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COLLECTION AND USE OF CORE HEALTH DATA

The Pan American Health Organization is collaborating with the Member States to strengthen the production, processing, and analysis of pertinent information for the formulation of health and Environmental policy, the reorganization of the health services, health promotion, disease prevention and control, the programming and evaluation of interventions, and mobilization of resources.

Technical information systems contribute to knowledge about the health and well-being of the population and stimulate the use of available information, helping to improve its quality and strategic utilization.

This document describes the core datacountry profile initiative, which is being developed at PAHO with the collaboration of the Member States, its regional technical programs, its Representative Offices in the countries, and its research and training centers, in order to improve the Organization's ability to describe, analyze, and explain, in a timely and up-to-date manner, the situation and trends of the health problems that it must address. This work is closely linked to technical cooperation activities so that the countries will strengthen their capacity to effectively analyze their health situation and the appropriateness of their health interventions in order to reduce inequities in health.

The components of the core datacountry profile initiative include, for each country of the Region: a list of basic indicators; an executive summary of the health situation and its trends; several figures and maps that illustrate the health situation; and a list of bibliographic references to support these components.

The purpose of the present document is to report to the Executive Committee on the progress made in implementing the core datacountry profile initiative and to request the members of the Committee to make recommendations to the Directing Council on mechanisms to ensure ongoing and timely use of the results of the initiative in the countries.

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EXECUTIVE SUMMARY

The core datacountry profile initiative of PAHO has been developed within the context of the Strategic and Programmatic Orientations of PAHO 1995-1998, which state that:

The primary challenge is overcoming inequity...Inequity is not manifested in the same way in all countries or population groups. It is therefore essential to approach the differences in health conditions and health care coverage ... In each country, it will be necessary to establish the profile and characteristics of the inequity in different population groups and geographic areas in order to determine what action should be taken to eliminate it (SPO, p. 14).

The core datacountry profile initiative is part of PAHO's Technical Information System (TIS), which contributes to knowledge about the state of health and well-being of the population and promotes the use of the available information, helping to improve its quality and strategic utilization.

The purpose of this initiative is to provide information on the health situation and its trends as input for: the establishment of policies and strategic planning; the programming, monitoring, adaptation, and evaluation of technical cooperation; the mobilization of resources; and routine dissemination of technical strategic policy reports.

The TIS produces the following four types of results geared toward the country, subregional, and regional levels of use: a list of core data; an executive summary of the health situation and trends; a series of figures and maps illustrating the health situation; and a list of bibliographic references to support these components.

The core data are the data and minimum information necessary for characterizing the health situation of a country or area or a specific health problem. The PAHOWHO mandates and commitments regarding the collection and dissemination of health statistics, supported by the resolutions of the Governing Bodies, define the criteria for selecting the indicators. These mandates involve the surveillance of public health problems, evaluation of plans and programs, and the global commitments assumed by the Region. Other important indicators have also been included to assess the countries' capacity to respond to the needs and demands of the population in areas such as human resources.

The 118 indicators selected are grouped into the following subject areas: demographic (11), socioeconomic (10), mortality (31), morbidity and risk factors (30), and resourcesservicescoverage (36). The values, when pertinent, are disaggregated by sex and age group. For each value, the reference year, the source, and the definition of the indicator and method for calculating it are indicated.

The system's features include: multiuser access, with text and numerical data processing; modular design; two languages (English and Spanish); requires a graphic interface (WindowsInternet); and can be accessed from one or more PAHO mirror servers on the World

Wide Web using Netscape, MS Explorer, or another available browser.

The selection, collection, organization, maintenance, and use of the data and information to describe, analyze, and explain the health situation are activities inherent to all levels from the Organization. It is hoped that use of the products of this system will serve as a reference for the Secretariat and the Member States and will lead to their continuing adaptation.

1.   Introduction

The selection, collection, organization, maintenance, and use of data and information to describe, analyze, and explain the health situation of the countries are essential functions of the Pan American Health Organization.

As stated in the Pan American Sanitary Code in 1924 for the Region of the Americas, the Fourth World Health Assembly resolved that one of the main purposes of the World Health Organization (WHO) is "to build up gradually at Headquarters a body of sound statistical information and advice, covering all parts of the world, by which the policy of the Organization, including the regions, can be guided and its operations and results measured . . ." (WHA4.3).

