POPULATION
AND HEALTH DATA
FOR LATIN AMERICA

Albert M. Marckwardt
Luis H. Ochoa

Demographic and Health Surveys (DHS)/
Macro International Inc.

Pan American Health Organization (PAHO)

Bureau for Latin America and the Caribbean/
U.S. Agency for International Development (USAID)

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For information about the DHS program, write to:

DHS/Macro International Inc.
8850 Stanford Boulevard Suite 4000
Columbia, MD 21045 USA
Telephone 410-290-2800/Telex 198116/Fax 410-290-2999.

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CONTENTS

Introduction ............................................... 1
Fertility ..................................................... 2
Contraception .............................................. 4
Fertility Planning .......................................... 6
Unmet Need for Contraception ...................... 8
Infant and Child Mortality ............................. 10
Antenatal Care and Attention at Delivery ........ 13
Breastfeeding and Supplemental Feeding .......... 15
Immunization of Children .............................. 17
Nutritional Status of Children ...................... 20
Prevalence and Treatment of Diarrhea ............ 22
Fertility Risk Status ................................... 24
Statistical Appendices ................................. 27
Introduction

The Demographic and Health Surveys (DHS) is a program begun in 1984 to assist governments and private agencies in developing countries to conduct national sample surveys on population and health.

The main objectives of the DHS program are: (1) to provide decisionmakers in survey countries with data and analyses useful for informed policy choices, (2) to expand the international population and health database, (3) to advance survey methodology, and (4) to develop in participating countries the skills and resources necessary to conduct demographic and health surveys.

Surveys in participating countries are nationally representative of women age 15-49. They are designed to provide information on levels and trends of fertility, infant and child mortality, family planning, and maternal and child health including nutritional status of children. The data are intended to be used by program managers and policymakers to evaluate and improve family planning and health programs.

In this report, comparative population and health data are analyzed for the following DHS surveys conducted between 1986 and 1989: Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, Guatemala, Mexico, and Peru. Two countries, El Salvador (1985) and Trinidad and Tobago (1987), are not included in this comparative analysis. The countries included in the report, with a population of 314 million out of an estimated total of 414 million in 1988, provide an overview of the Latin American region in the second half of the 1980s. Second-round surveys have already being conducted in Colombia (1990), Dominican Republic (1991), Peru and Brazil (1991/1992); and will be conducted soon in Mexico, Guatemala, and Bolivia. The new data will be included in an updated comparative report in 1995 which will further document the changes that Latin America is undergoing.

### Basic Background Data

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<thead>
<tr>
<th>Country</th>
<th>Year of DHS</th>
<th>Population size (millions)</th>
<th>Urban (%)</th>
<th>GNP per capita</th>
<th>Life expectancy (£)</th>
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<td>2020</td>
<td>65</td>
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<tr>
<td>Colombia</td>
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<td>69</td>
<td>1240</td>
<td>65</td>
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<tr>
<td>Dominican Rep.</td>
<td>1986</td>
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<td>59</td>
<td>730</td>
<td>67</td>
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<tr>
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<td>10.0</td>
<td>55</td>
<td>1040</td>
<td>66</td>
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<tr>
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<td>41</td>
<td>950</td>
<td>63</td>
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<tr>
<td>Mexico</td>
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<td>71</td>
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<td>69</td>
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<td>Peru</td>
<td>1986</td>
<td>21.0</td>
<td>69</td>
<td>1470</td>
<td>63</td>
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Fertility

Current Levels of Fertility and Recent Trends

According to various sources, by the mid-1980s the total fertility rate in Latin America had fallen below four children per woman. The total fertility rate (TFR) measures the number of children that would be born to a woman during her lifetime if she passed through her childbearing years conforming to the age-specific fertility rates of a given period for a given population. The range of fertility levels is well illustrated by the countries represented in the Demographic and Health Survey Program (DHS): rates of well below four children per woman in Colombia, Brazil and the Dominican Republic; rates of approximately four in Mexico, Ecuador and Peru; and much higher rates in Bolivia and Guatemala (see Chart 1).

The rapid drop in levels of fertility can be traced with DHS data, as well. Among the eight countries presented in Chart 1, the average decline in the total fertility rate from the period 4 to 7 years (48-95 months) prior to the survey to the period 0 to 3 years (1-47 months) prior to the survey was 0.85 children. This represents a sizable drop of two-tenths of a child per year. The pace of decline appears to be fairly constant, whether dealing with Colombia, with a starting TFR of 4.0, or Guatemala, with a starting fertility rate of 6.5.

Differential Fertility

It is well documented that fertility declines begin in the urban areas, often with the advent of organized family planning programs, and then gradually extend to rural areas. In four of the eight DHS countries represented in Chart 2, namely Bolivia, Guatemala, Mexico and Peru, the TFR for the rural areas varies between 6.3 and 6.9. In these countries the contraceptive revolution has not yet spread to rural areas, and the urban-rural differential in fertility is extreme (3.3 vs 6.9 in the case of Peru). In the remaining four countries, the TFR for rural areas is 5.5 or less, and the average difference in the TFR between rural and urban areas is just two children. In five of the eight countries, the TFR for urban areas varies between 2.8 to 3.3 children.
Undoubtedly the strongest social differential of fertility is the level of women's education. In all but two countries, the TFR for women with no formal education is well over 6, while for all of the countries except one, the TFR for women with 7 or more years of schooling is under 3 (see Chart 3). In general, the progressive decline of the TFR with increases in education is monotonic. However, in the cases of Bolivia, Ecuador and Mexico the TFRs appear to be unaffected until at least 4 years of education have been completed. The data can be summarized by calculating the unweighted means for the eight countries: the TFRs for women with no schooling, with 1-3 years, with 4-6 years and with 7 or more years of schooling are, respectively, 6.4, 5.7, 4.3 and 2.7 children.

It seems likely that increases in the level of education attained by women will lead to reduced fertility, apart from actions on the part of governmental or private family planning programs. To take an example, in the nine years separating the World Fertility Survey (WFS) and the DHS in Peru, the percentage of women of ages 15 to 49 with no schooling fell from 20 to 11, while the percentage with at least some secondary education rose from 36 to 51. During the same period, the contraceptive prevalence rate increased by 50 percent, in the absence of any aggressive family planning effort.
Contraception

Contraceptive Prevalence

The level of use of contraceptive methods by currently married women varies widely among countries in Latin America (see Chart 4). Contraceptive prevalence rates in Brazil and Colombia approach those of developed countries (66 percent and 65 percent, respectively); another set of countries, represented by the Dominican Republic, Ecuador, Mexico and Peru in DHS, present rates that vary from 44 percent to 53 percent; finally, two countries, Bolivia and Guatemala, have low rates (30 percent and 23 percent, respectively) which indicate that family planning is still at an incipient stage. In addition, traditional methods account for sixty percent of contraceptive prevalence in Bolivia and fifty percent in Peru.

Differentials in Prevalence of Use

Prevalence rates for contraceptive use are higher in urban areas than in rural areas in all eight countries. The differential is least in those countries with the longest tradition of activist family planning programs, represented here by Brazil, Colombia and the Dominican Republic. In the remaining countries, the differential is at least 20 percentage points, reaching an extreme of 35 points in the case of Peru. Surprisingly, contraceptive prevalence is relatively high in urban areas of Mexico and Peru.

The level of education of women is an even stronger differential of contraceptive use (see Chart 5). In four of the countries the prevalence of use among women with no formal schooling does not surpass 20 percent, while in another set of four the prevalence rate among women with at least some secondary education exceeds 60 percent. The difference in prevalence between women with no schooling and those with secondary education exceeds 40 percentage points in Guatemala, Mexico and Peru. Once again, the differential effect of education is least in those countries with the most mature programs, namely Brazil, Colombia and the Dominican Republic.
Use of Specific Contraceptive Methods

The mix of methods used in the various Latin American countries varies widely. The pill, once very popular in most of Latin America, is now utilized by less than 20 percent of users in all but Colombia and Brazil (Chart 6 highlights, for each country, the prevalence rate for the method most frequently used). Sterilization is the method most relied on by women in all countries except Bolivia and Peru. It is the preferred method of 66 percent of users in the Dominican Republic, and more than 40 percent in Brazil and Guatemala. In the absence of good delivery systems, traditional methods, principally rhythm, are relied on heavily in Bolivia and Peru.

Chart 6
Method mix of current use among currently married women

<table>
<thead>
<tr>
<th></th>
<th>Percent Distribution of Use</th>
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<tbody>
<tr>
<td></td>
<td>PILL</td>
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<tr>
<td>Legend</td>
<td></td>
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<tr>
<td>BOLIVIA</td>
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</tr>
<tr>
<td>BRAZIL</td>
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<tr>
<td>COLOMBIA</td>
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<td>GUATEMALA</td>
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<tr>
<td>MEXICO</td>
<td>0</td>
</tr>
<tr>
<td>PERU</td>
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</tbody>
</table>
Fertility Planning

The Levels of Unwanted Fertility

In all of the DHS surveys, except Mexico, each woman was asked, concerning each child born in the five years prior to the survey, whether at the time she became pregnant she had wanted that pregnancy then, would have preferred to wait until later, or would have preferred to have no more children at all. This type of question is known for its very low test/retest reliability in reinterview surveys, its very high correlated response variance (i.e., interviewer effect), and its subjectivity to memory lapse. In an attempt to overcome the last named problem, the following discussion is limited to children born in the 12 months prior to interview.

