

Child Health USA 2011



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PREFACE AND READER'S GUIDE

The Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is pleased to present *Child Health USA 2011*, the 21st annual report on the health status and service needs of America's children. MCHB envisions a Nation in which the right to grow to one's full potential is universally assured through attention to the comprehensive physical, psychological, and social needs of the maternal and child population. To assess the progress toward achieving this vision, MCHB has compiled this book of secondary data for more than 50 health status and health care indicators. It provides both graphical and textual summaries of relevant data, and addresses long-term trends where applicable and feasible.

All of the data discussed within the text of *Child Health USA* are from the same sources as the information in the corresponding graphs, unless otherwise noted. Data are presented for the target population of the Title V Maternal and Child Health Block Grant: infants, children, adolescents, children with special health care needs, and women of childbearing age. *Child Health USA 2011* addresses health status and health services utilization within this population, and offers insight into the Nation's prog-

ress toward the goals set out in the MCHB's strategic plan—to assure quality of care, eliminate barriers and health disparities, promote an environment that supports maternal and child health, and improve the health infrastructure and system of care for women, infants, children, and families.

Child Health USA is designed to provide the most current data available for public health professionals and other individuals in the public and private sectors. The book's succinct format is intended to facilitate the use of the information as a snapshot of children's health in the United States.

Population Characteristics is the first section and presents statistics on factors that influence the well-being of children, including poverty, education, and child care. The second section, entitled Health Status, contains vital statistics and health behavior data for the maternal and child population. Health Services Financing and Utilization, the third section, includes data regarding health care financing and utilization of selected health services. The final sections, State Data and City Data, contain information on selected indicators at those levels.

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INTRODUCTION

The health of the child population is reflective of the overall health of a Nation, and has many implications for the Nation's future as these children grow into adults. Physical, mental, and emotional health affect virtually every facet of life, such as learning, participation in leisure activities, and employment. Health habits established in childhood often continue throughout the lifespan, and many health problems in childhood, such as obesity and poor oral health, influence health into adulthood. Effective policies and programs are important to the establishment of healthy habits and the mitigation of risk factors for disease. However, the health and health care needs of children change over time, and current data on these issues is critically important as policy makers and program planners seek to maximize the health of children, now and into the future.

In 2010, nearly 25 percent of the U.S. population was under 18 years of age. The racial and ethnic composition of the child population is shifting, with a growing population of Hispanics and a decline in the representation of non-Hispanic Whites. In addition to race and ethnicity, the demographic composition of a population can also be characterized by factors such as nativity, poverty, and geographic location. In 2009, 21.9 percent of children in the United States had at least one foreign-born

parent. Of all children, 18.9 percent were U.S.-born with a foreign-born parent or parents, and 3.0 percent were themselves foreign-born. In the same year, over 15 million children under 18 years of age lived in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009), representing 20.7 percent of all children in the United States. Differences in health risks have also been observed for children by geographic location. In 2007, about 82 percent of children lived in urban areas while 18 percent lived in either large or small/isolated rural areas. Children in rural areas—particularly those in small or isolated rural communities—were more likely to be overweight or obese than children living in urban areas.

Good health begins before birth. Timely prenatal care is an important preventive strategy that can help protect the health of both mother and child. In 2008, 71.0 percent of women began prenatal care during the first trimester (according to data from areas using the “revised” birth certificate (For more information, please see page 67). A small proportion of women (7.0 percent) did not receive prenatal care until the third trimester, or did not receive any at all.

Following birth, there are a variety of preventive or protective factors that can affect a child's health. Vaccination is a preventive health measure that begins immediately after birth and

protects into adulthood. Vaccines are available for a number of public health threats, including measles, mumps, rubella (German measles), polio, diphtheria, tetanus, pertussis (whooping cough), hepatitis B, and varicella (chicken pox). In 2009, 70.5 percent of children 19–35 months of age received this recommended series of vaccines. This estimate excludes receipt of the *Haemophilus influenzae* type b vaccine (Hib) which has been presented in previous editions of *Child Health USA*. For more information, please see page 57.

Breastfeeding is also an important protective factor, and rates have increased steadily since the beginning of the last decade. In 2007, 75.5 percent of children through age 5 had been breastfed for some period of time. Although recommended by the American Academy of Pediatrics, only 12.4 percent of children were breastfed exclusively (without supplemental food or liquids) for the first 6 months of life. Exclusive breastfeeding through the first 6 months of life was more common among older mothers and mothers with more than a high school level education.

Family and neighborhood characteristics can also play a role in the health and well-being of children. In 2009, 71.4 percent of women with children under 18 years of age were in the labor force (either employed or looking for work). Mothers with children under 6 years of age were

less likely to be in the labor force (64.2 percent). In 2007, 54.2 percent of children from birth through age 5 were in child care for 10 or more hours per week, but not all families were able to secure needed child care: nearly 20 percent of families who did not receive 10 or more hours of child care per week reported that they needed it. Family activities and parent-child relationships can affect health and well-being, and in 2007, nearly 70 percent of parents with children aged 6-17 years reported that they could share ideas or talk about things that really matter with their children. The proportion of parents reporting that they could share ideas and have meaningful conversations with their child was higher among those with children aged 6-11 years than those with children aged 12-17 years.

Physical activity is another factor that can affect health through the lifespan. Results from the Youth Risk Behavior Surveillance System show that 18.4 percent of high school students met currently recommended levels of physical activity in 2009 (one hour or more of physical activity every day, most of which should be moderate- to vigorous-intensity aerobic activity). Nearly one-quarter of students did not participate in 60 or more minutes of physical activity on any day in the preceding week. Participation in physical activity can be adversely impacted by in media use—or “screen time”. The American Academy of Pediatrics recommends that parents

limit children’s daily use of media to 1-2 hours per day. Yet, in 2007, 12.8 percent of pre-school aged children and 10.8 percent of children aged 6-17 years engaged in 4 or more hours of media use on an average weekday, including watching TV or videos or playing video games.

Child Health USA also presents information on risk factors for adverse health outcomes. According to preliminary data, 8.2 percent of infants were born low birth weight (less than 2,500 grams or 5 pounds 8 ounces) in 2009, and 1.5 percent of infants were born very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces). Children born underweight are more likely to suffer from long-term disability and have higher rates of mortality than children born of normal weight.

Violence and neglect are also risk factors for poor health, and in 2009, investigations determined that an estimated 702,000 children were victims of abuse or neglect, equaling a victimization rate of 9.3 per 1,000 children in the population. Victimization rates were highest among young children. Among older children, peer violence is also of concern. In 2009, 11.1 percent of high school students reported that they had been in a physical fight on school property in the prior 12 months and 9.8 percent reported that they had experienced dating violence—having been hit, slapped or physically hurt on purpose—at the hands of a boyfriend

or girlfriend.

Information on the prevalence of various diseases and conditions in childhood is also important in the effort to improve health in the child population. For instance, obesity is a serious health concern for children—obese children are more likely to have risk factors for cardiovascular disease, such as high blood pressure, high cholesterol, and Type 2 diabetes. Obese children are also at increased risk of obesity in adulthood, which is associated with a host of serious health consequences. In 2007, 15.3 percent of children aged 10–17 years were overweight and 16.4 percent were obese, based on parent-reported height and weight.

HIV/AIDS and other sexually transmitted infections (STIs) are also of concern. In 2009, an estimated 166 children younger than 13 years of age and an estimated 8,294 people aged 13–24 years were diagnosed with HIV. Chlamydia continues to be the most common STI among adolescents and young adults. Based on the number of cases reported to the Centers for Disease Control and Prevention, there were 2,000 chlamydial infections per 100,000 adolescents and 2,165 infections per 100,000 young adults in 2009. Rates of gonorrhea were 405 and 479 per 100,000 adolescents and young adults, respectively.

In 2009, there were nearly 3.1 million hospital discharges among people aged 1–21 years.