The Strategic and Programmatic Orientations of PAHO, 1995-1998, state, "In each country, it will be necessary to establish the profile and characteristics of inequity in different population groups and geographic areas in order to determine what action should be taken to eliminate it" (SPO, p. 14).

The Ninth General Program of Work of WHO, 1996-2001, underscores the importance of health situation analysis and trend assessment in technical cooperation to the countries and validates the role of the responsible technical program (HDA) of PAHOWHO in directing and coordinating regional efforts.

Carrying out the essential function of managing information on the health situation implies the review, modernization, and interconnection of both the available databanks and information throughout the Organization and the systems for managing them.

Responsibility for coordinating this function at PAHO has been assigned to the Division of Health and Human DevelopmentProgram on Health Situation Analysis (HDPHDA), in coordination with various technical and administrative units. The Director of PAHO has also created an Interprogrammatic Advisory Group for Core Data and Health Situation Analysis that collaborates with HDPHDA in the preparation of recommendations for the Director concerning: the definition and selection of the regional core data and the proposed set of core data that will be established at the Representative Offices; the mechanisms for collecting and updating the data; and the monitoring of the implementation of the process as a whole.

2.   Goal of the Core DataCountry Profile Initiative

The goal is to strengthen the capacity of PAHO to generate knowledge that will make it possible to describe and explain the situation with respect to the health and well-being of the population of the Americas, and to select health interventions that are both equitable and effective.

3.   Purpose of the Core DataCountry Profile Initiative

The basic purpose is to provide, expeditiously and directly, ongoing updated information on the health situation and trends that will serve as input for:

(a)   strategic policy management;

(b)   the setting of priorities for health sector action;

(c)   the evaluation and modification of technical cooperation in each country and program, redefining priorities, action strategies, and resource allocation;

(d)   support for the countries in drafting investment strategies or proposals for special programs geared to the development of health policies or services and for the prevention and control of specific health problems;

(e)   the mobilization of financial resources;

(f)   the definition of research priorities;

(g)   the periodic dissemination of reports on trends in the health situation in each country and the Region as a whole, within the analytical frameworks defined by their mandates, such as health for all and renewal of health for all.

4.   Institutional Technical Information Needs

Technical information that provides knowledge of the situation with respect to health and well-being in the countries of the Region is an intrinsic part of the Organization's activities, both internal and external. Internal functions refer to the planning, programming, and evaluation of technical cooperation, and external functions, to the delivery of technical cooperation within and among the countries.

The term "health situation analysis" refers to the component that forms the basis for establishing policies and strategies in public health. In addition to providing information on the social, political, and economic context, this analysis contains detailed data on the health problems of the population, services, and other resources, thereby permitting identification of the principal obstacles to equitable and sustainable human development.

The latter facilitates the establishment of areas and topics that will guide the formulation of specific programs and projects, making it possible to monitor and evaluate their impact on the health and development of the population.

Since core data management is an essential function of PAHO's work, it should be permanently available and up-to-date at all operational levels of the Organization. It will serve to

produce, review, and provide more in-depth knowledge about the distribution and trends of the problems that the Organization must address. Each PAHOWHO Representative Office, center, and division is responsible for determining the specific datainformation needed to develop a profile of its respective areas andor problems. Maintenance and updating of the databases for each country should be carried out jointly with the national authorities and the staff in each Representative Office; these databases should be accessible to the other levels of the Organization.

The dissemination of technical information is a functional approach utilized by all of the divisions, Representative Offices, and centers when programming their technical cooperation activities. Reliable information on the health situation is needed for the preparation of publications such as the *Annual Report of the Director*, *Health Statistics from the Americas*, *Health Conditions in the Americas*, and *Evaluation and Monitoring of HFA-2000*. Preparation of these documents requires ongoing maintenance of the databases and analysis which, in turn, promotes the scientific enrichment and translates into information for decision-making.

One the most relevant challenges in technical cooperation within and among the countries is facilitating the upgrading and effective use of the information systems and analytical capability of the countries of the Region. This capability should permit expeditious quantification of unmet needs in health care and identification of neediest population groups at greatest epidemiological risk, to whom the priority actions should be directed. It should be underscored that use of the information should guide this processCnot the data itself or the infrastructure of the information systems.