The percentage of pregnancies which were wanted at the time they occurred varies widely, as highlighted in Chart 7, from 33 percent in Bolivia to 71 percent in Guatemala. Conversely, the levels of unwanted fertility range from 13 percent in Guatemala, on the one hand, to 32 percent in Brazil and Peru, and to 40 percent in Bolivia. The low figure for unwanted fertility in Guatemala results from a relatively large desired family size, coupled with only a recent awareness that women can control their fertility. The large amount of unwanted fertility in Peru and Bolivia stems in part from high failure rates of traditional methods of contraception, while in Brazil it is attributable principally to a small desired family size. Timing failures (i.e., children wanted at a later time) show the least amount of intercountry variability, ranging from 16 to 34 percent.
Differentials in Unwanted Fertility

The factor that is most highly correlated with unwanted fertility is the number of living children that a woman has. The figures included in Chart 8 highlight the difference between women with only one child and women with four or more. In Bolivia, Brazil and Peru more than half of women with four or more living children declared that they had not wanted the pregnancy leading to their last child. Unwanted fertility is also linked to the level of education attained by women (see Chart 9). The levels of unwanted fertility are generally much lower among women with at least some secondary education than among those with no schooling or with only primary school education. The fact that this relationship appears not to hold in Guatemala suggests once again that the concept of unwanted fertility is still poorly defined there. Considering only women with no schooling, the remaining countries cluster in two groups: Bolivia, Brazil and Peru, where roughly one-half of last births were unwanted, and Colombia, the Dominican Republic and Ecuador, where about a quarter were unwanted.
Unmet Need for Contraception

Unmet Need for Spacing and for Limiting

The concept of an unmet need for contraception grows out of the fact that many women wish to space their children, while others want no more children at all, but they are not using a contraceptive method. Women not using contraception, who are married and fecund, are classified as having an unmet need for contraception for limiting if they want no more children; and as having an unmet need for spacing if they don’t want a (another) child within the next two years. The total unmet need for contraception is the sum of these two components.¹

The two countries with the lowest levels of unmet need for contraception, Brazil and Colombia, both 13 percent of currently married women, are the two with the highest levels of contraceptive prevalence (see Chart 10). At the other extreme, with unmet need ranging from 28 percent to 36 percent, are Peru, Guatemala and Bolivia. As might be expected from the findings concerning unwanted fertility, the greatest need for contraception in Peru and Bolivia is for limiting childbearing, while in Guatemala it is more evenly balanced between spacing and limiting. The Dominican Republic, Ecuador and Mexico have moderate levels of unmet need, varying between 19 percent and 24 percent, with the need about evenly split between spacing and limiting.

Differentials of Unmet Need

In all of the countries studied, unmet need for contraception is greater in rural areas than in urban areas (see Chart 11). The differential is particularly strong in Peru, where unmet need in rural areas is 2.4 times greater than in urban areas. The greatest unmet need in urban areas is in Bolivia and Guatemala, and the greatest unmet need in rural areas is in Peru and Bolivia.

¹Details of the measurement procedure, particularly the treatment of pregnant and amenorrheic women, are contained in Charles F. Westoff and Luis H. Ochoa (1991) Unmet Need and the Demand for Family Planning. DHS Comparative Studies No 5. Columbia, Maryland: IRD
Unmet need for contraception is inversely related to the level of education attained by women (see Chart 12). Unmet need among women without schooling ranges from 22 percent in Colombia to 45 percent in Bolivia and 49 percent in Peru. At the other extreme, unmet need among women with secondary education varies between 5 percent and 16 percent, with Bolivia much higher at 22 percent. In all cases, unmet need among women with a primary education lies between that of unschooled women and those with a secondary education. The pattern is smoothly monotonic in all countries except Bolivia and Guatemala, where women with primary education have a greater unmet need than might be expected.

**Unmet Need and the Demand for Family Planning**

The levels of unmet need presented in the foregoing section reveal only partially the potential demand for family planning in Latin America. To estimate the total demand, women who are current users of contraception and those who became pregnant while using must be added to those with an unmet need. Except Guatemala, where demand amounts to only a little more than one-half of currently married women, in the surveyed countries total demand varies between 70 and 80 percent. This figure is similar to the mean prevalence of contraceptive use in developed countries during the past fifteen years.
Infant and Child Mortality

Levels and Trends in Infant and Child Mortality

According to several sources, the level of infant and child mortality differs widely among the various Latin American countries, and within individual countries. Some of the Caribbean islands, as well as Costa Rica in Central America, have infant mortality rates nearly as low as the most developed countries of the world. Infant mortality is the number of infants who die (per thousand births) before reaching their first birthday. Child mortality represents the number of children who die (per thousand) between their first and fifth birthdays, while neonatal mortality is the number of infants who die (per thousand births) in the first month after birth.

Among DHS countries, Colombia and Mexico stand out for their low infant mortality rates (see Chart 13). At the other extreme are Brazil, Guatemala and Peru, with infant mortality rates ranging from 73 to 76 per thousand, and finally Bolivia, with an estimated rate of 86 per thousand.

Neonatal mortality rates vary from 19 to 39 per thousand. The variability among postneonatal rates is much larger. Noteworthy are the low child mortality rates for Brazil, Colombia and Mexico, and the correspondingly high rates for Bolivia, Guatemala and Peru. The trend in child mortality has been downward during the past two decades in each of the countries represented in the DHS.

The under-five mortality rate is the number of children per thousand births who die before their fifth birthday. The steepest relative decline has occurred in Colombia; the largest numerical declines have occurred in Ecuador, and to a lesser extent, in Guatemala and Brazil (see Chart 14). Steep declines for the most recent period are evident for Brazil, Guatemala and Mexico.
Differential Infant Mortality

A number of biological factors are linked to infant mortality. Research based on data from the WFS and the DHS surveys has clearly established that birth order, mother’s age at birth, and birth spacing play important roles in determining the probability of an infant death. Of the three variables, the length of the preceding birth interval has the clearest differential effect on infant mortality (see Chart 15). In all of the DHS countries studied there is a steep drop in infant mortality when births are spaced by at least two years instead of shorter intervals. In only three of the countries (Bolivia, Colombia and Peru) is there any further gain by spacing births at least four years apart. One feature of Chart 15 that stands out is the extremely high mortality associated with intervals of less than two years in Bolivia, Brazil, Guatemala and Peru: rates in excess of 120 per thousand. A strong argument for family planning campaigns is, therefore, the reduction of short birth intervals, which are associated with higher levels of infant mortality.

In most of the countries studied there is an excess infant mortality in rural areas as compared to urban areas (see Chart 16). The most extreme cases are Mexico and Peru, where the rural infant mortality rates exceed the urban rates by more than 80 percent. On the other hand, in Colombia and the Dominican Republic there is no evidence of differential mortality by urban-rural residence. Noteworthy are the very high rates for rural areas in Bolivia, Brazil and Peru: well in excess of 100 per thousand.
The level of education of mothers is closely related to the frequency with which infants die (see Chart 17). The relationship is seen most clearly in Brazil, Mexico and Peru where the infant mortality among mothers without schooling exceeds that of mothers with secondary education by factors in the range of three to five. Even in Colombia and the Dominican Republic, which showed no urban-rural differentials, there is a strong educational differential. In both countries, the infant mortality rate for mothers with no formal education is about double that for mothers with secondary education. The gradient of decline in most DHS countries is monotonic with increases in education. However, in Bolivia and Guatemala, real gains become apparent only with some secondary schooling.

Rates and Probabilities

The complete birth histories collected in surveys of the DHS program are ideal from the standpoint of estimating mortality in the early years of life. They do not, however, permit estimation of adult mortality or other measures of general mortality conditions, such as life expectancy at birth.

The mortality estimates presented here are not rates but true probabilities, calculated according to the conventional life table approach from the complete birth histories in the DHS surveys. For a given calendar period, deaths and exposure in that period are first tabulated for the age intervals 0, 1-2, 3-5, 6-11, 12-23, 24-35, 36-47, and 48-59 months. Then age interval specific probabilities of survival are calculated. Finally, probabilities of mortality for larger age segments are produced by multiplying the relevant age interval survival probabilities together and subtracting the product from one.

Antenatal Care and
Attention at Delivery

Antenatal Care

The proportion of women receiving antenatal care varies widely among countries in Latin America: from less than half (47 percent) in Bolivia to nearly all (96 percent) in the Dominican Republic. Women who seek antenatal care nearly always receive professional attention, i.e., from a doctor, obstetrician or trained nurse. Only in Guatemala do midwives still play an important role.