While injuries are the leading cause of death among this age group, they were not the most common cause of hospitalization. In 2009, diseases of the respiratory system were the most common cause of hospitalization among children aged 1–4 and 5–9 years, while mental disorders were the most common cause of hospitalization among children aged 10–14 years, and pregnancy and childbirth was the most common cause of hospitalization for adolescents aged 15–19 years and young adults aged 20–21 years.

Depression and suicide remain critical public health challenges for the adolescent population, in particular. In 2009, 2.0 million adolescents—or 8.1 percent of children aged 12–17 years—experienced at least one major depressive episode (MDE). Occurrence of MDE was significantly higher among females (11.7 percent). In the same year, data from the Youth Risk Behavior Surveillance System found that 13.8 percent of all high school students had considered attempting suicide in past 12 months while 6.3 percent reported at least one suicide attempt during the same period.

The health status and health services utilization indicators reported in *Child Health USA* can help policymakers and public health officials better understand current trends in pediatric health and wellness and determine what programs might be needed to further improve the

public's health. These indicators can also help identify positive health outcomes which may allow public health professionals to draw upon the experiences of programs that have achieved success. The health of our children and adolescents relies on effective public health efforts that include providing access to knowledge, skills, and tools; providing drug-free alternative activities; identifying risk factors and linking people

to appropriate services; building community supports; and supporting approaches that promote policy change, as needed. Such preventive efforts and health promotion activities are vital to the continued improvement of the health and well-being of America's children and families.





POPULATION CHARACTERISTICS

The increasing diversity of the United States population is reflected in the sociodemographic characteristics of children and their families. The percentage of children who are Hispanic has more than doubled since 1980, while the percentage who are non-Hispanic White has declined. The percentage of children who are Black has remained relatively stable. This reflects the changes in the racial and ethnic makeup of the population as a whole.

At the national, State, and local levels, policymakers use population information to address health-related issues that affect mothers, children, and families. By carefully analyzing and comparing available data, public health professionals can often identify high-risk populations that could benefit from specific interventions.

This section presents data on several population characteristics that influence maternal and child health program development and evaluation. Included are data on the age and racial and ethnic distribution of the U.S. population, as well as data on the poverty status of children and their families, child care arrangements, and education.

POPULATION OF CHILDREN

In 2009, there were more than 74 million children under 18 years of age in the United States, representing nearly 25 percent of the population. Young adults aged 18–24 years made up another 9.9 percent of the population, while adults aged 25–64 years composed 52.9 percent of the population, and adults aged 65 years and older composed 12.9 percent.

The age distribution of the population has shifted significantly in the past several decades. The percentage of the population that is under 18 fell from 28.2 percent in 1980 to 24.3

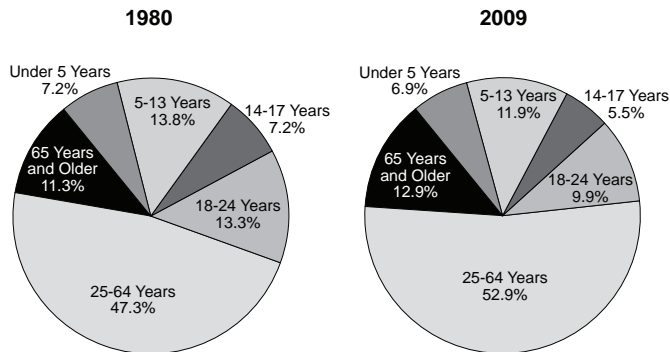
percent in 2009. The representation of young adults (aged 18–24 years) has also declined, from 13.3 percent to 9.9 percent. During this time period, the percentage of the population that is aged 25–64 years increased from 47.3 percent to 52.9 percent, and the percentage that is over 65 years increased from 11.3 percent to 12.9 percent. The median age in the United States has increased from 30.0 years in 1980 to 36.8 years in 2009 (data not shown).

The shifting racial/ethnic makeup of the child population (under 18 years) reflects the increasing diversity of the population as a

whole. Hispanic children represented less than 9 percent of children in 1980, compared to more than 22 percent in 2009, while the percentage of children who are Black remained relatively steady over the same period, around 15 percent. However, the percentage of children who are non-Hispanic White fell significantly, from 74.3 percent in 1980 to 55.3 percent in 2009. Changes in the ways that racial and ethnic data were collected after 2000 limit comparison over time for some groups, including Asians and Native Hawaiians and Other Pacific Islanders, and individuals of more than one race.

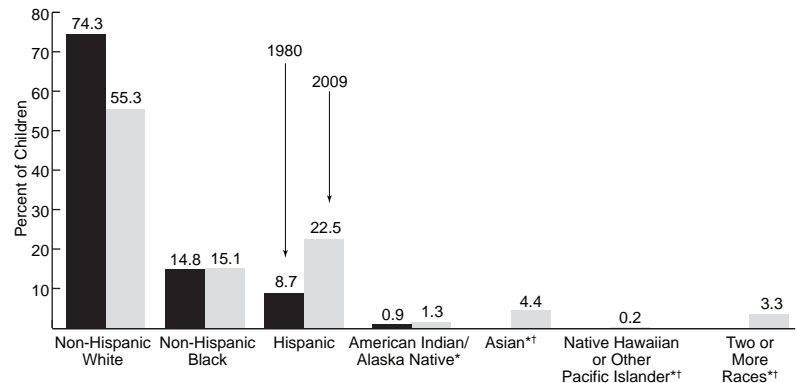
U.S. Population, by Age Group, 1980 and 2009

Source (I.1): U.S. Census Bureau, Annual Population Estimates



Population of Children Under Age 18, by Race/Ethnicity, 1980 and 2009

Source (I.1): U.S. Census Bureau, Annual Population Estimates



*May include Hispanics. **1980 data are not available.

CHILDREN IN POVERTY

In 2009, more than 15 million children under 18 years of age lived in households with incomes below 100 percent of the U.S. Census Bureau’s poverty threshold (\$21,954 for a family of four in 2009); this represents 20.7 percent of all children in the United States. Poverty affects many aspects of a child’s life, including living conditions, nutrition, and access to health care. A number of factors affect poverty status, and significant racial/ethnic disparities exist. In 2009, 35.7 percent of non-Hispanic Black children, 34.0 percent of non-Hispanic American Indian/Alaska Native children, and 33.1 percent of Hispanic children lived in households with incomes below 100

percent of the poverty threshold, compared to 11.9 percent of non-Hispanic White children.

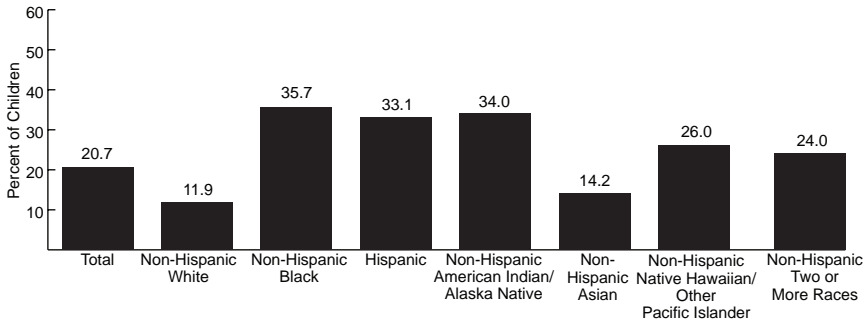
Single-parent families are particularly vulnerable to poverty. In 2009, 44.3 percent of children living in a female-headed household experienced poverty, as did 26.5 percent of children living in a male-headed household. Only 11.1 percent of children living in married-couple families lived in poverty (data not shown). The proportion of children living in poverty varies by age and family type. In 2009, 54.3 percent of children under 5 years of age living in female-headed households lived in poverty, while the same was true of 39.5 percent of children aged 6–17 years.