5.   Characteristics of the Core Data

The core data are the minimum data and information needed to describe the health situation in a country or area or even a specific problem, including the response of the health services and available resources. The PAHOWHO mandates and commitments regarding the collection and dissemination of health statistics, specified in resolutions of the Governing Bodies, define the initial criteria for selecting the indicators (see Annex A). These mandates concern surveillance of public health problems, the evaluation of plans and programs, and the global commitments of the Region. Other indicators are included that are considered necessary for the evaluation of human resource capabilities in health. All of the selected indicators are quantitative in nature and at the same time meet the basic criteria of validity, objectivity, sensitivity, and specificity. The feasibility of obtaining the necessary data for calculating the indicators at the current time was considered, but not as a sine qua non condition, so that they could be included in the list of basic indicators.

The availability of the set of basic indicators should reduce the demand on the PAHOWHO Representative Offices and the Member Governments and eliminate multiple requests for information by the various units at Headquarters which need data on the overall health situation of the population and on health services in order to manage technical cooperation.

The list of indicators for the regional level is common to all the countries of the Region. However, the system has been conceived as an open one in which the inclusion or exclusion of indicators from the basic list does not imply breaking the structure of the database. Moreover, the regional technical programs are in the process of organizing expanded databases for the core data that is specific for the data that best characterize their respective topics and areas.

It is proposed that the countries be the primary users of the basic indicators; this will require the identification of the specific information needs of each country. A decision is needed about the level of geographical and demographic disaggregation of the data. Under the present system, the national level is the initial level for disaggregating the data; it is recommended that the disaggregation be extended to the subnational level in countries that can do so with the current information available.

Members of the Advisory Group and staff from the regional technical programs and the Representative Offices participated in the identification and selection of the indicators, under the coordination of the Program on Health Situation Analysis of the Division of Health and Human Development.

The initial version of the core data includes 118 indicators. Of these, 11 are demographic, 10 are socioeconomic, 31 are on specific mortality by age group, sex, and groups of causes, 30 are on morbidity and risk factors, and 36 are on the availability of resources, health care, and service coverage (see Annex B). Approximately 50% of the indicators on the determinants of health and disease, risk factors, and health promotion should be expanded to the extent that the existence of efficient registries or results from reliable special studies can be guaranteed in the countries.

The validation of the data included in the system will be initiated at the country level with the formation of national interinstitutional groups and will continue with a review of the data sources (which can be integrated into the system in its documentation component). At the regional level, the data will be checked against the data from available international sources and against the expected values for countries with similar levels of socioeconomic development.

The core data are stored in the following database structure:

(a)   countries: geographical level (subregion, countries, provinces, and municipalities);

(b)   subject areas: demographic, socioeconomic, mortality, morbidity and risk factors, and resourcesservicescoverage;

(c)   components of the health situation: human development, health problems, health promotion and disease prevention, health services, scientific and technological resources;

(d)   variables: 118 indicators, grouped with their values, breakdown (sex and age group), reference year, sources, and notes;

(e)   glossary: text with the definition and method for calculating each indicator.

6.   General Characteristics of the Core DataCountry Profile System

The current core datacountry profile system possesses the following structural characteristics:

(a)   The system can process numerical data and text; users need a graphic interface (WindowsInternet).

(b)   It is a multiuser system that permits simultaneous and parallel access to the information by several users.

(c)   The system has a modular design; the current prototype captures numerical data and text; thematic maps will be added later.

(d)   All fields will initially be available in two languages: English and Spanish.

The database structure uses a format compatible with the Micro ISIS package, which is the version for the mini-microcomputers of UNESCO's CDCISIS. The current structure permits its use in several platforms: Windows, OS2, UNIX, and in PC, VAX, and HP equipment.

The core data can be accessed from one or more servers on the World Wide Web using Netscape, MS Explorer, or another browser for accessing the Internet. At the present time, virtually all the PAHOWHO Representative Offices, as well as the ministries of health, have this access. However, for those that do not have it, the Organization will provide the system with the databases on diskettes that will be periodically updated.

The Program on Health Situation Analysis of the Division of Health and Human Development is responsible for developing the system described herein, in collaboration with the Latin American and Caribbean Center on Health Sciences Information (BIREME). The data were obtained from the PAHOWHO Representative Offices in the countries, from other regional technical programs of the Organization, and from national and international agencies.