The practice of vaccinating pregnant women to protect infants from neonatal tetanus has grown considerably in the past decade. The percentage of women receiving tetanus toxoid vaccine varies greatly: from about 15 percent in Peru and Guatemala to 87 percent in the Dominican Republic. The greatest increase in tetanus coverage has been in the countries in which coverage is lowest. In Bolivia, for example, tetanus coverage increased from 15 percent five years before the survey, to 32 percent in the year preceding the survey.

The differentials in antenatal care are similar to those discussed below in relation to attention at birth.

Attention at Delivery

The type of attention women receive at the time of delivery varies widely in Latin America. The proportion of mothers receiving professional health care (from a doctor, obstetrician or professional nurse) varies from 29 percent in Guatemala to 90 percent in the Dominican Republic (see Chart 18). The bulk of births in Guatemala are attended by midwives (60 percent), while in Bolivia 41 percent of births are attended by friends or relatives.
Differentials of Professional Attention

Since most health professionals reside in urban areas, the proportion of mothers receiving professional care at the national level depends largely on the geographical distribution of births. In all of the countries studied, with the exception of Bolivia and Guatemala, over 80 percent of mothers residing in urban areas received professional care on giving birth in the five years preceding the survey (see Chart 19). The situation in rural areas is much more variable: while less than a fifth of rural mothers receive professional attention in Peru and Guatemala, one-half or more of mothers do so in the rural areas of Colombia, Brazil and the Dominican Republic. The Dominican Republic stands out for the high proportion (83 percent) of rural births attended by a health professional.

The strongest determinant of the type of attention received at birth is the educational level attained by the mothers (see Chart 20). In all eight of the surveyed countries, over 80 percent of births to mothers with secondary education were attended by health professionals. The contrast with mothers having no schooling is particularly sharp in Bolivia, Guatemala and Peru, where only 11 to 13 percent were attended by a professional.
Breastfeeding and Supplemental Feeding

Prevalence and Duration

Breastfeeding is an important public health concern, because breast milk is the ideal source of nutrition for infants and also provides antibodies to protect them from disease. A large majority of women in Latin America breastfeed their children. Among the eight countries surveyed in the DHS, the proportion of births who started breastfeeding ranges from 83 percent in Mexico to 96 percent in Bolivia (see Chart 21).

Despite the high percentage of infants who were breastfed, the median duration of breastfeeding varies widely: from 6 months in Brazil to 21 months in Guatemala. DHS countries in Latin America show two distinct groupings with respect to duration of breastfeeding: the traditional pattern of prolonged breastfeeding, reflected in Guatemala and the three Andean countries (Bolivia, Ecuador and Peru); and the pattern of short breastfeeding in Brazil, Colombia, the Dominican Republic and Mexico.

Differentials in the Duration of Breastfeeding

Women residing in urban areas have shorter durations of breastfeeding than those in rural areas (see Chart 22). The differences are often modest, only 2 or 3 months in four countries, but reach 8 and 9 months in Peru and Mexico, respectively. Even larger differences in the duration of breastfeeding are seen when the level of women’s education is considered (see Chart 23, page 16).
In each of the countries the relationship is monotonic: women without schooling have longer durations than women who attended primary school, and these in turn have longer durations than women who attended secondary school. The contrasts between the most extreme educational categories are particularly notable in Guatemala, Mexico and Peru. In Bolivia and Ecuador, primary education has little impact on shortening the duration of breastfeeding.

Fears are often expressed that, over time, with increasing education and urbanization, women will be less likely to breastfeed their children, and that those who do so will breastfeed for shorter durations. This is not a necessary outcome. During the nine years separating the WFS and DHS surveys in Peru, the prevalence of breastfeeding rose from 91 percent to 94 percent, and the mean duration increased from 13 to 16 months. It is thought that this came about as a result of the Ministry of Health’s campaigns to promote breastfeeding, and the increasingly difficult economic situation, which restricted the purchase of milk substitutes among large segments of the population.
Immunization of Children

Immunization Coverage

During the 1980s immunization became a major focus of child survival programs throughout the world. Mass immunization programs were undertaken in a majority of less developed countries, with the result that in many of these countries a higher percentage of children are today protected against disease than are their counterparts in the United States. In the majority of DHS countries, information on immunizations was collected from health cards; in others this information was either replaced by or supplemented with maternal recall, while in two countries no information was collected on immunization (Dominican Republic and Ecuador). The vaccinations inquired about were: BCG, three doses of DPT and of polio vaccine, and measles vaccine.

Data available for Latin America are summarized in Chart 24 for DPT vaccine. The coverage for the first dose is good, ranging from 70 percent in Bolivia to 90 percent in Colombia. But only Brazil and Colombia have good followup coverage, with 70 percent and 72 percent (respectively) fully immunized by their second birthday. The proportion of children lost to followup is particularly high in Bolivia, Guatemala and Mexico.
Chart 25
Immunization coverage for DPT among children 12-35 months by residence

Differentials in Immunization Coverage

Differentials in coverage are examined for the third dose of DPT vaccine among children 12 to 35 months of age. (Two-year-olds are included to increase the size of the denominators.) Coverage is greater in urban than in rural areas (see Chart 25), and is greater among children of women with secondary education than among children of women with lesser amounts of schooling (see Chart 26).

Overall, the differentials for immunization coverage are much smaller than those for other phenomena (fertility, contraception, infant mortality, etc.). Thus, immunization campaigns appear to be reaching a wide range of population subgroups.

Little trend data are available for analysis. However, comparing similarly defined groups of children from the WFS and DHS surveys in Peru, the percentage who had ever received a vaccination increased from 67 percent in 1977 to 90 percent in 1986. This impressive gain is indicative of what has happened throughout Latin America.
Immunization coverage for polio is nearly identical to DPT coverage in Colombia and Peru and slightly higher for the other countries. Coverage for BCG is relatively high (over 70 percent) in Colombia, Mexico and Brazil, while Brazil and Peru have the highest level of coverage for the measles vaccine (79 percent and 72 percent, respectively) (see Chart 27).
Nutritional Status of Children

Types and Levels of Undernutrition

The collection of anthropometric data on young children was an option exercised by many countries participating in the first round of the DHS surveys. In Latin America, such data were collected in Bolivia, Colombia, the Dominican Republic, Guatemala and in the Northeastern region of Brazil. The purpose of taking height and weight measures of children is to determine their nutritional status. Deficient height for a given age measures chronic undernutrition; deficient weight for height measures acute undernutrition; and deficient weight for age is a composite measure of undernutrition. A well-nourished reference population is used for comparative purposes. A child is defined as undernourished if he/she falls below a point that is two standard deviations below the mean of the reference population. This standard for defining undernutrition has been adopted by the World Health Organization for use throughout the world.

Chronic undernutrition is a problem in each of the populations surveyed, ranging from 21 percent in the Dominican Republic to 40 percent in Bolivia and 61 percent in Guatemala (see Chart 28). Stunting, a descriptive term used for chronic undernutrition, arises because of long-term insufficiency in proteinic and caloric intake. There is no evidence of acute undernutrition (wasting) in any of the DHS countries in Latin America (i.e., the expected statistical value of 2.3 percent is not exceeded). The composite measure of undernutrition ranges from 12 percent to 15 percent in four countries, rising to 36 percent in Guatemala.
Differentials of Chronic Undernutrition

Chronic undernutrition is more of a problem in rural areas than in urban areas (see Chart 29), but the differences are not large compared to urban-rural differentials for other demographic variables. The additional undernutrition in rural areas varies from 11 to 16 percentage points. Overall, half of the children living in urban areas of Guatemala, and fully two-thirds of those in rural areas, suffer from chronic undernutrition.

Differences in chronic undernutrition according to mother's level of education are much greater than those associated with area of residence (see Chart 30). The percentage of children of mothers with no education who suffer from undernutrition exceeds that of children of mothers with secondary education by ratios of 3 to 1 and 4 to 1 in the surveyed countries. This may, in part, reflect economic differentials, but it is also likely that greater education helps mothers deal more effectively with the problems associated with poverty.
Prevalence and Treatment of Diarrhea

Prevalence of Diarrhea

Diarrheal disease is considered the leading cause of infant and child mortality in developing countries. Given the international concern regarding childhood diarrhea, DHS surveys collect information on the frequency (prevalence) of diarrhea episodes and the treatment received by children who had diarrhea.

Unlike other topics considered in this report, there are some real problems of comparability in measuring the prevalence of diarrhea. There are both cross-national and intra-country variations in respondents' perceptions of diarrheal disease. Data collected are also affected by the seasonality of diarrheal episodes. Thus, frequencies may vary depending on when the fieldwork was conducted.