A number of Federal programs work to protect the health and well-being of children living in low-income families. One of these is the National School Lunch Program, administered by the U.S. Department of Agriculture’s Food and Nutrition Service. The program provides nutritionally-balanced low-cost or free lunches to children based on income. In 2009, the program served free lunch to 16.3 million children and reduced-price lunch to another 3.2 million children. This represents 62.5 percent of all lunches served in participating schools.¹

1 U.S. Department of Agriculture, Food and Nutrition Service. Child nutrition tables: National Level Annual Summary Tables. Available online: <http://www.mypyramidforkids.gov/pdf/cnpmain.htm>. Accessed March 2011.

Children Under Age 18 Living in Households with Incomes Below 100 Percent of the Poverty Threshold,* by Race/Ethnicity, 2009

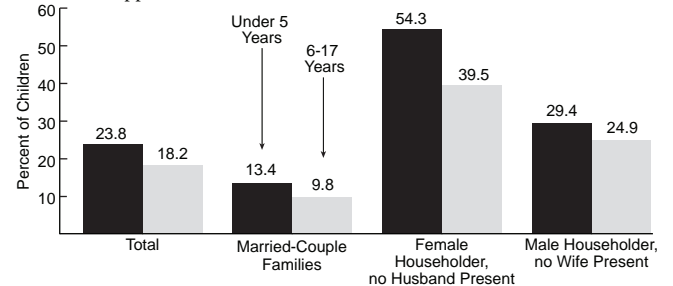
Source (I.2): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009.

Children Under Age 18 Living in Families* with Incomes Below 100 Percent of the Poverty Threshold, by Age and Family Type, 2009**

Source (I.2): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



*Includes only children who are related to the head of household by birth, marriage, or adoption.

**The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009.

CHILDREN OF FOREIGN-BORN PARENTS

The foreign-born population in the United States has increased substantially since the 1970s, largely due to immigration from Asia and Latin America. In 2009, 21.9 percent of children in the United States had at least one foreign-born parent. Of all children, 18.9 percent were U.S.-born with a foreign-born parent or parents, and 3.0 percent were themselves foreign-born. Most children (73.8 percent) were native-born with native-born parents.

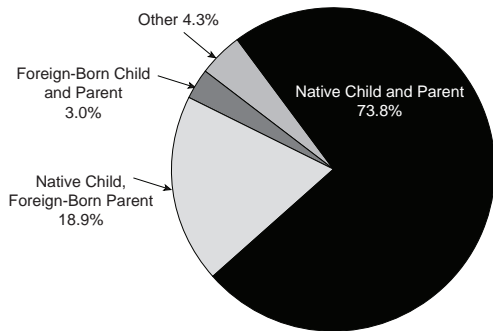
Children's poverty status varies with their nativity. In 2009, foreign-born children with foreign-born parents were most likely to live in poverty, with 32.7 percent living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009). Another 29.0 percent of these children lived in households with family incomes of 100–199 percent of the poverty threshold. Native-born children with native parents were the least likely to experience poverty, with 16.4 percent living in households with incomes below 100 percent of the poverty

threshold, and another 19.4 percent living in households with incomes of 100–199 percent of the poverty threshold.

A number of other sociodemographic factors vary by the nativity of children and their parents. For instance, native-born children with native parents were most likely to have health insurance in 2009 (92.8 percent), while foreign-born children with foreign-born parents were least likely (66.3 percent). Almost 87 percent of native-born children with foreign-born parents had health insurance in 2009 (data not shown).

Children Under Age 18, by Nativity of Child and Parent(s)* 2009

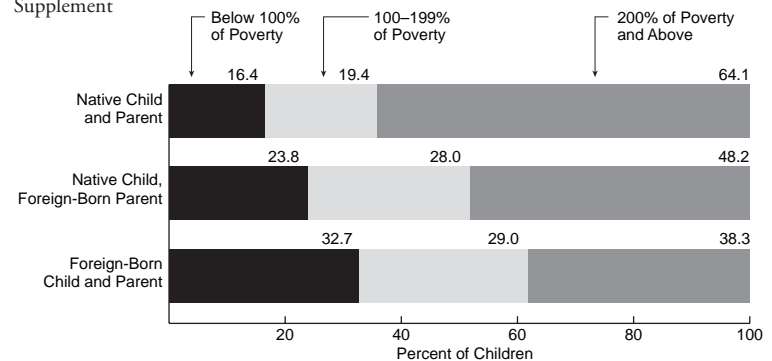
Source (I.3): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



*"Native parent" indicates that both of the child's parents were U.S. citizens at birth, "foreign-born parent" indicates that one or both parents were born outside of the United States, and "other" includes children with parents whose native status is unknown and foreign-born children with native parents.

Children Under Age 18, by Nativity of Child and Parent(s)* and Poverty,** 2009

Source (I.3): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



**"Native parent" indicates that both of the child's parents were U.S. citizens at birth, "foreign-born parent" indicates that one or both parents were born outside of the United States. **The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009.

ADOPTED CHILDREN

In 2007, there were approximately 1.8 million adopted children living in the United States. Of all adopted children, 38 percent were placed with families through private domestic adoption, meaning the child was voluntarily placed for adoption by his or her biological parents. Another 37 percent of adopted children were placed with their families through foster care adoption, and the remaining 25 percent of adopted children came to their families through international adoption (data not shown).

Overall, the sex distribution of adopted children is about even, but this varies by adoption type. Only one-third of children

adopted internationally are male (33 percent) compared to 57 percent of children adopted from foster care and 51 percent of children adopted privately in the U.S. The racial/ethnic distribution of adopted children also varies across adoption types, with private adoptions most likely to involve non-Hispanic White children and international adoptions most likely to involve Asian children (data not shown).

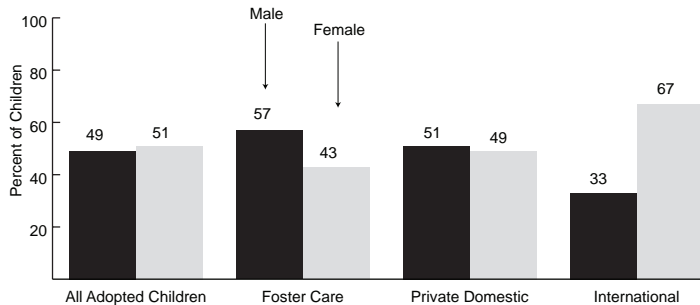
The majority of adopted children, 85 percent, were reported by their parents to be in “excellent” or “very good” health; however, nearly 40 percent of adopted children have special health care needs. Children with special health care needs are those who have or are at increased

risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.¹ Children adopted from foster care are more likely to have a special health care need (54 percent) compared to children adopted privately from the United States (32 percent) or internationally (29 percent).

1 McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. A new definition of children with special health care needs. Pediatrics, 102(1):137-140, 1998.

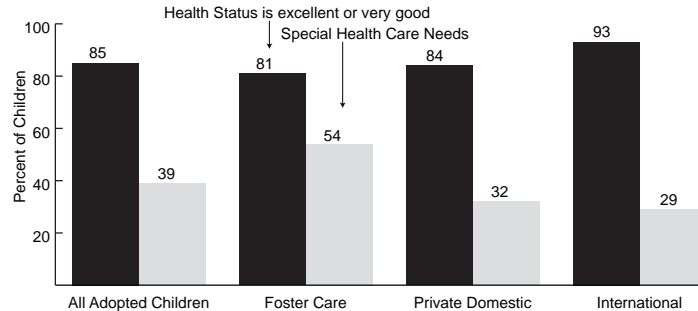
Adopted Children,* by Adoption Type and Sex,** 2007

Source (I.4): Office of the Assistant Secretary for Planning and Evaluation and the Administration for Children and Families, National Survey of Adoptive Parents



Adopted Children,* by Adoption Type and Selected Health Status Indicators,** 2007

Source (I.4): Office of the Assistant Secretary for Planning and Evaluation and the Administration for Children and Families, National Survey of Adoptive Parents



*Adopted children were defined as those with at least one adoptive parent, but no biological parents, in the household. **Published analyses of this data source round all estimates to the nearest whole number.

