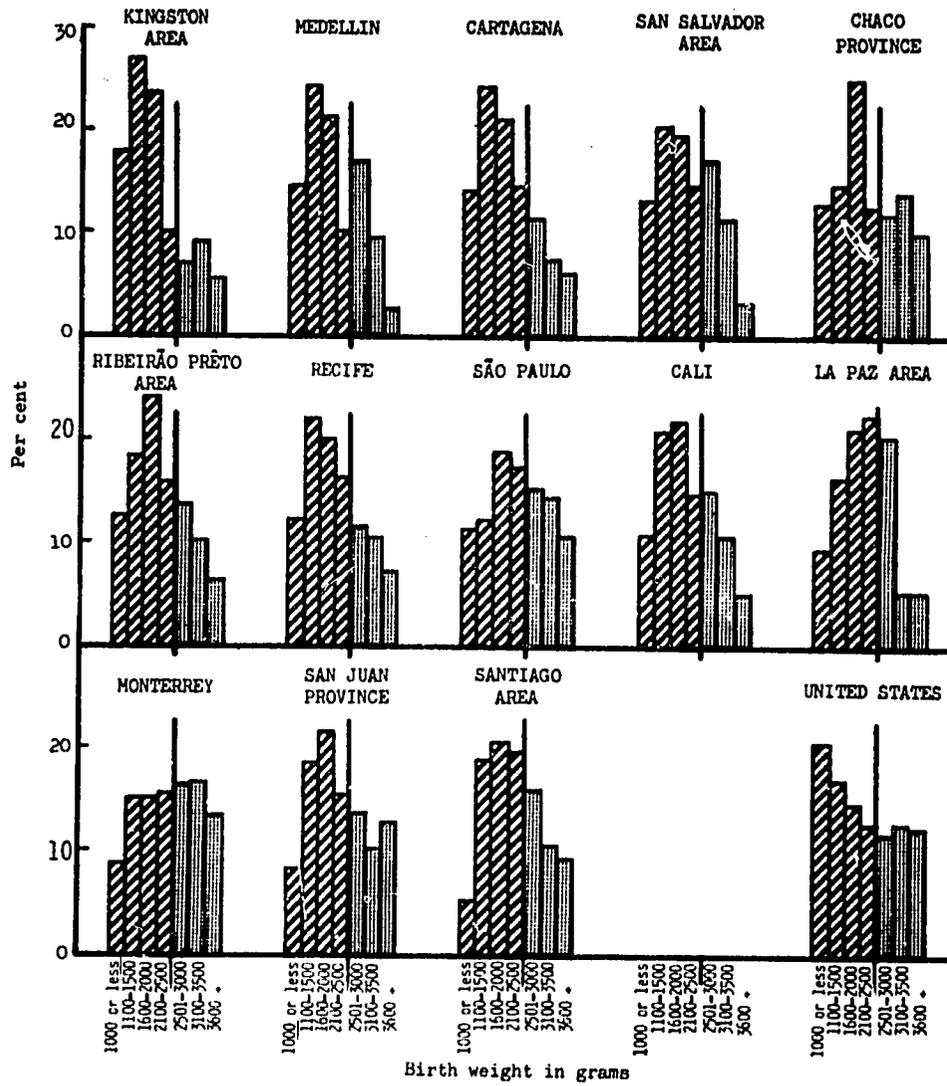
NEONATAL DEATHS WITHOUT REGISTRATION FOR TWO AGE GROUPS IN 9 PROJECTS,
FIRST YEAR OF INVESTIGATION



b) Incomplete and puzzling data by birth weight.

Figure 21

PERCENTAGE DISTRIBUTION OF NEONATAL DEATHS* BY BIRTH WEIGHT IN 13 PROJECTS, FIRST YEAR OF INVESTIGATION, AND UNITED STATES, 1950



*Excluding those with weight not stated.

II. MORTALITY BY AGE

a) Under 5 years in cities and suburban and rural areas.