The proportion of children under five years of age who experienced an episode of diarrhea in the two weeks preceding the survey varies widely in the Latin American countries surveyed: from 17 percent in Brazil and Guatemala to 39 percent in Ecuador. However, the pattern of diarrhea prevalence by age is consistent for all countries: the highest prevalence rates are reported for children 12-23 months, which coincides with weaning. After the second birthday, the prevalence of diarrhea declines rapidly and is lowest among four-year-olds. For children one year of age, diarrhea prevalence varies from 26 to 47 percent, while among children four years of age, it varies from 7 to 24 percent (see Chart 31).

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2Actually, it is the dehydration which accompanies it, rather than the diarrhea itself that causes death.
The socioeconomic differentials for diarrhea prevalence are much less pronounced than the age differential. Prevalence was found to be inversely related to the mother's level of education. There is no consistent relationship across countries between diarrhea prevalence and urban-rural residence. Children living in homes with such amenities as piped water, a flush toilet, and a covered floor, are less likely to suffer from diarrhea than other children (particularly in the cases of Colombia, Mexico and Peru).

**Treatment of Diarrhea**

Since most of the mortality attributed to childhood diarrhea is due to dehydration, in recent years, international health authorities have emphasized the benefits of oral rehydration therapy (ORT) to counteract dehydration. National educational campaigns have been undertaken in many developing countries on the benefits of providing ORT to children with diarrhea. Provision of ORT may include the use of either prepackaged oral rehydration salts (ORS), or homemade solutions of sugar, salt and water.

There are some problems with the comparability of data on the treatment of diarrhea as well. Information on diarrhea treatment was gathered in a variety of ways and with varying degrees of completeness in the different countries. The format ranged from a single open-ended question to a series of specific closed questions. Data on the treatment of diarrhea are provided in Chart 32 for six countries. In Brazil and Guatemala, use of oral rehydration therapy is low, while reliance on other treatments (mostly antibiotics) is high. In the remaining countries, 30 to 50 percent of children were treated with ORT, and another 40 percent with other treatments. The DHS data show no consistent sociodemographic differentials in the usage of oral rehydration therapy across Latin American countries.
Fertility Risk Status

Types and Levels of Risk

In the section on infant and child mortality, it was seen that certain biological factors are closely linked to mortality. These include the age of the mother at time of birth, birth order, and birth interval. Children of very young mothers or children of older mothers, those born less than two years after their next oldest sibling, and those of birth order seven or higher are disproportionately at risk of early death. It is useful, therefore, to analyze the proportion of women who are at risk of conceiving a child with an elevated risk of mortality.

For purposes of this analysis, the data are restricted to currently married women who have not been sterilized (i.e. those most likely to conceive). Young is defined as under 18 years of age; old is 35 years or older; parity risk is assigned to women who have already had six or more births; and interval risk is assigned to women whose last birth occurred less than 15 months ago and who are not currently amenorrheic (i.e., those at risk of conceiving a child who would be born less than two years after the prior birth).

In all countries, the most frequent risk is that for older mothers, varying from 26 to 41 percent (see Chart 33). The percentage of mothers 35 years or older is below 30 percent in three countries: Brazil, Guatemala and the Dominican Republic; the reason for this is that in Brazil and Guatemala women age 45-49 years were excluded from the sample, and the Dominican Republic is unique because women tend to marry early, have children rapidly, then choose to be sterilized. Since sterilized women are not included for risk analysis, and since a majority of older Dominican women are sterilized, the proportion of older women in the old age risk category is low. At the same time, Dominican women are more likely to be in the interval risk and young age risk categories.
The second most common risk in six of the eight countries is that of high parity. For Brazil and the Dominican Republic the second most common is interval risk, again because higher parity women in these countries opt for sterilization.

Women may be subject to more than one type of risk. Thus, it would be incorrect to sum the figures in Chart 33 to arrive at the percentage of women subject to risk. The percentage of nonsterilized married women at risk, and those subject to one risk and to two or more risks are shown in Chart 34. The proportion of women subject to just one risk varies from 30 percent to 36 percent. The percentage subject to two or more risks is more variable, ranging from 12 percent in Brazil to 22 percent in Peru. The most common combination of risks is that of older age and parity. Overall, the percentage of women subject to any kind of risk varies from 47 percent in Guatemala to 56 percent in Peru.

**Differential Risk**

In each of the surveyed countries the proportion of nonsterilized married women at risk of conceiving a child with an elevated risk of mortality is higher in rural areas than in urban areas (see Chart 35). This is due to the greater proportion of older women giving birth and to higher fertility in rural areas. What is surprising is the relative homogeneity of the figures across countries: the variation for urban areas is from 44 percent to 53 percent, and for rural areas is from 49 percent to 61 percent.
The variation in risk according to level of education is much greater (see Chart 36). On average, across countries, only 37 percent of nonsterilized married women with at least some secondary schooling are at risk, compared to 68 percent of women with no schooling. The differential effect of education is particularly strong in Peru and Bolivia, and is weakest in Guatemala.

**Risk Status and the Use of Contraception**

The fact that a woman may be at risk of conceiving a child with a heightened risk of early death may be ameliorated through the use of contraception. But in only two countries, Colombia and Brazil, are at least half of these women using a contraceptive method (see Chart 37). Only one-fourth or less of women at risk are using contraception in the Dominican Republic, Bolivia and Guatemala. In fact, in seven of the eight countries, contraceptive use is higher among women with no risk factor than among those at risk. Women at risk should be the principal targets of campaigns by national family planning programs.
STATISTICAL APPENDICES
APPENDIX 1

FERTILITY
### Table 1.1 Trends in Total Fertility Rates

Change in the total fertility rates between two four-year periods preceding the survey

<table>
<thead>
<tr>
<th>Country</th>
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<th>4-7 years preceding the survey</th>
<th>Percent change</th>
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</thead>
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<td>-11.0</td>
</tr>
<tr>
<td>Brazil</td>
<td>3.6</td>
<td>4.5</td>
<td>-20.0</td>
</tr>
<tr>
<td>Colombia</td>
<td>3.2</td>
<td>4.0</td>
<td>-20.0</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>3.7</td>
<td>4.6</td>
<td>-19.6</td>
</tr>
<tr>
<td>Ecuador</td>
<td>4.1</td>
<td>5.2</td>
<td>-21.2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>5.6</td>
<td>6.5</td>
<td>-13.8</td>
</tr>
<tr>
<td>Mexico</td>
<td>4.0</td>
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<td>-11.1</td>
</tr>
<tr>
<td>Peru</td>
<td>4.2</td>
<td>5.3</td>
<td>-20.8</td>
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</table>

Note: Rates are for women 15-44.

### Table 1.2 Total and Age-specific Fertility Rates

Total and age-specific fertility rates for the four-year period preceding the survey

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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<td>247</td>
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NA= Not available

¹For women 15-44
### Table 1.3 Fertility Differentials

Total fertility rates by place of residence and education for the five-year period preceding the survey.

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<th>Education</th>
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<td>6.1</td>
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APPENDIX 2

CONTRACEPTION
### Table 2.1  Current Use of Contraception

Current use of contraception among currently married women by method

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<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
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<td>45.8</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
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<td>56.5</td>
<td>52.5</td>
<td>46.5</td>
<td>35.8</td>
<td>19.0</td>
<td>44.6</td>
<td>23.1</td>
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<td>11.0</td>
<td>3.0</td>
<td>9.8</td>
<td>1.8</td>
<td>10.2</td>
<td>7.4</td>
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<td>18.8</td>
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<td>15.0</td>
<td>11.3</td>
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<td>6.3</td>
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Note: Figures for Brazil and Guatemala are for women 15-44.

### Table 2.2  Method Mix

Use of specific contraceptive methods among currently married women

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<td>Pill</td>
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Note: Figures for Brazil and Guatemala are for women 15-44.
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1Figures are for women 15-44
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APPENDIX 3

FERTILITY PLANNING
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\(^1\)Figures are for women 15-44
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Table 3.4 Fertility Planning: Ecuador and Guatemala

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¹Figures are for women 15-44
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Wanted status of children born in the year preceding the survey by selected characteristics, Peru

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<td>19.8</td>
<td>23.1</td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>51.4</td>
<td>35.1</td>
<td>13.5</td>
</tr>
<tr>
<td>20-24</td>
<td>46.0</td>
<td>37.4</td>
<td>16.6</td>
</tr>
<tr>
<td>25-29</td>
<td>39.3</td>
<td>30.1</td>
<td>30.6</td>
</tr>
<tr>
<td>30-34</td>
<td>34.7</td>
<td>25.8</td>
<td>39.5</td>
</tr>
<tr>
<td>35-49</td>
<td>19.4</td>
<td>19.4</td>
<td>61.2</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>23.2</td>
<td>28.4</td>
<td>48.4</td>
</tr>
<tr>
<td>Primary</td>
<td>34.4</td>
<td>27.1</td>
<td>38.5</td>
</tr>
<tr>
<td>Secondary+</td>
<td>48.2</td>
<td>33.7</td>
<td>18.1</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>43.7</td>
<td>32.9</td>
<td>23.4</td>
</tr>
<tr>
<td>Rural</td>
<td>32.2</td>
<td>26.7</td>
<td>41.1</td>
</tr>
</tbody>
</table>
APPENDIX 4