*Adopted children were defined as those with at least one adoptive parent, but no biological parents, in the household. **Published analyses of this data source round all estimates to the nearest whole number.

RURAL AND URBAN CHILDREN

The health risks facing children often vary by geographic location. For instance, children living in rural areas are more vulnerable to death from injuries,¹ and are more likely to use tobacco than their urban counterparts.² Rural families may also not have the same access to health care because health services are not always located nearby.³ Understanding these potential risks can provide program planners and policymakers information that can be used to design and target services.

In 2007, 81.7 percent of children lived in urban areas, while about 9 percent lived in large and small/isolated rural areas, respectively (data not shown). These areas were classified based on zip code, the size of the city or town, and the commuting pattern in the area. Urban areas include metropolitan areas and surrounding towns, large rural areas include towns with populations of 10,000 to 49,999 persons and their surrounding areas, and small/isolated rural areas include towns with populations of 2,500 to 9,999 persons and their surrounding areas.

Rural and urban children did not differ in the proportion who were insured; however, rural children were more likely to have public insurance (38.3 percent among those in small/isolated rural areas and 35.6 percent in large rural areas) compared to urban children (27.2 percent). While the majority of children had a preventive physical or oral health visit in the past

year (88.5 percent), children in both large and small/isolated rural communities were slightly less likely to have had either such visit compared to their urban counterparts (data not shown).

Rural and urban children did not differ in their overall physical and oral health status; however, differences were found for specific health indicators by location. Children aged 10-17 years in small/isolated rural areas were more likely to be overweight or obese than children in urban areas (35.2 versus 30.9 percent) and were also more likely to spend more than 1 hour per weekday watching TV or videos or playing video games than urban children of the same age (55.3 versus 50.9 percent). However, children in small/isolated rural areas were more likely to engage in

physical activity everyday (28.9 percent) than those in urban (24.6 percent) or large rural areas (23.3 percent) and also had a higher rate of daily shared family meals than children living in urban areas (40.7 percent versus 35.0 percent).

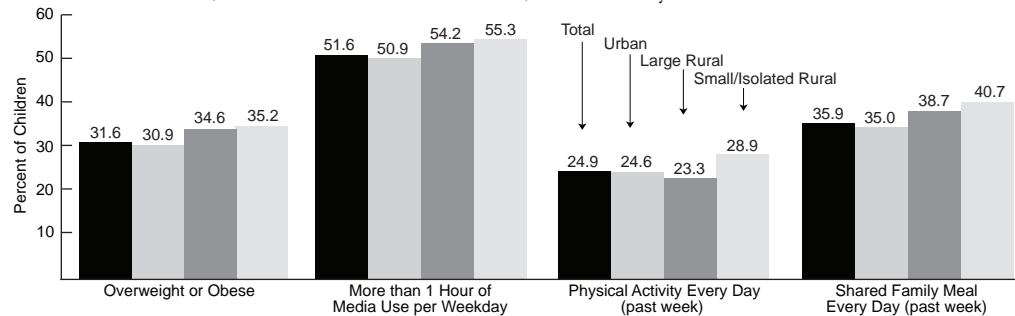
1 Cherry DC, Huggins B, Gilmore K. *Children's health in the rural environment. Pediatric Clinics of North America* 54 (2007):121-133.

2 Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. (2009) *Monitoring the Future: National Survey Results on Drug Use, 1975-2008. (NIH Publication No. 09-7402.)* Bethesda, MD: National Institute on Drug Abuse.

3 Probst JC, Laditka SH, Wang J-Y, Johnson AO. *Effects of residence and race on burden of travel for care: cross sectional analysis of the 2001 US National Household Travel Survey. BMC Health Serv Res* 2007 Mar 9;7:40.

Selected Indicators Among Children Aged 10-17, by Location,* 2007

Source (I.5): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health.



*Urban areas include metropolitan areas and surrounding towns, large rural areas include towns with populations of 10,000 to 49,999 persons and their surrounding areas, and small/isolated rural areas include towns with populations of 2,500 to 9,999 persons and their surrounding areas.

EDUCATION

In 2008, there were nearly 3.3 million high school status dropouts in the United States, representing a “status dropout” rate of 8.0 percent. Status dropout refers to those 16–24 years of age who are not enrolled in school and have not earned high school credentials (diploma or equivalent). This rate has declined steadily over the past several decades, with a decrease of 43 percent since 1980 (when the rate was 14.1 percent).

Historically, Hispanic students have had the highest dropout rates among youth of all racial/ethnic groups. Racial/ethnic differences in status dropout rates also vary by student sex

and nativity. In 2008, the status dropout rate among Hispanics born in the United States (10.8 percent) was much lower than the rate for foreign-born Hispanics (34.6 percent; data not shown). Overall, 10.4 percent of males were status dropouts compared to 7.9 percent of females. The highest rate observed was for Hispanic males (21.9 percent).

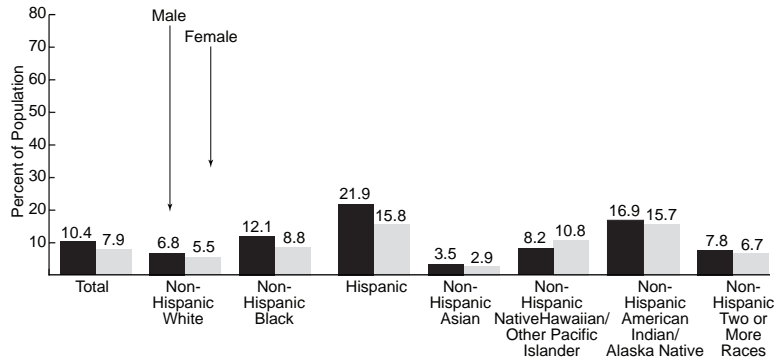
Children are educated in a variety of settings, including public and private schools and at home. In 2007, the majority of all children aged 5-17 years attending kindergarten through 12th grade were in public schools, including 70.6 percent who attended their assigned public school and 15.0 percent who attended another

public school of choice. An additional 11.4 percent of students attended private schools while 2.9 percent were homeschooled.² School type and setting varied by race/ethnicity. A higher proportion of Hispanic students were enrolled in assigned public schools than non-Hispanic Whites (74.6 versus 69.9 percent, respectively); non-Hispanic Whites were also less likely to be enrolled in a public school of choice (12.0 percent) than non-Hispanic Blacks (23.0 percent). Conversely, a higher proportion of non-Hispanic White children attended private school or were homeschooled.

² Percentages may not sum to 100 due to rounding.

School Status Dropout* Rates Among Persons Aged 16–24 Years, by Race/Ethnicity and Sex, 2008

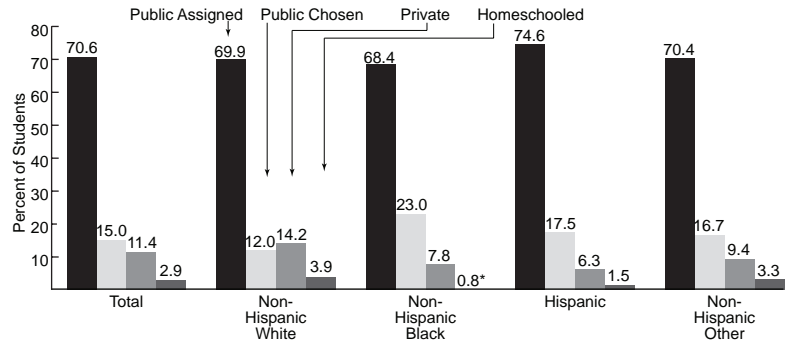
Source (I.6): U.S. Census Bureau, American Community Survey



*Status dropout refers to those 16-24 years of age who are not enrolled in school and have not earned high school credentials (diploma or equivalent).