Figure 4

MORTALITY UNDER 5 YEARS IN CENTRAL CITIES,
FIRST YEAR OF INVESTIGATION

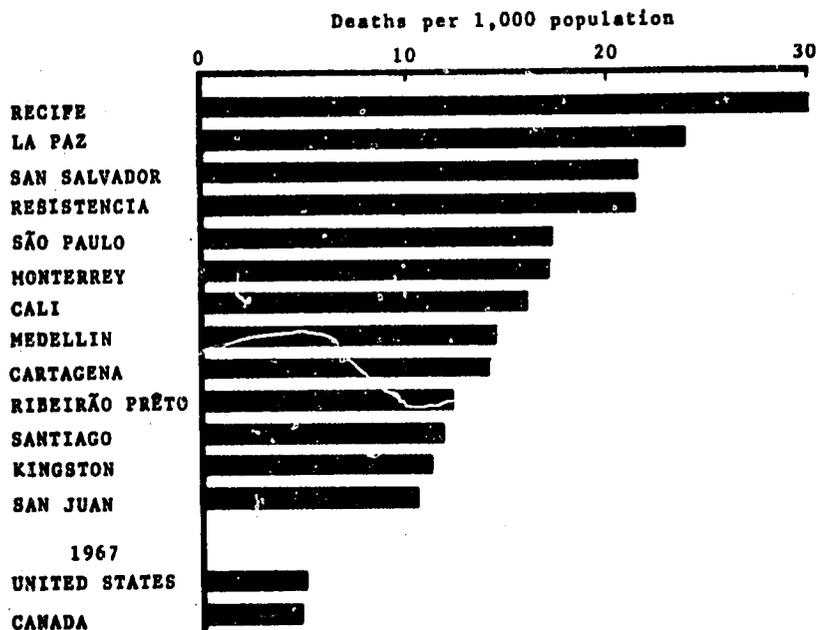
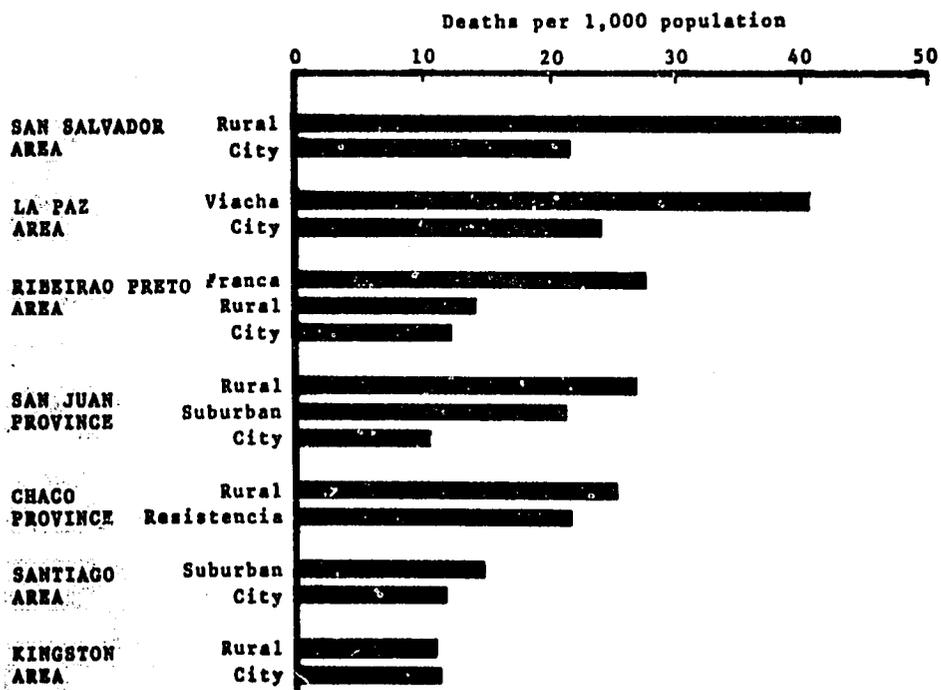


Figure 5

MORTALITY UNDER 5 YEARS IN 7 PROJECTS WITH URBAN AND RURAL AREAS,
FIRST YEAR OF INVESTIGATION



b) Infant mortality.

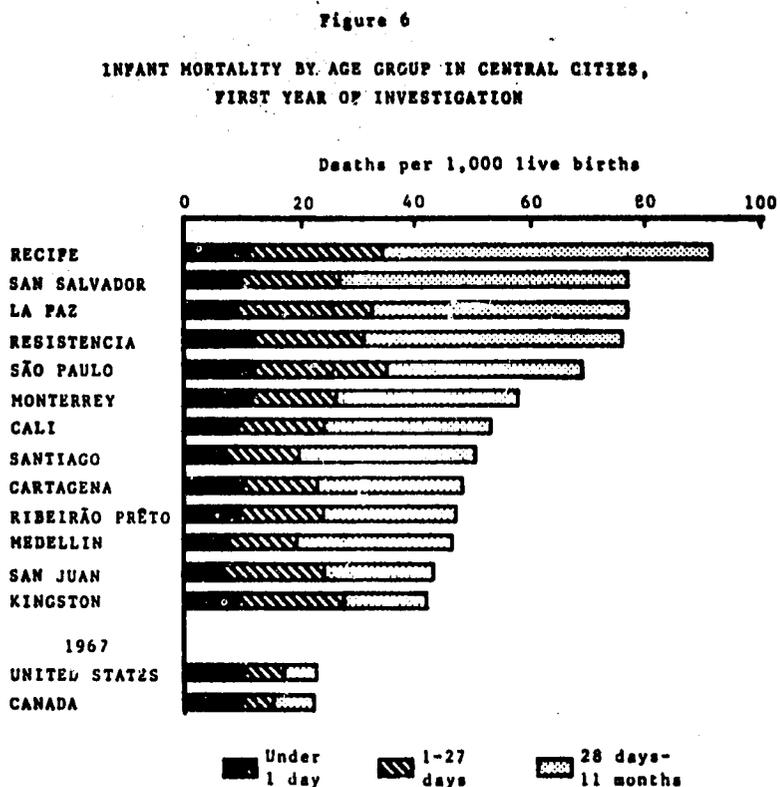


Table 6. Neonatal Deaths and Deaths Under 5 Years Expected* and Obtained in Selected Cities, First Year of Investigation