UNMET NEED
FOR CONTRACEPTION
Table 4.1 Unmet Need for Contraception

Total unmet need for contraception by selected characteristics of currently married women

<table>
<thead>
<tr>
<th>Country</th>
<th>Age groups</th>
<th>Number of children</th>
<th>Residence</th>
<th>Level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-19</td>
<td>20-24</td>
<td>25-29</td>
<td>30-34</td>
</tr>
<tr>
<td>Bolivia</td>
<td>40.0</td>
<td>41.9</td>
<td>40.8</td>
<td>38.4</td>
</tr>
<tr>
<td>Brazil</td>
<td>20.4</td>
<td>16.5</td>
<td>11.9</td>
<td>9.6</td>
</tr>
<tr>
<td>Colombia</td>
<td>21.4</td>
<td>16.2</td>
<td>12.6</td>
<td>11.9</td>
</tr>
<tr>
<td>Dominican Rep.</td>
<td>30.1</td>
<td>30.8</td>
<td>21.6</td>
<td>17.2</td>
</tr>
<tr>
<td>Ecuador</td>
<td>32.6</td>
<td>30.8</td>
<td>26.0</td>
<td>22.4</td>
</tr>
<tr>
<td>Guatemala</td>
<td>29.0</td>
<td>29.1</td>
<td>30.2</td>
<td>30.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>Information not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>42.2</td>
<td>30.9</td>
<td>27.7</td>
<td>27.0</td>
</tr>
</tbody>
</table>

Note: Unmet need as a percentage of currently married women.

Table 4.2 Total Demand for Contraception

Total demand and its components for currently married women

<table>
<thead>
<tr>
<th>Country</th>
<th>Demand for contraception</th>
<th>Unmet need</th>
<th>Current use</th>
<th>Percent of demand satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For spacing</td>
<td>For limiting</td>
<td>Total</td>
<td>For spacing</td>
</tr>
<tr>
<td>Bolivia</td>
<td>69.8</td>
<td>17.5</td>
<td>52.3</td>
<td>35.7</td>
</tr>
<tr>
<td>Brazil</td>
<td>81.1</td>
<td>24.2</td>
<td>56.9</td>
<td>12.8</td>
</tr>
<tr>
<td>Colombia</td>
<td>80.9</td>
<td>22.1</td>
<td>58.9</td>
<td>13.5</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>71.2</td>
<td>20.8</td>
<td>50.4</td>
<td>19.4</td>
</tr>
<tr>
<td>Ecuador</td>
<td>70.8</td>
<td>23.8</td>
<td>47.0</td>
<td>24.2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>53.4</td>
<td>22.1</td>
<td>31.4</td>
<td>29.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>79.0</td>
<td>25.9</td>
<td>53.1</td>
<td>24.1</td>
</tr>
<tr>
<td>Peru</td>
<td>77.8</td>
<td>21.7</td>
<td>56.1</td>
<td>27.7</td>
</tr>
</tbody>
</table>

Note: Total demand as a percentage of currently married women. Total demand includes method failure, current use and unmet need.
Table 4.3  Total Demand for Contraception by Selected Characteristics

Total demand for contraception by selected characteristics of currently married women

<table>
<thead>
<tr>
<th>Country</th>
<th>Age groups</th>
<th>Number of children</th>
<th>Residence</th>
<th>Level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0 1 2 3 4+</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No education</td>
<td>Primary</td>
</tr>
<tr>
<td>Bolivia</td>
<td>60.4 71.7 82.4 85.3 74.1 48.3 28.7 57.7 73.1 79.6 76.3</td>
<td>73.7 67.5 59.6 71.8 78.8 76.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>73.2 76.2 84.0 88.7 84.8 79.4 44.1 72.6 88.3 94.8 89.9</td>
<td>82.0 84.0 79.0 83.3 82.2 81.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>55.5 83.1 87.5 88.8 90.4 72.1 34.8 73.8 90.9 91.4 87.5</td>
<td>84.9 77.9 78.3 81.0 86.8 84.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominican Rep.</td>
<td>59.5 73.0 76.3 82.2 77.4 58.3 27.0 64.8 75.6 84.6 81.6</td>
<td>71.6 73.0 66.7 71.6 77.3 71.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>51.3 68.6 78.2 79.7 76.6 61.8 32.3 63.9 76.4 76.7 78.0</td>
<td>75.7 66.9 55.4 71.2 77.2 80.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>34.8 46.2 53.0 62.2 61.1 54.3 20.3 36.5 57.2 58.6 60.5</td>
<td>69.1 46.4 44.3 58.9 77.5 74.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>Information not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>70.6 82.5 88.5 88.9 83.8 64.2 47.1 72.6 84.7 89.6 81.2</td>
<td>83.0 74.4 70.6 77.5 85.8 89.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Total demand as a percentage of currently married women. Total demand includes method failure, current use and unmet need.

Table 4.4  Percentage of Demand Satisfied by Selected Characteristics

Percentage of demand for contraception satisfied by selected characteristics of currently married women

<table>
<thead>
<tr>
<th>Country</th>
<th>Age groups</th>
<th>Residence</th>
<th>Level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No education</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Bolivia</td>
<td>27.6 33.5 43.9 48.5 49.8 46.2</td>
<td>55.0</td>
<td>29.9</td>
</tr>
<tr>
<td>Brazil</td>
<td>67.5 74.7 82.6 86.0 83.3 84.4</td>
<td>86.5</td>
<td>70.1</td>
</tr>
<tr>
<td>Colombia</td>
<td>54.2 73.0 81.5 84.6 85.1 82.5</td>
<td>84.6</td>
<td>71.2</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>43.0 53.6 68.5 75.8 83.9 84.6</td>
<td>74.2</td>
<td>64.4</td>
</tr>
<tr>
<td>Ecuador</td>
<td>31.0 51.2 61.5 69.1 72.1 68.6</td>
<td>72.0</td>
<td>50.1</td>
</tr>
<tr>
<td>Guatemala</td>
<td>15.5 34.4 40.0 49.7 50.9 51.4</td>
<td>63.4</td>
<td>29.7</td>
</tr>
<tr>
<td>Mexico</td>
<td>Information not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>33.7 52.4 60.8 64.8 66.1 58.7</td>
<td>73.5</td>
<td>34.0</td>
</tr>
</tbody>
</table>
APPENDIX 5

INFANT AND CHILD MORTALITY
<table>
<thead>
<tr>
<th>Table 5.1 Infant and Child Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant and child mortality rates for the five-year period preceding the survey</td>
</tr>
<tr>
<td>Mortality rate</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Infant (&lt; 1 year)</td>
</tr>
<tr>
<td>Neonatal</td>
</tr>
<tr>
<td>Postneonatal</td>
</tr>
<tr>
<td>Child (1-4 years)</td>
</tr>
<tr>
<td>Under-five</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5.2 Mortality Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-five mortality rates for three five-year periods preceding the survey</td>
</tr>
<tr>
<td>Period</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>0-4 years</td>
</tr>
<tr>
<td>5-9 years</td>
</tr>
<tr>
<td>10-14 years</td>
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</tbody>
</table>
## Table 5.3 Infant Mortality Differentials