7.   Country Profiles

The country profiles are analytical reports on the general health situation and on specific problems in the country. These reports include the most recent and significant political, economic, and social developments; changes in the organization of the services, health resources, and emerging health problems; and the principal technical cooperation activities of the Organization and other agencies.

8.   Bibliographic Documentation and Dissemination

Appropriate documents and bibliographies will support the quality and credibility of the data and its analysis. One of the components of the core data initiative is selecting, organizing, and making available bibliographic materials and documentation for consultation and reference on a country, as well as documenting trends in multilateral and bilateral technical and financial cooperation, specific health problems, services, and health resources.

The resulting information will be disseminated by utilizing the different media available from the Headquarters library and BIREME, in addition to other entities proposed by the Interprogrammatic Group. For the core data, the principal vehicle will be the InternetIntranet. It is proposed that the data be available on three mirror servers located at Headquarters and in two other countries of the Region (Brazil and Barbados). Another medium for information dissemination will continue to be the publication of pamphlets, such as "Basic Indicators 1996," which since 1995 has presented 54 selected indicators from the initiative.

Health Conditions in the Americas (HCA) a quadrennial publication issued since 1954, will benefit from the establishment of the core data and the country profiles. The Organization intends to document the changes and progress in health achieved by the countries, as well as the existing inequities among and within them. This publication presents the health situation of the peoples of the Region to the Pan American Sanitary Conference, as evaluated by the Secretariat of the Organization. In addition to the printed HCA document, summaries of the country chapters are available on the PAHO Home Page.

A complementary publication is *Health Statistics from the Americas*. This biennial publication is devoted primarily to mortality and demographic data prepared from the mortality and demographic databases administered by HDPHDA at Headquarters. Other kinds of data on the health situation of the population have been gradually incorporated (morbidity, for example).

The *Epidemiological Bulletin,* which appears four times a year, contains original articles prepared jointly with the different programs at Headquarters. This publishing effort represents an attempt to promote the exchange of priority information for advances in the theory and practice of public health. Moreover, mention is made of the various international resources for eliminating obstacles to policy-making or to the implementation of public health programs.

Dissemination of information and epidemiological data includes, significantly, the response to ad hoc requests from other United Nations agencies, governments, researchers, health administrators, the mass media, business, and the general public that are channeled to the Organization through different mechanisms (telephone, fax, E-mail, mail).

9.   Conclusions

The collection, analysis, use, and dissemination of health information are essential

activities of the Organization as a whole, both in technical cooperation and in PAHO's own strategic policy management.

The core datacountry profile initiative represents the most significant attempt by the Secretariat of the Organization to strengthen the existing technical information system in health in the Region of the Americas. This system will make it possible to bolster national capabilities together with those of the Secretariat in the production and utilization of the health situation analyses required to determine the unmet health needs of the population. It will also make it possible to guide the formulation of health policies and programs in a responsible and timely manner and to undertake the reorientation and organization of the health services and a strengthening of the public health surveillance systems. Obtaining results will clearly require national efforts and technical cooperation to improve the countries' analytical capacity.

Since the indicators are the markers of the health situation, service performance, or resource availability, they are subject to change in accordance with the changes in the health situation. Since the indicators included do not necessarily contain all the information used by the health programs, they should be complemented with the available bibliographic documentation and specific indicators, especially those of an operational nature. This will enable the programs to monitor the technical cooperation processes.

Finally, it is hoped that the products of the present core datacountry profile initiative will be used as a reference by health professionals and encourage ongoing system adjustment.

ANNEX A: MANDATES

-        Pan American Sanitary Code (Havana, 1924).

-        HFA (CFM3, WHOHSTGSP93.3, 1993).

-        World Summit for Children (Interagency Coordinating Committee for the Americas).

-        Regional Plan for the Reduction of Maternal Mortality in the Americas (CE111.R6, June 1993).

-        International Drinking Water Supply and Sanitation Decade (Environmental Series No. 6, 1987).

-        Expanded Program on Immunization (EPI).

-        Implementation of the Expanded Program on Immunization and the Plan of Action for the Eradication of Indigenous Transmission of Wild Poliovirus from the Americas (CE109.R8, June 1992).

-        Measles Elimination in the Americas (CE116.R7, June 1995).

-        Reportable Diseases.

-        Elimination of Rabies (RIMSA8.R6, April 1993).