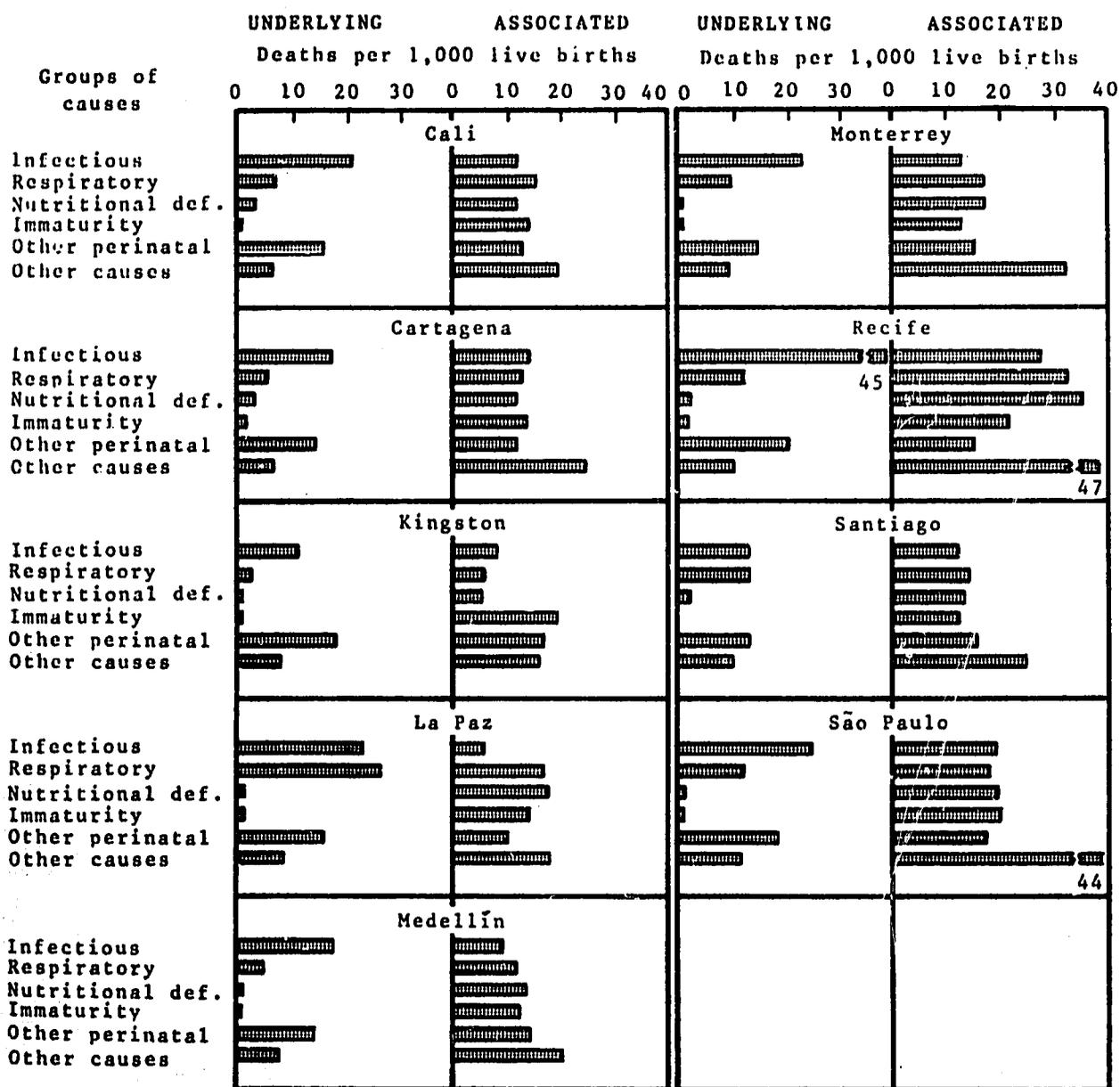
City	Neonatal deaths		Deaths under 5 years		
	Expected	Obtained Num- Per ber cent	Expected	Obtained Num- Per ber cent	
Cali	372	297 79.8	1039	964	92.8
Cartagena	235	218 92.8	638	621	97.3
Medellin	250	191 76.4	751	692	92.1
Monterrey	993	856 86.2	2458	2321	94.4
Ribeirão Preto	112	108 96.4	255	251	98.4
San Juan	72	68 94.4	137	133	97.1
San Salvador	399	361 90.5	1378	1334	96.8
Santiago	474	309 65.2	1080	915	84.7

*Based on 30 neonatal deaths expected per 1,000 live births in cities with infant death rates of 50 or over and 25 neonatal deaths per 1,000 live births in cities with infant death rates of less than 50.

III. UNDERLYING AND ASSOCIATED CAUSES OF MORTALITY

Figure 12

UNDERLYING AND ASSOCIATED CAUSES OF INFANT DEATHS BY BROAD GROUPS IN 9 CITIES, FIRST YEAR OF INVESTIGATION



IV. MORTALITY WITH NUTRITIONAL DEFICIENCY

Figure 25
MORTALITY FROM ALL CAUSES AND WITH NUTRITIONAL DEFICIENCY OF CHILDREN 1-4 YEARS
IN CENTRAL CITIES, FIRST YEAR OF INVESTIGATION