Infant mortality rates for the ten-year period preceding the survey by selected characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>96</td>
<td>86</td>
<td>39</td>
<td>70</td>
<td>65</td>
<td>79</td>
<td>56</td>
<td>79</td>
</tr>
<tr>
<td><strong>Child's sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>106</td>
<td>98</td>
<td>41</td>
<td>79</td>
<td>70</td>
<td>91</td>
<td>60</td>
<td>84</td>
</tr>
<tr>
<td>Female</td>
<td>86</td>
<td>73</td>
<td>38</td>
<td>62</td>
<td>60</td>
<td>68</td>
<td>52</td>
<td>74</td>
</tr>
<tr>
<td><strong>Birth Order</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>80</td>
<td>62</td>
<td>30</td>
<td>70</td>
<td>59</td>
<td>84</td>
<td>42</td>
<td>62</td>
</tr>
<tr>
<td>2-3</td>
<td>88</td>
<td>73</td>
<td>41</td>
<td>64</td>
<td>52</td>
<td>71</td>
<td>50</td>
<td>63</td>
</tr>
<tr>
<td>4-6</td>
<td>101</td>
<td>100</td>
<td>42</td>
<td>68</td>
<td>69</td>
<td>78</td>
<td>60</td>
<td>89</td>
</tr>
<tr>
<td>7 or higher</td>
<td>124</td>
<td>160</td>
<td>51</td>
<td>91</td>
<td>104</td>
<td>100</td>
<td>88</td>
<td>115</td>
</tr>
<tr>
<td><strong>Duration of Preceding Birth Interval</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 months</td>
<td>154</td>
<td>143</td>
<td>53</td>
<td>88</td>
<td>95</td>
<td>123</td>
<td>84</td>
<td>124</td>
</tr>
<tr>
<td>24-47 months</td>
<td>77</td>
<td>61</td>
<td>42</td>
<td>59</td>
<td>53</td>
<td>53</td>
<td>48</td>
<td>67</td>
</tr>
<tr>
<td>48 or more months</td>
<td>43</td>
<td>56</td>
<td>30</td>
<td>60</td>
<td>47</td>
<td>59</td>
<td>46</td>
<td>37</td>
</tr>
<tr>
<td><strong>Mother's Age</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>101</td>
<td>103</td>
<td>46</td>
<td>85</td>
<td>62</td>
<td>99</td>
<td>63</td>
<td>100</td>
</tr>
<tr>
<td>20-29</td>
<td>92</td>
<td>82</td>
<td>37</td>
<td>60</td>
<td>63</td>
<td>72</td>
<td>53</td>
<td>68</td>
</tr>
<tr>
<td>30-39</td>
<td>93</td>
<td>86</td>
<td>40</td>
<td>79</td>
<td>63</td>
<td>78</td>
<td>57</td>
<td>86</td>
</tr>
<tr>
<td>40 or older</td>
<td>140</td>
<td>143</td>
<td>45</td>
<td>105</td>
<td>141</td>
<td>166</td>
<td>74</td>
<td>104</td>
</tr>
<tr>
<td><strong>Mother's Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>124</td>
<td>115</td>
<td>55</td>
<td>99</td>
<td>106</td>
<td>82</td>
<td>83</td>
<td>119</td>
</tr>
<tr>
<td>Primary</td>
<td>108</td>
<td>91</td>
<td>42</td>
<td>74</td>
<td>68</td>
<td>82</td>
<td>58</td>
<td>88</td>
</tr>
<tr>
<td>Secondary+</td>
<td>56</td>
<td>25</td>
<td>29</td>
<td>47</td>
<td>40</td>
<td>40</td>
<td>27</td>
<td>42</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>79</td>
<td>76</td>
<td>38</td>
<td>72</td>
<td>52</td>
<td>65</td>
<td>43</td>
<td>56</td>
</tr>
<tr>
<td>Rural</td>
<td>112</td>
<td>107</td>
<td>41</td>
<td>68</td>
<td>77</td>
<td>84</td>
<td>79</td>
<td>105</td>
</tr>
</tbody>
</table>
APPENDIX 6

ANTENATAL CARE AND ATTENTION AT DELIVERY
### Table 6.1 Tetanus Toxoid Coverage

Percentage of births in the five-year period preceding the survey whose mothers received at least one tetanus toxoid injection by place of residence

<table>
<thead>
<tr>
<th>Residence</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20.2</td>
<td>40.5</td>
<td>38.9</td>
<td>87.1</td>
<td>38.6</td>
<td>13.8</td>
<td>NA</td>
<td>15.5</td>
</tr>
<tr>
<td>Urban</td>
<td>25.7</td>
<td>42.8</td>
<td>37.9</td>
<td>88.4</td>
<td>43.1</td>
<td>15.9</td>
<td>NA</td>
<td>22.2</td>
</tr>
<tr>
<td>Rural</td>
<td>15.1</td>
<td>36.1</td>
<td>40.4</td>
<td>85.4</td>
<td>34.3</td>
<td>13.1</td>
<td>NA</td>
<td>8.2</td>
</tr>
</tbody>
</table>

NA= Not available

### Table 6.2 Changes in Tetanus Toxoid Coverage

Percentage of births whose mothers received at least one tetanus toxoid injection in the five-year period preceding the survey

<table>
<thead>
<tr>
<th>Period</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in preceding 5 years</td>
<td>20.2</td>
<td>40.5</td>
<td>38.9</td>
<td>87.1</td>
<td>38.6</td>
<td>13.8</td>
<td>NA</td>
<td>15.5</td>
</tr>
<tr>
<td>Preceding year¹</td>
<td>32.2</td>
<td>38.1</td>
<td>48.1</td>
<td>86.1</td>
<td>39.4</td>
<td>22.2</td>
<td>NA</td>
<td>19.8</td>
</tr>
<tr>
<td>5 years ago¹</td>
<td>14.8</td>
<td>42.8</td>
<td>27.8</td>
<td>90.9</td>
<td>35.4</td>
<td>9.6</td>
<td>NA</td>
<td>13.6</td>
</tr>
</tbody>
</table>

NA= Not available

¹Standardized on birth order
### Table 6.3 Antenatal Care

Type of antenatal care received by mothers for all births in the five-year period preceding the survey

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of antenatal care</th>
<th>No antenatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Professional</td>
</tr>
<tr>
<td>Bolivia</td>
<td>46.7</td>
<td>45.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>73.9</td>
<td>73.2</td>
</tr>
<tr>
<td>Colombia</td>
<td>74.1</td>
<td>72.8</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>95.6</td>
<td>94.9</td>
</tr>
<tr>
<td>Ecuador</td>
<td>72.9</td>
<td>69.7</td>
</tr>
<tr>
<td>Guatemala</td>
<td>72.7</td>
<td>34.1</td>
</tr>
<tr>
<td>Mexico</td>
<td>84.3</td>
<td>71.0</td>
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Note: Percentage of births with antenatal care.

### Table 6.4 Attention at Delivery

Type of attention received at delivery by mothers for all births in the five-year period preceding the survey

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Note: Percent distribution.
### Table 6.5 Antenatal Care and Attention at Delivery: Bolivia and Brazil

Antenatal care and attention at delivery for births in the five-year period preceding the survey by selected characteristics, Bolivia and Brazil.

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| **BRAZIL**                      |      |      |      |      |      |      |      |      |      |
| **Total**                       | 40.5 | 73.2 | 0.0 | 0.7 | 26.1 | 80.7 | 14.6 | 2.3  | 2.4 |
| **Birth Order**                 |      |      |      |      |      |      |      |      |      |
| First birth                     | 43.6 | 83.1 | 0.1 | 0.5 | 16.3 | 89.8 | 7.0  | 2.4  | 0.8 |
| 2-3                             | 39.4 | 78.3 | 0.0 | 1.0 | 20.7 | 83.9 | 12.9 | 1.7  | 1.5 |
| 4-6                             | 37.9 | 63.0 | 0.0 | 1.0 | 36.0 | 71.0 | 21.8 | 2.8  | 4.4 |
| 7 or higher                     | 41.7 | 50.6 | 0.0 | 0.0 | 49.4 | 65.4 | 26.0 | 3.0  | 5.6 |
| **Mother’s Age**                |      |      |      |      |      |      |      |      |      |
| 15-19                           | 43.8 | 66.2 | 0.8 | 0.8 | 32.2 | 80.1 | 15.4 | 2.2  | 2.3 |
| 20-24                           | 38.5 | 74.2 | 0.0 | 0.5 | 25.3 | 82.9 | 12.9 | 2.4  | 1.8 |
| 25-29                           | 39.1 | 75.1 | 0.0 | 0.7 | 24.2 | 81.2 | 13.9 | 1.7  | 3.2 |
| 30-34                           | 40.1 | 76.7 | 0.0 | 0.9 | 22.4 | 80.3 | 15.3 | 2.8  | 1.6 |
| 35-39                           | 46.4 | 69.9 | 0.0 | 1.3 | 28.8 | 80.2 | 15.0 | 1.8  | 3.0 |
| 40 or older                     | 41.5 | 59.8 | 0.0 | 0.0 | 40.2 | 71.6 | 21.7 | 4.1  | 2.6 |
| **Mother’s Education**          |      |      |      |      |      |      |      |      |      |
| None                            | 33.3 | 45.6 | 0.0 | 0.0 | 54.4 | 63.8 | 29.8 | 1.9  | 4.5 |
| Primary                         | 41.1 | 73.3 | 0.1 | 0.8 | 23.8 | 79.9 | 14.8 | 2.7  | 2.6 |
| Secondary                       | 46.5 | 94.2 | 0.0 | 1.4 | 4.4  | 97.9 | 1.1  | 1.6  | 0.0 |
| Higher                          | 34.8 | 98.1 | 0.0 | 0.0 | 1.9  | 98.3 | 1.7  | 0.0  | 0.0 |
| **Residence**                   |      |      |      |      |      |      |      |      |      |
| Urban                           | 42.8 | 84.6 | 0.0 | 1.0 | 14.4 | 91.5 | 6.1  | 1.2  | 1.2 |
| Rural                           | 36.1 | 50.5 | 0.1 | 0.2 | 49.2 | 59.4 | 31.5 | 4.4  | 4.7 |