Students Aged 5-17 Years, by Race/Ethnicity and School Type or Setting, 2007

Source (I.7): U.S. Department of Education, National Center for Education Statistics, National Household Education Survey, Parent and Family Involvement in Education Survey



*Interpret with caution; coefficient of variation is >30 percent.



HOMELESS AND SHELTERED FAMILIES

Children and youth are considered to be homeless if they do not have a fixed, regular, and adequate nighttime residence. This includes children living in shelters, transitional housing, cars, campgrounds, motels and hotels, or sharing housing with others due to loss of housing or economic hardship.¹ The exact number of children and adults who are homeless is not known, however, the US Department of Housing and Urban Development (HUD) estimated that approximately 1.6 million people, or one in every 200 Americans, spent at least one night in emergency shelter or transitional housing in 2009. Although the majority of those in shelter are individuals, persons in families – households with at least one adult and one child – accounted for 34.1 percent (or 535,477) of those using emergency shelters or

transitional housing. Between 2007 and 2009, family homelessness (as reflected by emergency and transitional shelter use) increased approximately 30 percent while a decrease in the number of individuals using shelter was observed during the same period (data not shown).²

Homeless families in emergency shelter or transitional housing differ substantially from homeless individuals. While sheltered individuals are more likely to be male (72.7 percent), over the age of 30 (75.2 percent), disabled (42.9 percent), and of veteran-status (13.0 percent), the majority of persons in sheltered families are female (79.6 percent), African American (47.9 percent), and under the age of 31 (82.4 percent). Overall, 22.2 percent of all sheltered homeless persons are under the age of 18, the majority of whom (52.6 percent) are under the age of 6 (data not shown).

The path into and out of emergency shelter

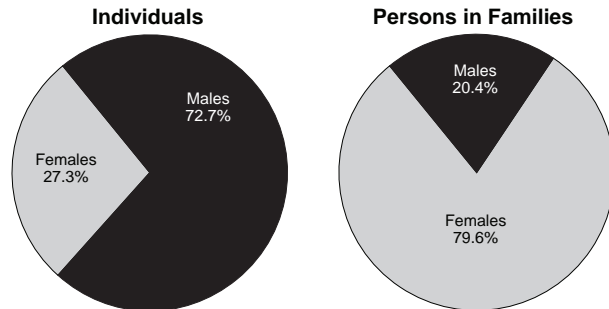
and transitional housing is also different for families and individuals. Among adults in families, 62.6 percent entered emergency shelter or transitional housing from some other form of shelter, including a rented or owned housing unit. The same was true for only 36.6 percent of individuals, the majority of whom were already homeless before seeking emergency shelter. Families are also more likely to stay in shelter for longer periods of time than individuals. In 2009, the average number of nights spent in emergency shelter among persons in families was 36 compared to 17 among individuals (data not shown).

1 National Coalition for the Homeless. *Who is homeless?* Available at: <http://nationalhomeless.org/factsheets/who.html>. Accessed May 2011.

2 U.S. Department of Housing and Urban Development. *The 2009 Annual Homeless Assessment Report to Congress.* Available at: <http://www.hudhre.info/documents/5thHomelessAssessmentReport.pdf>. Accessed May 2011.

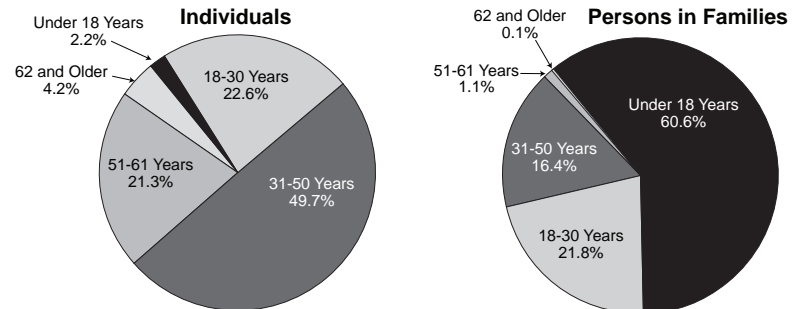
Sheltered Homeless Persons by Household Type and Sex, 2009

Source (I.8): U.S. Department of Housing and Urban Development. Homeless Management Information System.



Sheltered Homeless Persons by Household Type and Age, 2009

Source (I.8): U.S. Department of Housing and Urban Development. Homeless Management Information System.



CHILD-FAMILY CONNECTEDNESS

Family activities can promote bonding and help children lay the groundwork for future health and well-being. Sharing meals is a bonding activity that can also encourage good nutritional habits. In 2007, 45.8 percent of children under 18 years of age ate at least one meal every day with all other members of their household in the prior week while less than 5 percent of children did not share at least one meal with all the other members of their household. Sharing of meals varied by family income, with 58.2 percent of children living in households with incomes below 100 percent of the Federal pov-

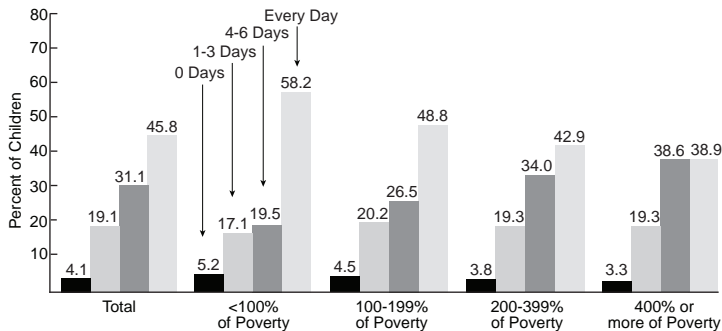
erty level (\$20,650 for a family of four in 2007) sharing meals daily compared to 48.8 and 42.9 percent of children living in households with incomes between 100-199 and 200-399 percent of the Federal poverty level, respectively, sharing daily family meals. Only 38.9 percent of children with household incomes of 400 percent or more of the Federal poverty level shared a meal every day with all other members of their household in the prior week.

In 2007, the parents of nearly 70 percent of children between the ages of 6 and 17 years reported that they could share ideas or talk about

things that really matter very well with their children. Less than one third (27.1 percent) reported that they could share ideas or talk about things that really mattered only somewhat well with their children and 3.1 percent reported that they could not share or talk about important issues well at all. This varied by age, with 75.4 percent of parents with children between the ages of 6 and 11 years reporting that they could share ideas and talk about important issues very well and 64.5 percent of parents with children aged 12-17 reporting the same level of communication with their children.

Frequency of Family Meals* Among Children, by Poverty,** 2007

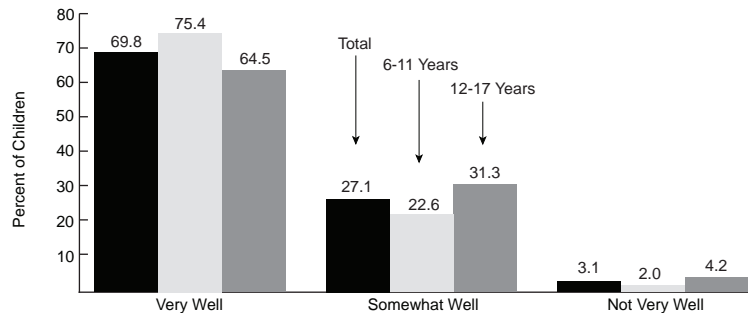
Source (I.8): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Number of days that the child ate a meal with all other family members living in the household. **The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$20,650 in 2007.

Parents and Children Sharing Ideas and Meaningful Conversation,* by Age, 2007

Source (I.8): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Based on parent report of how well they share ideas or talk about things that really matter with their children.