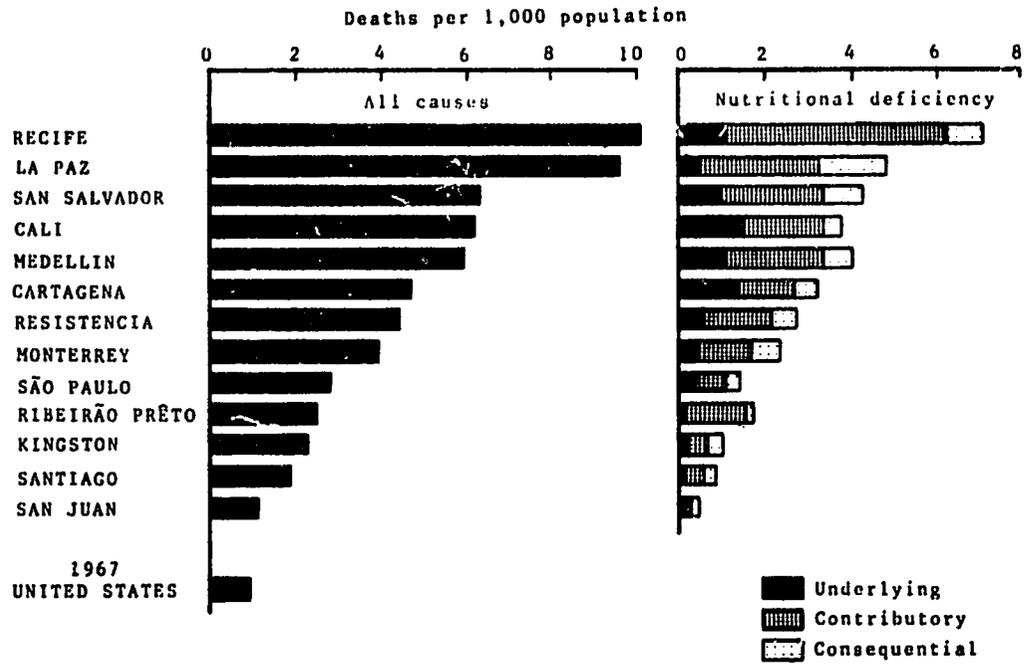
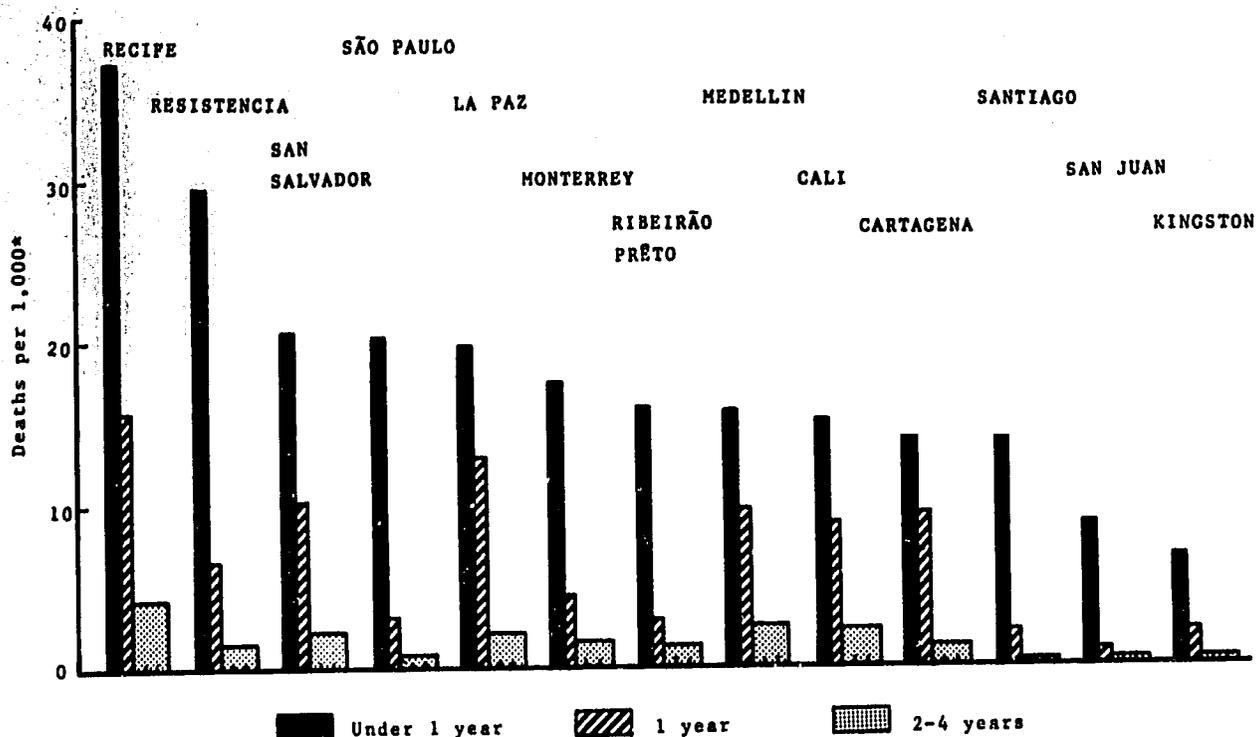
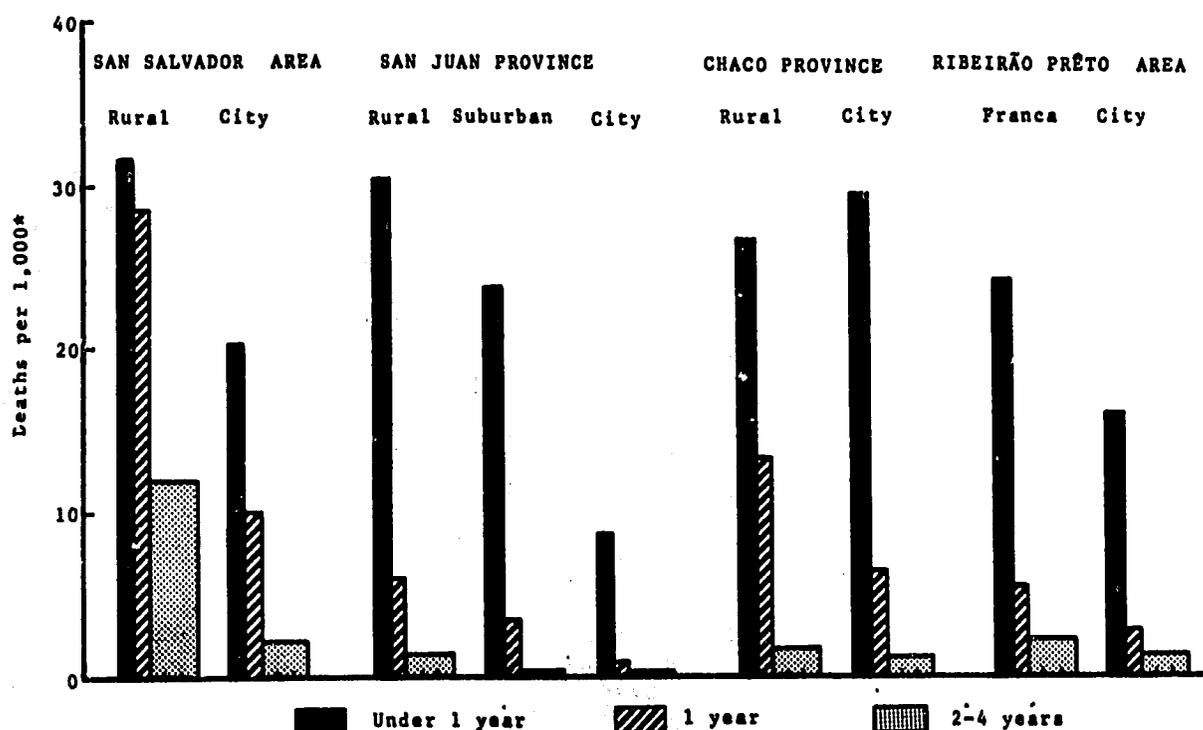