1Figures are for women 15-44
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<td>41.4</td>
<td>40.0</td>
<td>6.6</td>
</tr>
<tr>
<td>Primary</td>
<td>13.5</td>
<td>46.3</td>
<td>6.8</td>
<td>1.9</td>
<td>45.0</td>
<td>36.1</td>
<td>37.4</td>
<td>24.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Secondary</td>
<td>22.9</td>
<td>81.9</td>
<td>11.7</td>
<td>0.0</td>
<td>16.4</td>
<td>83.4</td>
<td>12.8</td>
<td>3.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Higher</td>
<td>19.1</td>
<td>97.5</td>
<td>0.0</td>
<td>0.0</td>
<td>2.5</td>
<td>96.8</td>
<td>3.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>22.2</td>
<td>79.5</td>
<td>2.1</td>
<td>0.1</td>
<td>18.3</td>
<td>80.5</td>
<td>15.4</td>
<td>3.8</td>
<td>0.3</td>
</tr>
<tr>
<td>Rural</td>
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<td>28.8</td>
<td>9.7</td>
<td>2.6</td>
<td>58.9</td>
<td>15.7</td>
<td>43.5</td>
<td>36.8</td>
<td>4.0</td>
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</table>

NA= Not available
APPENDIX 7

BREASTFEEDING
AND SUPPLEMENTAL FEEDING
### Table 7.1 Breastfeeding

Percentage of children under five breastfed and median duration of breastfeeding in months

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed</td>
<td>Median duration</td>
<td>Breastfed</td>
<td>Median duration</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>96.3</td>
<td>16.5</td>
<td>86.7</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Birth Order</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>96.0</td>
<td>15.3</td>
<td>85.8</td>
<td>5.1</td>
</tr>
<tr>
<td>3-4</td>
<td>96.5</td>
<td>18.2</td>
<td>86.5</td>
<td>6.9</td>
</tr>
<tr>
<td>5+</td>
<td>96.6</td>
<td>17.8</td>
<td>89.1</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>96.3</td>
<td>15.9</td>
<td>86.8</td>
<td>5.3</td>
</tr>
<tr>
<td>25-34</td>
<td>96.5</td>
<td>17.2</td>
<td>87.1</td>
<td>6.4</td>
</tr>
<tr>
<td>35+</td>
<td>95.7</td>
<td>19.2</td>
<td>85.2</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>Education</strong></td>
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<td></td>
<td></td>
<td></td>
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<td>None</td>
<td>97.7</td>
<td>19.0</td>
<td>85.8</td>
<td>9.3</td>
</tr>
<tr>
<td>Primary</td>
<td>96.7</td>
<td>17.5</td>
<td>86.2</td>
<td>5.8</td>
</tr>
<tr>
<td>Secondary</td>
<td>94.6</td>
<td>14.1</td>
<td>89.8</td>
<td>5.5</td>
</tr>
<tr>
<td>Higher</td>
<td>94.3</td>
<td>9.7</td>
<td>91.1</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>95.1</td>
<td>14.7</td>
<td>85.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Rural</td>
<td>97.5</td>
<td>18.3</td>
<td>88.8</td>
<td>7.3</td>
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</table>

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Ecuador</th>
<th>Guatemala¹</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed</td>
<td>Median duration</td>
<td>Breastfed</td>
<td>Median duration</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>93.0</td>
<td>13.9</td>
<td>94.6</td>
<td>20.8</td>
</tr>
<tr>
<td><strong>Birth Order</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>92.6</td>
<td>13.0</td>
<td>93.1</td>
<td>18.9</td>
</tr>
<tr>
<td>3-4</td>
<td>93.5</td>
<td>13.9</td>
<td>95.8</td>
<td>21.7</td>
</tr>
<tr>
<td>5+</td>
<td>93.0</td>
<td>16.8</td>
<td>95.2</td>
<td>22.3</td>
</tr>
<tr>
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<tr>
<td>Under 25</td>
<td>93.9</td>
<td>13.6</td>
<td>94.3</td>
<td>19.8</td>
</tr>
<tr>
<td>25-34</td>
<td>92.3</td>
<td>14.6</td>
<td>95.5</td>
<td>21.1</td>
</tr>
<tr>
<td>35+</td>
<td>91.8</td>
<td>13.0</td>
<td>92.9</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>94.4</td>
<td>16.3</td>
<td>96.2</td>
<td>23.1</td>
</tr>
<tr>
<td>Primary</td>
<td>94.2</td>
<td>15.1</td>
<td>93.6</td>
<td>18.9</td>
</tr>
<tr>
<td>Secondary</td>
<td>89.5</td>
<td>12.3</td>
<td>89.2</td>
<td>10.1</td>
</tr>
<tr>
<td>Higher</td>
<td>93.4</td>
<td>9.8</td>
<td>91.9</td>
<td>9.3</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>90.7</td>
<td>12.3</td>
<td>92.3</td>
<td>19.2</td>
</tr>
<tr>
<td>Rural</td>
<td>95.2</td>
<td>15.6</td>
<td>95.5</td>
<td>21.4</td>
</tr>
</tbody>
</table>

¹Figures are for women 15-44
Table 7.2 Breastfeeding and Supplemental Feeding among Children 0-4 Months

Among children 0-4 months, percentage with breastfeeding and supplemental feeding

<table>
<thead>
<tr>
<th>Country</th>
<th>Breastfed exclusively</th>
<th>Breastfed and plain water</th>
<th>Breastfed and other foods</th>
<th>Any breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>55</td>
<td>4</td>
<td>38</td>
<td>97</td>
</tr>
<tr>
<td>Brazil</td>
<td>3</td>
<td>11</td>
<td>57</td>
<td>71</td>
</tr>
<tr>
<td>Colombia</td>
<td>18</td>
<td>5</td>
<td>63</td>
<td>86</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>13</td>
<td>13</td>
<td>56</td>
<td>82</td>
</tr>
<tr>
<td>Ecuador</td>
<td>27</td>
<td>10</td>
<td>53</td>
<td>90</td>
</tr>
<tr>
<td>Guatemala</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mexico</td>
<td>33</td>
<td>1</td>
<td>38</td>
<td>72</td>
</tr>
<tr>
<td>Peru</td>
<td>31</td>
<td>4</td>
<td>57</td>
<td>92</td>
</tr>
</tbody>
</table>

Note: Information is for last-born living child.
NA= Not available

Table 7.3 Breastfeeding and Supplemental Feeding among Children 7-14 Months

Among children 7-14 months, percentage with breastfeeding and supplemental feeding

<table>
<thead>
<tr>
<th>Country</th>
<th>Children 7-11 months</th>
<th>Children 12-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed plus solids/no bottle</td>
<td>Breastfed/no solids</td>
</tr>
<tr>
<td>Bolivia</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>Brazil</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Colombia</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Ecuador</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>Guatemala</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mexico</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Peru</td>
<td>24</td>
<td>23</td>
</tr>
</tbody>
</table>

Note: Information is for last-born living child.
NA= Not available
APPENDIX 8

IMMUNIZATION OF CHILDREN
### Table 8.1 Immunization Coverage

Percentage of children 12-23 months immunized for specific vaccines, including health card information and maternal recall

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>55</td>
<td>70</td>
<td>85</td>
<td>NA</td>
<td>NA</td>
<td>50</td>
<td>73</td>
<td>57</td>
</tr>
<tr>
<td>DPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPT 1</td>
<td>70</td>
<td>85</td>
<td>90</td>
<td>NA</td>
<td>NA</td>
<td>77</td>
<td>77</td>
<td>84</td>
</tr>
<tr>
<td>DPT 2</td>
<td>51</td>
<td>77</td>
<td>83</td>
<td>NA</td>
<td>NA</td>
<td>57</td>
<td>60</td>
<td>76</td>
</tr>
<tr>
<td>DPT 3</td>
<td>28</td>
<td>70</td>
<td>72</td>
<td>NA</td>
<td>NA</td>
<td>36</td>
<td>34</td>
<td>58</td>
</tr>
<tr>
<td>Dropout rate(^1)</td>
<td>60</td>
<td>17</td>
<td>20</td>
<td>NA</td>
<td>NA</td>
<td>54</td>
<td>56</td>
<td>31</td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio 1</td>
<td>79</td>
<td>91</td>
<td>90</td>
<td>NA</td>
<td>NA</td>
<td>80</td>
<td>94</td>
<td>85</td>
</tr>
<tr>
<td>Polio 2</td>
<td>61</td>
<td>85</td>
<td>83</td>
<td>NA</td>
<td>NA</td>
<td>60</td>
<td>87</td>
<td>77</td>
</tr>
<tr>
<td>Polio 3+</td>
<td>38</td>
<td>75</td>
<td>72</td>
<td>NA</td>
<td>NA</td>
<td>39</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>Measles</td>
<td>58</td>
<td>79</td>
<td>64</td>
<td>NA</td>
<td>NA</td>
<td>55</td>
<td>59</td>
<td>72</td>
</tr>
<tr>
<td>Full immunization</td>
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<td>57</td>
<td>54</td>
<td>NA</td>
<td>NA</td>
<td>18</td>
<td>21</td>
<td>36</td>
</tr>
<tr>
<td>Number of children</td>
<td>1108</td>
<td>578</td>
<td>556</td>
<td>NA</td>
<td>NA</td>
<td>823</td>
<td>1017</td>
<td>526</td>
</tr>
</tbody>
</table>