-        Elimination of Congenital Syphilis in the Americas (CE116.R3, June 1995).

-        Plan of Action for the Elimination of Vitamin A Deficiency from the Americas (CE109.R3, June 1992).

-        Plan of Action for the Elimination of Leprosy from the Americas (CE109.R4, June 1992).

-        Acquired Immunodeficiency Syndrome (AIDS) in the Region of the Americas (CE116.R8, June 1995).

-        Ninth General Program of Work (WHOHQISMIDD.0795) (this mandate includes only those that were not contained in WHOHSTGSP93.3, 1993).

ANNEX B: REGIONAL CORE DATA

A.   DEMOGRAPHIC

A.1   Population (S, E1)
A.2   Life expectancy at birth (S)
A.3   Total fertility rate
A.4   Annual population growth rate (%)
A.5   Percent urban population
A.6   Number of births registered
A.7   Estimated crude birth rate
A.8   Number of deaths registered
A.9   Estimated crude death rate (S)
A.10   Population under 15 years as a % of
          total population
A.11   Population 65 years and over as a
          % of total population (S)

B.   SOCIOECONOMIC

B.1   Availability of calories (Kcaldayper
          capita)
B.2   Literacy rate (S)
B.3   Average number of schooling of the
          population
B.4   Gross domestic product per capita, in
          constant 1990 US$
B.5   Gross domestic product per capita, in
          US$ adjusted for purchasing power
          parity (PPP)
B.6   Ratio of 20% highest income
          20% lowest income
B.7   Percent of population living in
          poverty
B.8   Percent of population living in
          extreme poverty
B.9   Rate of unemployment
B.10   Inflation: Annual change in consumer
          price index

C. MORTALITY

C.1 Infant mortality rate
C.2 Neonatal mortality rate
C.3 Postneonatal death rate
C.4 Perinatal mortality rate
C.5 Estimated death rate (S,E1)
C.6 Mortality rate under 5 years
      (UNICEF) (S)
C.7 Percent of deaths under 1 year of age
      due to certain conditions originating
      in the perinatal period
C.8 Number of registered deaths under
      5 years of age due to measles for the
      year specified
C.9 Registered deaths among children
      under 5 years from other diseases
      preventable by immunization (diph-
      theria, whooping cough, tetanus,   polio) for the year specified
C.10 Estimated death rate among children
      under 5 years due to intestinal infec-
      tious diseases
C.11 Estimated death rate among children
      under 5 years due to acute respira-
      tory infections
C.12 Number of registered deaths due to
      tetanus neonatorum for the year
      specified
C.13 Maternal mortality rate
C.14 Estimated death rate due to commu-
      nicable diseases (S, E1)
C.15 Number of registered death from
      tuberculosis for the year specified (S)
C.16 Number of registered deaths from
      AIDS for the year specified (S)
C.17 Estimated death rates due to diseases
      of the circulatory system (S, E1)

C.18 Estimated death rates due to ischemic
      heart disease (S, E2)
C.19 Estimated death rates due to cerebro-
      vascular diseases (S, E2)
C.20 Estimated death rates due to malig-
      nant neoplasms (all types) (S, E1)
C.21 Estimated deaths rates due to malig-

nant neoplasms of lung, trachea, and bronchus (S, E2)

C.22   Estimated death rates (female) due to malignant neoplasms of uterus (E3)

C.23   Estimated death rates (female) due to malignant neoplasms of the breast (E3)

C.24   Estimated death rates due to malig-nant neoplasms of the stomach (S, E2)

C.25   Estimated death rates from external causes (S, E1)

C.26   Estimated death rates due to acci-dents, excluding transport (S, E4)

C.27   Estimated death rates due to trans-port accidents (S, E4)

C.28   Estimated death rates due to suicides and self inflicted injury, age 15 years and over (S)

C.29   Estimated death rates due to homi-cides, age 15 years and over

C.30   Estimated death rates due to cirrhosis and chronic liver diseases (S, E3)

C.31   Estimated death rates due to diabetes mellitus (S, E2)

D.   MORBIDITY AND RISK FACTORS

D.1   Percentage of live births weighing less than 2,500 grams

D.2   Proportion of children under 5 years of age with weight for age less than minus 2 standard deviations from the WHO reference median - moderate and severe deficit (S)