Figure 32
 NUTRITIONAL DEFICIENCY AS UNDERLYING OR ASSOCIATED CAUSE OF DEATH
 FOR THREE AGE GROUPS IN CENTRAL CITIES, FIRST YEAR OF INVESTIGATION



*Under 1 year: deaths per 1,000 live births
 1-4 years: deaths per 1,000 population

Figure 33
 NUTRITIONAL DEFICIENCY AS UNDERLYING OR ASSOCIATED CAUSE OF DEATH FOR THREE AGE GROUPS
 IN URBAN AND RURAL AREAS OF 4 PROJECTS, FIRST YEAR OF INVESTIGATION



*Under 1 year: deaths per 1,000 live births
 1-4 years: deaths per 1,000 population

VI. OUTCOME OF PREVIOUS PREGNANCIES - EXAMPLE OF INFANT MORTALITY

Figure 60
 INFANT MORTALITY IN CENTRAL CITIES AND IN PRODUCTS OF PREVIOUS PREGNANCIES
 OF MOTHERS OF DECEASED CHILDREN, FIRST YEAR OF INVESTIGATION

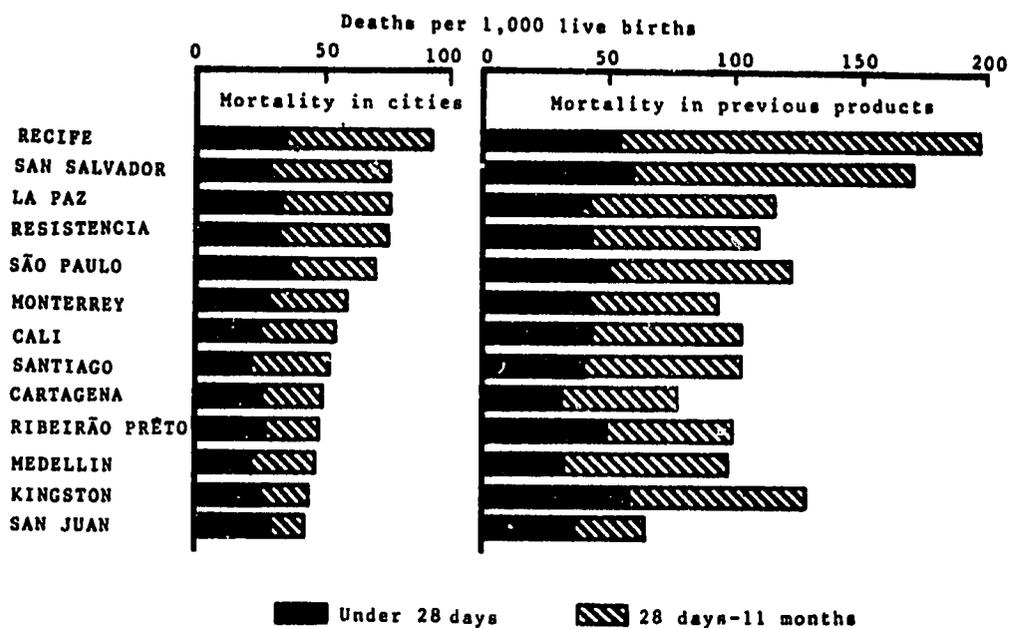
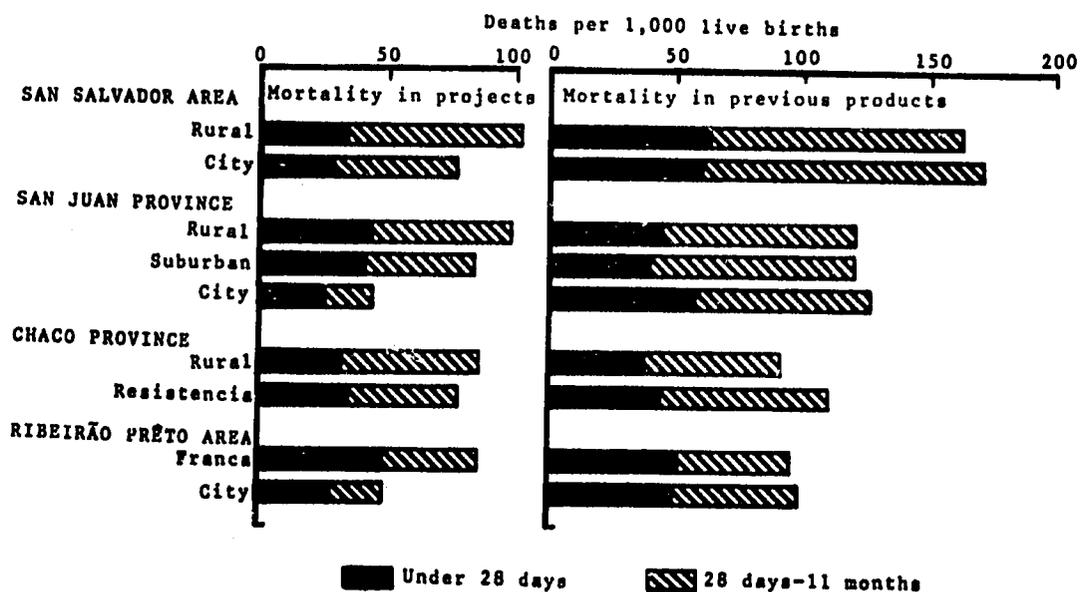