\(^1\)From DPT 1 to DPT 3
NA: Not available

### Table 8.2 Immunization Coverage Differentials for DPT 3

Percentage of children 12-35 months with a health card immunized for DPT 3 by mother’s education and residence

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s education</td>
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<td></td>
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<td></td>
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<tr>
<td>None</td>
<td>43</td>
<td>65</td>
<td>68</td>
<td>NA</td>
<td>NA</td>
<td>58</td>
<td>NA</td>
<td>60</td>
</tr>
<tr>
<td>Primary</td>
<td>48</td>
<td>82</td>
<td>87</td>
<td>NA</td>
<td>NA</td>
<td>65</td>
<td>NA</td>
<td>64</td>
</tr>
<tr>
<td>Secondary+</td>
<td>70</td>
<td>95</td>
<td>91</td>
<td>NA</td>
<td>NA</td>
<td>70</td>
<td>NA</td>
<td>84</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>64</td>
<td>88</td>
<td>89</td>
<td>NA</td>
<td>NA</td>
<td>70</td>
<td>NA</td>
<td>80</td>
</tr>
<tr>
<td>Rural</td>
<td>46</td>
<td>70</td>
<td>84</td>
<td>NA</td>
<td>NA</td>
<td>59</td>
<td>NA</td>
<td>62</td>
</tr>
<tr>
<td>Number of children</td>
<td>490</td>
<td>857</td>
<td>560</td>
<td>NA</td>
<td>NA</td>
<td>942</td>
<td>NA</td>
<td>433</td>
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</tbody>
</table>

NA: Not available
APPENDIX 9

NUTRITIONAL STATUS
OF CHILDREN
**Table 9.1 Undernutrition among Children under Three**

Percentage of undernutrition among children 6-35 months by type

<table>
<thead>
<tr>
<th>Type</th>
<th>Index</th>
<th>Bolivia</th>
<th>Brazil¹</th>
<th>Colombia</th>
<th>Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic</td>
<td>Height-for-age</td>
<td>39.8</td>
<td>30.4</td>
<td>26.4</td>
<td>20.5</td>
<td>NA</td>
<td>61.1</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Acute</td>
<td>Weight-for-height</td>
<td>1.5</td>
<td>1.1</td>
<td>1.4</td>
<td>2.3</td>
<td>NA</td>
<td>1.3</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Composite</td>
<td>Weight-for-age</td>
<td>14.6</td>
<td>12.2</td>
<td>12.7</td>
<td>12.7</td>
<td>NA</td>
<td>36.0</td>
<td>NA</td>
<td>NA</td>
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</tbody>
</table>

Note: Percentage of children 6 to 35 months of age who are below -2 standard deviations from the mean of the NCHS/CDC/WHO reference population for each index.

¹Northeast only

**Table 9.2 Chronic Undernutrition among Children under Three**

Percentage of chronic undernutrition among children 6-35 months by selected characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Bolivia</th>
<th>Brazil¹</th>
<th>Colombia</th>
<th>Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>39.8</td>
<td>30.4</td>
<td>26.4</td>
<td>20.5</td>
<td>NA</td>
<td>61.1</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>42.0</td>
<td>30.3</td>
<td>27.3</td>
<td>24.3</td>
<td>NA</td>
<td>62.6</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Female</td>
<td>37.8</td>
<td>30.6</td>
<td>25.5</td>
<td>16.9</td>
<td>NA</td>
<td>59.7</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-11 months</td>
<td>21.0</td>
<td>27.7</td>
<td>15.1</td>
<td>10.0</td>
<td>NA</td>
<td>39.0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>12-17 months</td>
<td>37.6</td>
<td>38.1</td>
<td>19.8</td>
<td>17.5</td>
<td>NA</td>
<td>66.8</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>18-23 months</td>
<td>49.7</td>
<td>27.7</td>
<td>30.4</td>
<td>27.9</td>
<td>NA</td>
<td>72.7</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>24-29 months</td>
<td>47.9</td>
<td>29.8</td>
<td>32.6</td>
<td>26.3</td>
<td>NA</td>
<td>64.7</td>
<td>NA</td>
<td>NA</td>
</tr>
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<td>30-35 months</td>
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Note: Percentage of children 6 to 35 months of age who are below -2 standard deviations from the mean of the NCHS/CDC/WHO reference population for height-for-age.

¹Northeast only
APPENDIX 10

PREVALENCE AND TREATMENT OF DIARRHEA
Table 10.1 Prevalence of Diarrhea

<table>
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<th>Characteristic</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
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<td>18.8</td>
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<td>35.9</td>
<td>46.8</td>
<td>25.9</td>
<td>33.7</td>
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<td>11.7</td>
<td>19.6</td>
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Table 10.2 Knowledge of Packets of Oral Rehydration Salts (ORS)

Knowledge of ORS packets used for oral rehydration therapy (ORT) by education and place of residence

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<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
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Note: Asked of mother who had a child in the five years preceding interview.
NA= Not available
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</tr>
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<td>6.9</td>
<td>44.5</td>
<td>100.0</td>
</tr>
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<td>32.4</td>
<td>9.4</td>
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<td>100.0</td>
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<td>40.7</td>
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<td>18.0</td>
<td>10.6</td>
<td>30.6</td>
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</tr>
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<td>24.7</td>
<td>7.2</td>
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</tr>
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<td>10.7</td>
<td>49.4</td>
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</tr>
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ORS= Oral rehydration salts
Information for children to women 15-44
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ORS= Oral rehydration salts
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ORS= Oral rehydration salts  
NA= Not available  
¹Information for children to women 15-44
Table 10.6. Treatment of Diarrhea: Peru

Treatment of diarrhea by selected characteristics, Peru

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<th>Recommended fluid</th>
<th>Other</th>
<th>Total</th>
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ORS = Oral rehydration salts
APPENDIX 11

FERTILITY RISK STATUS
### Table 11.1 High-risk Fertility Status

Percentage of nonsterilized currently married women at risk of conceiving a child with an elevated risk of mortality by type of risk

<table>
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<th>Risk</th>
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<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
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<td>48.3</td>
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<td>2.4</td>
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<td>11.3</td>
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<td>0.6</td>
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<td>1.3</td>
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| **Total-All Women**                                        | 30.2    | 20.7   | 21.1     | 17.9               | 25.8    | 27.8      | 26.5   | 30.4 |

Note: High-risk categories are defined as follows:

- **Young**: Under 18 years of age
- **Old**: 35 years or older
- **Parity**: 6 or more births
- **Interval**: Less than 15 months since last birth and not currently amenorrheic.

<sup>1</sup>Women at high-risk as a percentage of all women interviewed
### Table 11.2 High-risk Fertility Status by Selected Characteristics

Percentage of nonsterilized currently married women at risk of conceiving a child with an elevated risk of mortality by selected characteristics

<table>
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<th>Ecuador</th>
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<td>55.0</td>
<td>53.2</td>
<td>48.6</td>
<td>59.4</td>
<td>60.8</td>
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<tr>
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<td>33.9</td>
<td>34.0</td>
<td>37.4</td>
<td>35.6</td>
<td>36.3</td>
<td>38.9</td>
<td>34.5</td>
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<td>40.8</td>
<td>36.8</td>
<td>46.3</td>
<td>43.2</td>
<td>51.6</td>
<td>45.5</td>
<td>49.1</td>
</tr>
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<td>59.2</td>
<td>56.5</td>
<td>63.4</td>
<td>55.2</td>
<td>58.0</td>
<td>59.9</td>
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<tr>
<td>Using</td>
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<td>46.5</td>
<td>46.0</td>
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<td>42.6</td>
<td>45.0</td>
<td>49.3</td>
<td>50.3</td>
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<tr>
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<td>49.9</td>
<td>51.5</td>
<td>49.4</td>
<td>51.3</td>
<td>47.7</td>
<td>56.6</td>
<td>59.8</td>
</tr>
<tr>
<td>Want no more &amp; not using</td>
<td>60.2</td>
<td>62.0</td>
<td>61.7</td>
<td>65.2</td>
<td>57.9</td>
<td>59.0</td>
<td>63.3</td>
<td>63.4</td>
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### Table 11.3 Contraceptive Use and High-risk Fertility Status

Percentage of nonsterilized currently married women who are using a contraceptive method

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<th>Risk category</th>
<th>Bolivia</th>
<th>Brazil</th>
<th>Colombia</th>
<th>Dominican Republic</th>
<th>Ecuador</th>
<th>Guatemala</th>
<th>Mexico</th>
<th>Peru</th>
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<tr>
<td>In Any High-risk Category¹</td>
<td>23.9</td>
<td>52.0</td>
<td>54.1</td>
<td>25.1</td>
<td>30.4</td>
<td>13.6</td>
<td>38.5</td>
<td>38.1</td>
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<tr>
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<td>55.5</td>
<td>59.5</td>
<td>25.2</td>
<td>38.3</td>
<td>14.9</td>
<td>45.7</td>
<td>47.5</td>
</tr>
</tbody>
</table>

¹At risk of conceiving a child with an elevated risk of mortality