D.3   Percent of infants exclusively breast- fed through 120 days of age

D.4   Average number of decayed missing and filled teeth at age 12

D.5   Number of confirmed cases of polio-myelitis registered during the year

D.6   Number of measles cases registered during the year among children under 5 years of age

D.7   Number of cases of diphtheria regis-

tered during the year among children under 5 years

D.8 Number of cases of whooping cough registered during the year among children under 5 years of age

D.9 Reported cases of tetanus neonatorum registered during the year

D.10 Number of cases of yellow fever registered during the year

D.11 Reported cases of plague registered during the year

D.12 Number of cases of dengue registered during the year

D.13 Number of cases of human rabies registered during the year

D.14 Number of cases of congenital syphilis registered during the year

D.15 Number of cases of cholera registered during the year

D.16 Malaria annual parasitic index (S)

D.17 Number of cases of syphilis registered during the year

D.18 Number of cases of tuberculosis registered during the year (S)

D.19 Number of cases of AIDS registered during the year (S)

D.20 Prevalence of leprosy cases (S)

D.21 Proportion of women of childbearing age (15-49 years) currently using any type of contraceptive method

D.22 Adolescent fertility rate (under 20 years of age)

D.23 Incidence of malignant neoplasms of lung (S)

D.24 Incidence of malignant neoplasms of stomach (S)

D.25 Incidence of malignant neoplasms of female breast

D.26 Incidence of malignant neoplasms of the cervix uteri

D.27 Prevalence of hypertension (S)

D.28 Prevalence of diabetes mellitus type 2 (S)

D.29 Prevalence of overweight among adults (20-74 years) (S)

D.30   Proportion of youth 15-19 years of age who smoke (S)

E.   RESOURCES, SERVICES AND COVERAGE

E.1   Percent of population with access to health services

E.2   Percent of urban population with potable water through house connections

E.3   Percentage of urban population with reasonable access to public sources of potable water

E.4   Percent of rural population with reasonable access to potable water

E.5   Percent of urban population with house connections to public sewer systems

E.6   Percent of urban population served by individual systems of excreta disposal

E.7   Percent of rural population having adequate sanitary means of excreta disposal

E.8   Percent of population with access to disinfected water supplies

E.9   Percent of urban population with regular solid waste collection

E.10   Percent of children under 1 year attended by trained personnel

E.11   Percent of children under 1 year vaccinated against diphtheria, whooping cough and tetanus (DPT3)

E.12   Percent of children under 1 year vaccinated against measles

E.13   Percent of children under 1 year vaccinated against poliomyelitis (OPV3)

E.14   Percent of children under 1 year vaccinated against tuberculosis (BCG)

E.15   Percent of pregnant women attended by trained personnel during pregnancy

E.16   Percent of pregnant women attended
        by trained personnel during first
        trimester of pregnancy
E.17   Percent of deliveries attended by
        trained personnel
E.18   Cumulative % (over the last 5 years)
        of women of childbearing age (12-40
        yrs) living in at-risk areas who have
        received tetanus toxoid
E.19   Ambulatory care consultations (any
        type) per inhabitant per year
E.20   Number of hospital discharges per
        100 population
E.21   Population per physician
E.22   Number of graduates in medicine
E.23   Population per university-trained
        professional nurse
E.24   Number of university graduates in
        professional nursing
E.25   Population per non-university trained
        nursing personnel
E.26   Population per dentist
E.27   Population per hospital bed
E.28   Number of ambulatory care estab-
        lishments. Ministry of health and
        social security
E.29   National health expenditure as
        percent of Gross National Product
E.30   Public hospital expenditures as
        percent of government health
        expenditure
E.31   Government health expenditure as
        percent of national health expenditure
E.32   Underregistration of births (%)
E.33   Percentage of birth registration
        which are for children over 1 year
        old at time of registration
E.34   Underrregistration of mortality (%)
E.35   Deaths with medical care as % of
        registered deaths (if unavailable,
        % of deaths with medical cause-of-
        death certification)
E.36   Deaths due to signs, symptoms, and
        ill defined conditions as % of
        registered deaths

Detail:

S   By sex
E1   Under 1 year, 1-4, 5-14, 15-44, 45-64, 65 and over
E2   45-64, 65 and over
E3   35-44, 45-64, 65 and over
E4   Under 15 years and 15 years and over