Figure 61

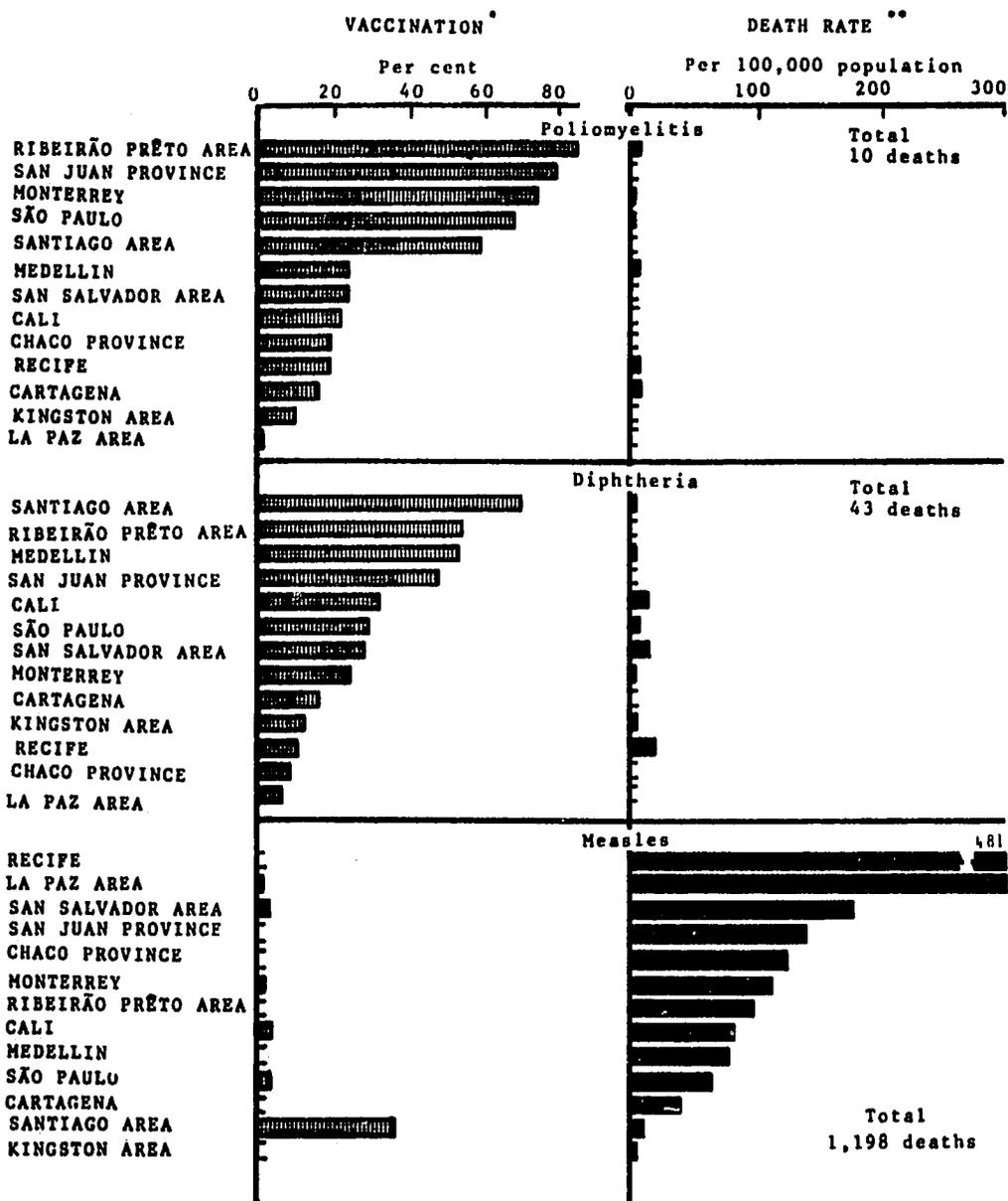
INFANT MORTALITY IN URBAN AND RURAL AREAS OF 4 PROJECTS AND IN PRODUCTS OF PREVIOUS
 PREGNANCIES OF MOTHERS OF DECEASED CHILDREN, FIRST YEAR OF INVESTIGATION