MATERNAL AGE

According to preliminary data, the general fertility rate fell slightly to 66.7 live births per 1,000 women aged 15–44 years in 2009 (from a rate of 68.6 in 2008). Birth rates for nearly every age and racial/ethnic group declined. The rate for teenagers aged 15–19 years decreased to 39.1 per 1,000 females in this age group, which continues the general decline in teenage birthrates since 1991, when the rate was 61.8 births per 1,000. Although the birth rate for women aged 25–29 years fell in 2009, this group still experienced the highest birth rate of all age groups (110.5 births per 1,000). Birth rates for women aged 35–39

years (46.6 births per 1,000) also declined slightly (from 46.9 in 2008), representing the second year of decline after increasing rates for three decades. Birth rates for women aged 40–44 years (10.1 births per 1,000) increased slightly over the previous year.¹ Average age at first birth rose 3.6 years between 1970 and 2006 to 25.0 years (the latest year for which data are available; data not shown).²

The age distribution of births varies by race/ethnicity. Among non-Hispanic Black, Hispanic, and American Indian/Alaska Native women, 16.5 percent, 13.8 percent, and 17.3 percent of births, respectively, were to females younger than

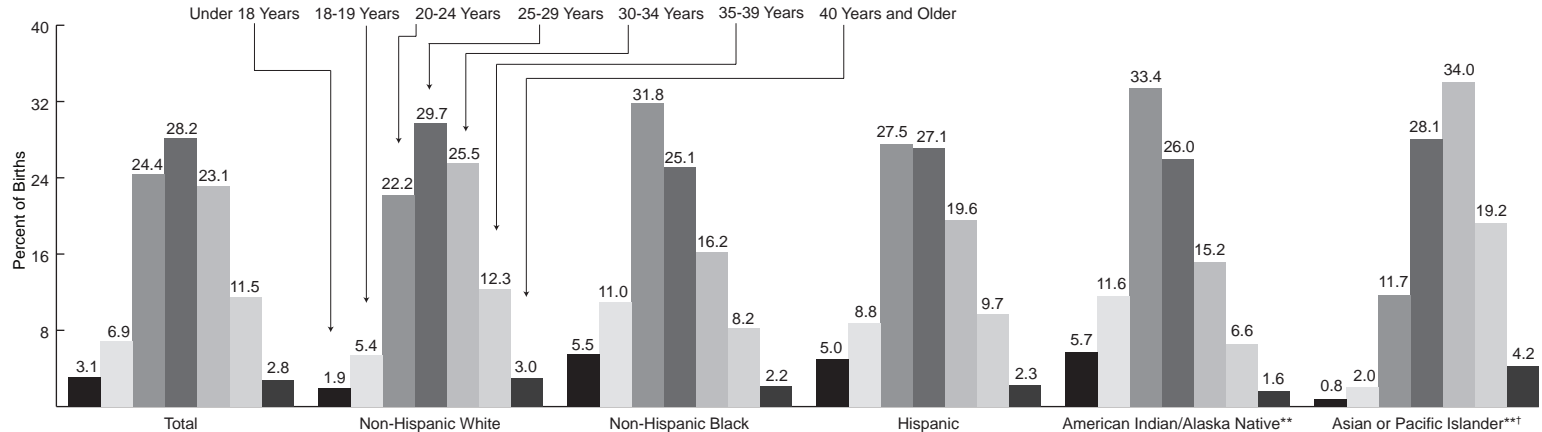
20 years of age, compared to 7.3 percent of births to non-Hispanic White females. The percentage of births to women aged 20–24 years was higher among non-Hispanic Black and Hispanic women (31.8 percent and 27.5 percent, respectively) than among non-Hispanic White women (22.2 percent). However, births to women aged 35 and older represented a higher proportion of births among non-Hispanic White and Asian/Pacific Islander women than among non-Hispanic Black and Hispanic women.

1 Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2009. National vital statistics reports; vol 59 no 3. National Center for Health Statistics. 2010.

2 Mathews TJ, Hamilton BE. Delayed childbearing: More women are having their first child later in life. NCHS data brief, no 21. Hyattsville, MD: National Center for Health Statistics. 2009

Distribution of Births, by Maternal Age and Race/Ethnicity, 2009*

Source (1.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Preliminary data. **May include Hispanics. †Separate estimates were not available for Asians and Native Hawaiians and Other Pacific Islanders.

WORKING MOTHERS AND CHILD CARE

In 2009, 71.4 percent of women with children under 18 years of age were in the labor force (either employed or looking for work), and 65.5 percent were employed (data not shown). Among men, rates were 93.8 percent and 86.8 percent, respectively. Labor force participation among women varied by a number of factors. Of mothers with children aged birth through 5 years, 64.2 percent were in the labor force, while among those whose youngest child was aged 6–17 years, 77.3 percent were in the labor force. Employed mothers with children birth to age five were more likely to be employed part time than mothers with older children (29.2 versus 24.2

percent, data not shown).

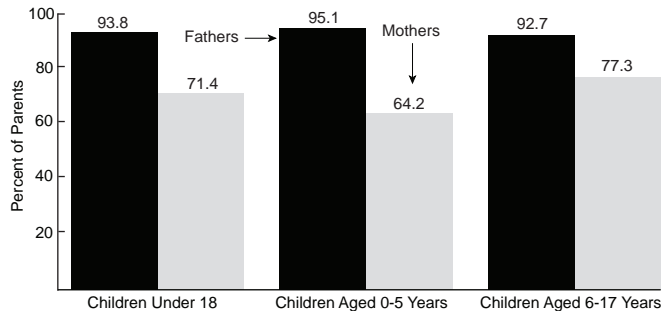
In 2007, 54.2 percent of children aged birth through 5 years were in childcare for 10 or more hours per week. Overall, 29.1 percent of children were in the care of a non-relative, while 14.7 percent were cared for by a relative and 10.4 percent received both relative and non-relative care. Childcare arrangements varied by race/ethnicity: 55.8 percent of Hispanic children did not receive 10 or more hours of childcare per week while the same was true of 45.2 percent of non-Hispanic White children and 32.0 percent of non-Hispanic Black children. A greater proportion of both non-Hispanic Black and Hispanic children received 10 or more hours of childcare per week

from a relative (20.5 percent and 15.6 percent, respectively) than non-Hispanic White children (13.2 percent).

Securing childcare can be difficult for families. In 2007, nearly 20 percent of families who did not receive 10 or more hours of childcare per week for their child reported that they needed child care during the prior month. Families with incomes of 400 percent or more of the Federal poverty level (\$20,650 for a family of four in 2007) were most likely to report needing care (27.3 percent) compared to 16.9 percent of children living in families with household incomes under 100 percent of the Federal poverty level (data not shown).

Parents' Labor Force* Participation Rate, by Age of Youngest Child,** 2009

Source (I.10): U.S. Department of Labor, Bureau of Labor Statistics

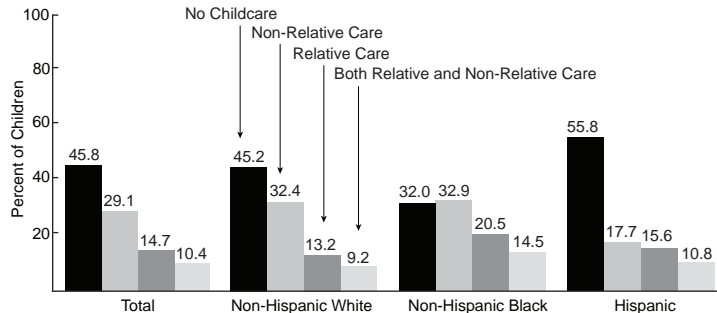


*Includes people who are employed and those who are actively seeking work.

**Children include sons, daughters, step-children, and adopted children.

Childcare Arrangements* for Children Aged 0-5 Years, by Race/Ethnicity, 2007

Source (I.5): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*10 or more hours of childcare per week.