V. MORTALITY DUE TO MEASLES AND VACCINATIONS

Figure 49

FREQUENCY OF VACCINATION AGAINST SPECIFIED DISEASES AND DEATH RATES FOR 13 PROJECTS, FIRST YEAR OF INVESTIGATION

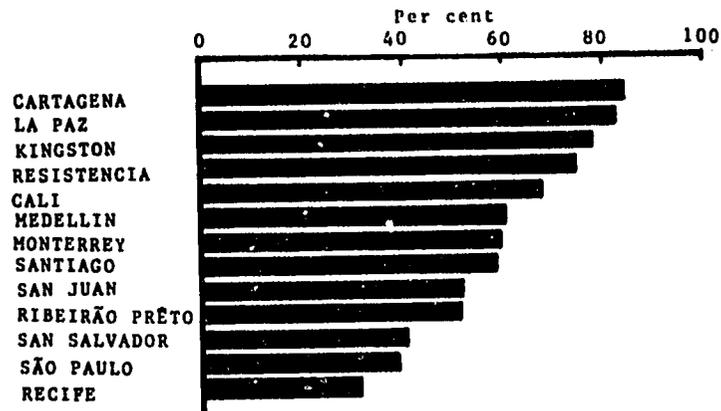


*Children 1-4 years
 **Deaths under 5 years

VII. BREAST FEEDING

Figure 64

PERCENTAGE OF DECEASED CHILDREN UNDER 5 YEARS* BREAST FED ONE MONTH OR LONGER IN CENTRAL CITIES, FIRST YEAR OF INVESTIGATION



*Excluding neonatal deaths

VIII. PROVISION OF WATER SUPPLIES

Figure 68

PERCENTAGE OF HOMES OF DECEASED CHILDREN WITH PIPED WATER IN CENTRAL CITIES, FIRST YEAR OF INVESTIGATION

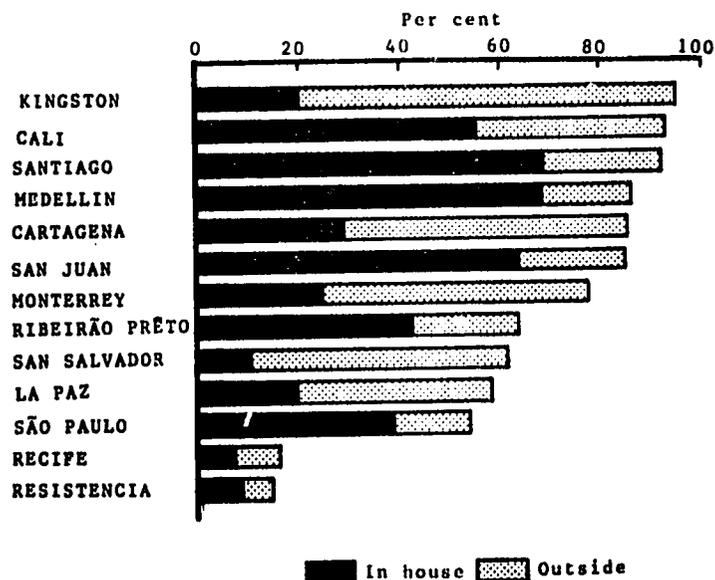


Figure 69
 PERCENTAGE OF HOMES OF DECEASED CHILDREN WITH PIPED WATER IN URBAN
 AND RURAL AREAS OF 4 PROJECTS, FIRST YEAR OF INVESTIGATION

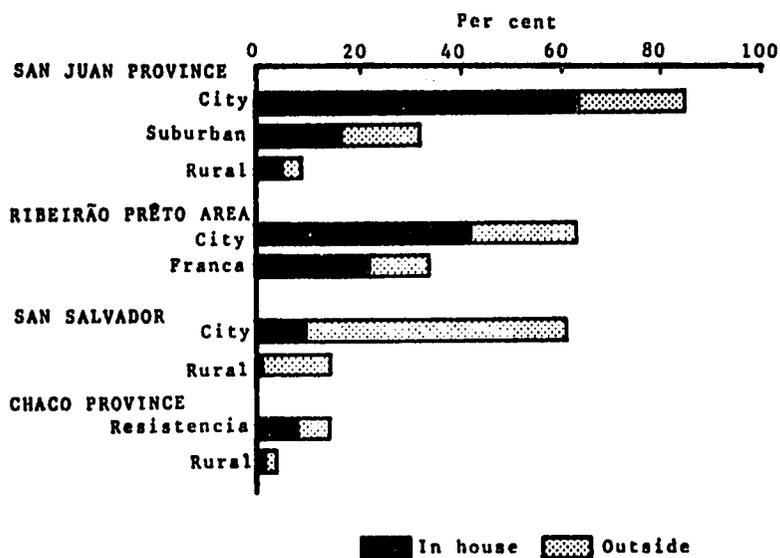


Figure 70
 PERCENTAGE OF HOMES OF DECEASED CHILDREN WITH PIPED WATER AND MORTALITY
 UNDER 5 YEARS IN URBAN AND RURAL AREAS OF 4 PROJECTS,
 FIRST YEAR OF INVESTIGATION

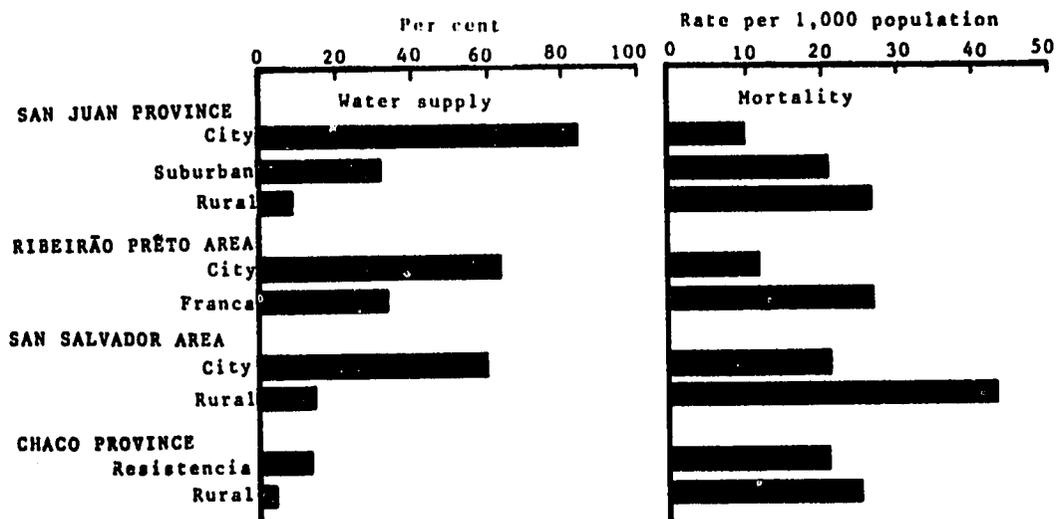
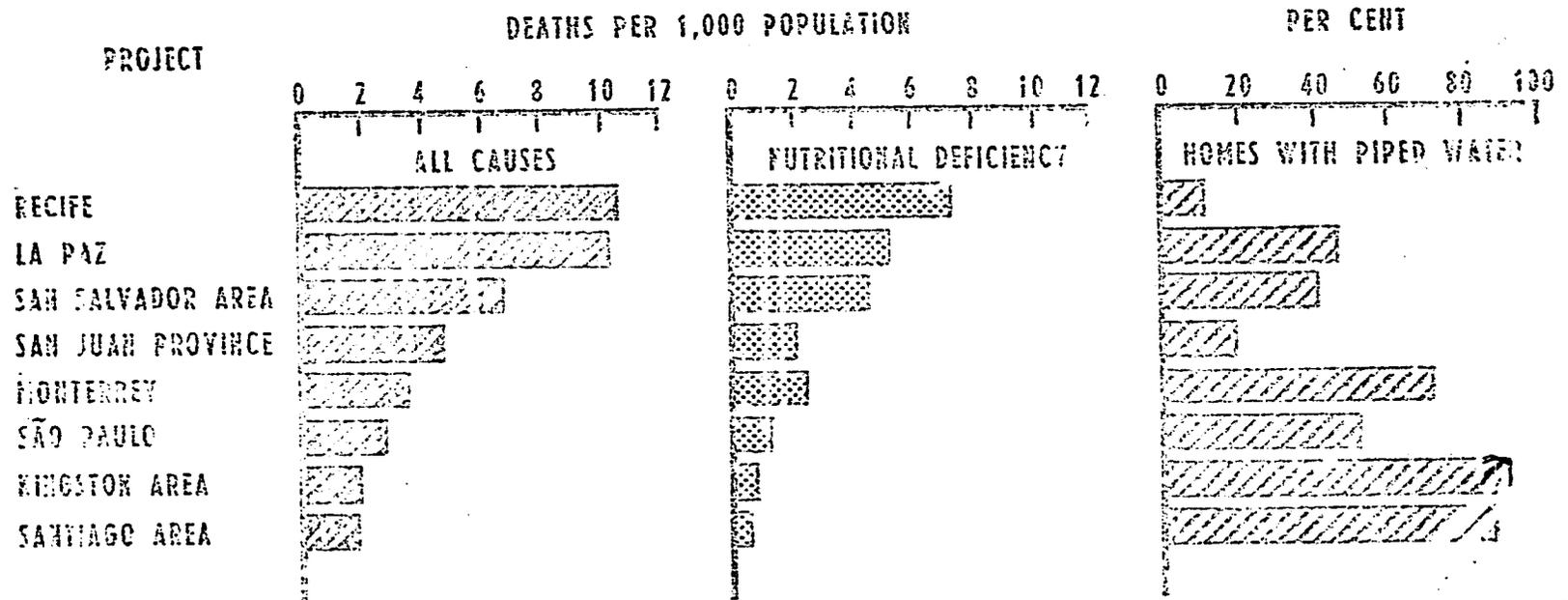


Figure 5

DEATH RATE FROM ALL CAUSES AND FROM NUTRITIONAL DEFICIENCY AS UNDERLYING OR ASSOCIATED CAUSE AND PERCENTAGE OF HOMES WITH PIPED WATER IN AGE GROUP 1-4 YEARS, FOR 6 PROJECTS



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