HEALTH STATUS

Monitoring the health status of infants, children, and adolescents allows health professionals, program planners, and policymakers to assess the impact of past and current health intervention and prevention programs and identify areas of need within the child population. Although indicators of child health and well-being are often assessed on an annual basis, some surveillance systems collect data at regular intervals, such as every 2, 4, or 5 years. Trends can be identified by examining and comparing data from one data collection period to the next whenever multiple years of data are available.

In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys and surveillance systems. Population-based samples are designed to yield information that is representative of the maternal and child populations that are affected by, or in need of, specific health services or interventions.



HEALTH STATUS - INFANTS



LOW BIRTH WEIGHT

Low birth weight is a leading cause of neonatal mortality (death before 28 days of age). Low birth weight infants are more likely to experience physical and developmental health problems or die during the first year of life than are infants of normal weight.^{1,2}

According to preliminary data, 8.2 percent of infants were born low birth weight (less than 2,500 grams, or 5 pounds 8 ounces) in 2009. In 2006, the rate of low birth weight was the highest recorded in four decades (8.3 percent). The increase in multiple births, which are at high risk of low birth weight, strongly influenced this increase; however, rates of low birth weight also rose for singleton births.³

In 2009, the rate of low birth weight was much higher among infants born to non-Hispanic Black women (13.6 percent) than infants born to mothers of other racial/ethnic groups. The second highest rate, which occurred among Asian/Pacific Islanders, was 8.3 percent, followed by a rate of 7.3 percent among American Indian/Alaska Natives. Low birth weight occurred among 7.2 percent of infants born to non-Hispanic White women, while infants of Hispanic women experienced the lowest rate (6.9 percent). Low birth weight levels in 2009 were not significantly different from 2008 for non-Hispanic White, non-Hispanic Black, and Hispanic infants.

Low birth weight also varied by maternal age. In 2008 (the latest year for which data are available), the rate of low birth weight was highest among babies born to women younger than 15 years of age (12.4 percent), followed by babies born to women aged 40–54 years (11.8 percent). The lowest rates occurred among babies born to mothers aged 25–29 years and 30–34 years (7.4 and 7.6 percent, respectively; data not shown).

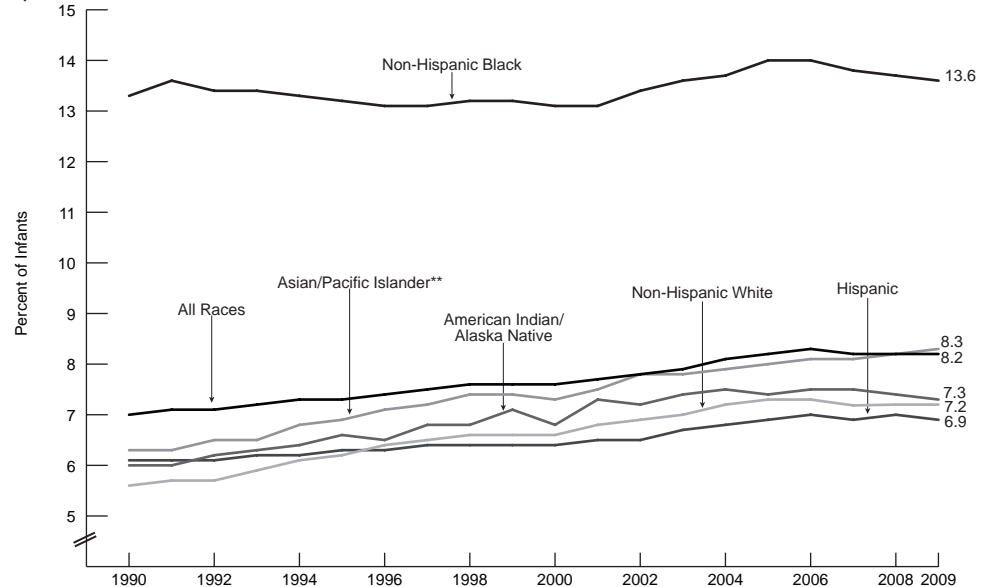
1 Stein REK, Siegel MJ, Bauman LJ. Are children of moderately low birth weight at increased risk for poor health? A new look at an old question. *Pediatrics* 2006;118: 217-223.

2 Matthews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth/infant death data set. *National vital statistics reports; vol 58 no 17*. Hyattsville, MD: National Center for Health Statistics. 2010.

3 Martin JA, Hamilton BE, Sutton PD, Ventura SJ, et al. Births: Final data for 2006. *National vital statistics reports; vol 57 no 7*. Hyattsville, MD: National Center for Health Statistics. 2009.

Low Birth Weight Among Infants, by Maternal Race/Ethnicity, 1990–2009*

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary. **Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

VERY LOW BIRTH WEIGHT

According to preliminary data, 1.5 percent of infants were born very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces) in 2009. The proportion of very low birth weight infants has slowly climbed from just over 1 percent in 1980.

Infants born at such low weight are more than 100 times more likely to die in the first year of life than are infants of normal birth weight (above 5 pounds 8 ounces).¹ Very low birth weight infants who survive are at a significantly increased risk of severe health and developmental problems, including physical and sensory difficulties, developmental delays, and cognitive impairment, which may require increased levels of medical, educational, and parental care.²

Infants born to non-Hispanic Black women are over two times more likely than infants born to mothers of other racial/ethnic groups to be very low birth weight. Among infants born to non-Hispanic Black women, 3.1 percent were very low birth weight in 2009, compared to 1.2 percent of infants born to non-Hispanic White and Hispanic women, 1.3 percent born to American Indian/Alaska Native women, and 1.1 percent born to Asian/Pacific Islander women. This difference is a major contributor to the disparity in infant mortality rates between non-Hispanic Black infants and infants of other racial/ethnic groups.³ Although, overall, the rate of very low birth weight was not statistically different from

2008, rates for non-Hispanic White and non-Hispanic Black newborns were down 2-3 percent from 2006.⁴

In 2008 (the latest year for which data are available), the rate of very low birth weight was highest among babies born to mothers aged 45-54 years (3.6 percent). Mothers under 15 years of age also had high rates of very low birth weight (3.0 percent.) The rate was lowest among mothers aged 25-29 years (1.3 percent; data not shown).

1 Matthews TJ, MacDorman MF. *Infant mortality statistics from the 2006 period linked birth/infant death data set. National vital statistics reports; vol 58 no 17.* Hyattsville, MD: National Center for Health Statistics. 2010.

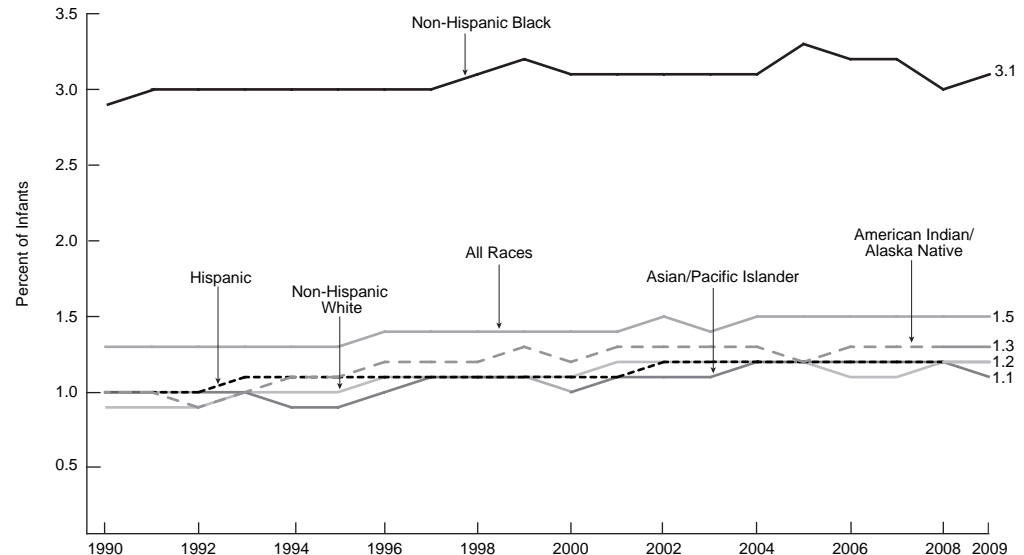
2 Eichenwald EC, Stark AR. *Management and outcomes of very low birth weight.* N Engl J Med 2008;358:1700-1711.

3 Wise PH. *The anatomy of a disparity in infant mortality.* Annu Rev Public Health. 2003;24:341-62.

4 Hamilton BE, Martin JA, Ventura SJ. *Births: Preliminary data for 2009. National vital statistics reports web release; vol 59 no 3.* Hyattsville, MD: National Center for Health Statistics. 2010.

Very Low Birth Weight Among Infants, by Maternal Race/Ethnicity, 1990–2009*

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary. **Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

PRETERM BIRTH

Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate and long-term complications, as well as mortality. Complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ ges-

tation) are more likely than full-term babies to experience these types of problems.¹

According to preliminary data, 12.2 percent of infants were born preterm in 2009. Overall, 8.7 percent of babies were born at 34 to 36 weeks’ gestation, 1.6 percent were born at 32-33 weeks, and 2.0 percent were “very preterm” (less than 32 weeks). The preterm birth rate increased more than 20 percent from 1990 to 2006, but has declined in the three years since (data not shown).

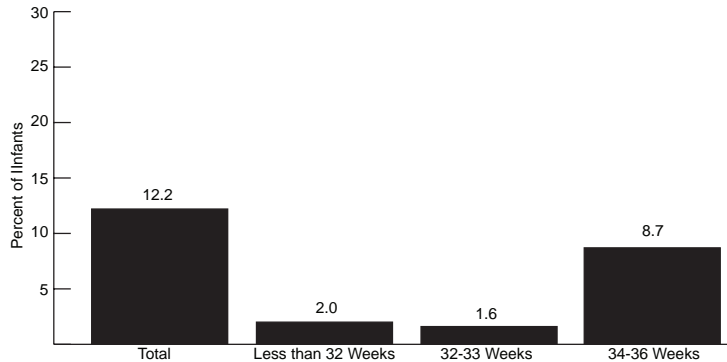
The preterm birth rate varies by race/ethnicity. In 2009, 17.5 percent of babies born to

non-Hispanic Black women were born preterm, compared to 10.8 percent of babies born to Asian/Pacific Islander women. Among babies born to non-Hispanic White women, 10.9 percent were born preterm, while the same was true of 12.0 percent of babies born to Hispanic women and 13.5 percent of babies born to American Indian/Alaska native women.

1 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health. Prematurity. November 2009. Available online: <http://www.cdc.gov/Features/PrematureBirth/>. Accessed March 2011.

Preterm Birth Among Infants, by Completed Weeks of Gestation, 2009*

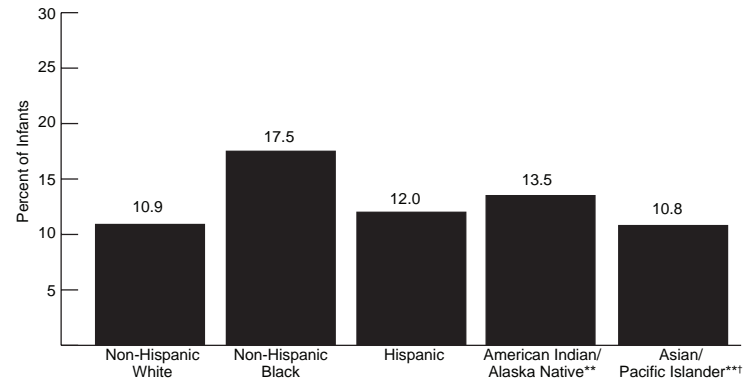
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary

Preterm Birth Among Infants, by Maternal Race/Ethnicity, 2009*

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary. **Includes Hispanics. †Separate data for Asians and Native Hawaiians and Other Pacific Islanders not available.

BREASTFEEDING

Breastfeeding has been shown to promote the health and development of infants, including their immunity to disease. It also confers a number of maternal benefits, such as a decreased risk of breast and ovarian cancers.¹ The American Academy of Pediatrics Section on Breastfeeding recommends exclusive breastfeeding—with no supplemental food or liquids—through the first 6 months of life, and continued supplemental breastfeeding through at least the first year.²

Breastfeeding practices vary considerably by a number of factors including maternal age, maternal education, household income, and race/ethnicity. In 2007, the parents of 75.5 percent of children from birth to 5 years of age reported that

the child had ever been breastfed or fed breast milk. While this represents a substantial increase in breastfeeding initiation over the past 25 years, the overall prevalence of any breastfeeding for 6 months and the prevalence of exclusive breastfeeding for 6 months remain below national objectives.³ Parents of 45.0 percent of children aged 6 months to 5 years reported that the child was breastfed for 6 months. Exclusive breastfeeding for 6 months was reported for 12.4 percent of children aged 6 months to 5 years.

Children born to mothers aged 30 years or older are the most likely to be breastfed (79.8 percent), while children born to mothers aged 20 years or younger are the least likely (58.5 percent). A similar trend exists for exclusive breast-

feeding; 14.1 percent of children born to mothers aged 30 years or older are exclusively breastfed for 6 months compared to 4.6 percent of children born to mothers aged 20 years or younger. Mothers with more than a high school education are more likely to both initiate breastfeeding and to breastfeed for 6 months exclusively than those with less than a high school education.

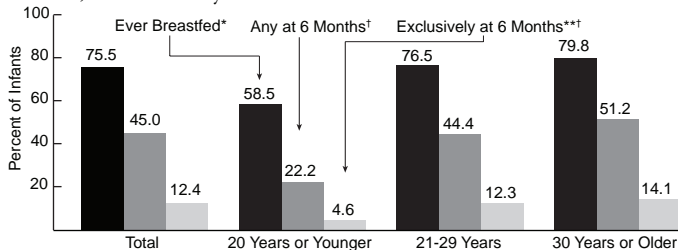
1 Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, et al. *Breastfeeding and maternal and infant health outcomes in developed countries*. Evid Rep Technol Assess (Full Rep). 2007(153):1-186.

2 Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, et al. *Breastfeeding and the use of human milk*. Pediatrics. 2005;115(2):496-506.

3 U.S. Department of Health and Human Services. *Healthy People 2020*. Available at: www.healthypeople.gov. Accessed March 2011.

Breastfeeding Among Children Aged 0-5 Years, by Maternal Age and Duration, 2007

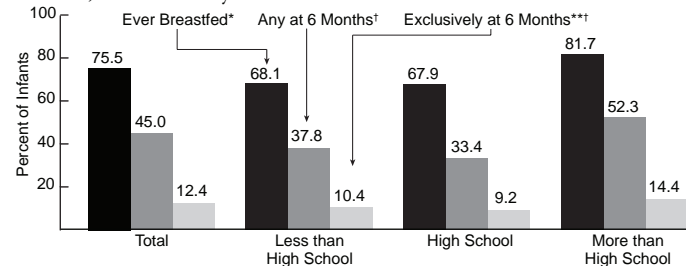
Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Ever fed breast milk. **Exclusive breastfeeding is defined as only human breastmilk—no solids, water, or other liquids. †Data is for infants aged 6 months to 5 years. Those less than 6 months of age were excluded.

Breastfeeding Among Children Aged 0-5 Years, by Maternal Education and Duration, 2007

Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Ever fed breast milk. **Exclusive breastfeeding is defined as only human breastmilk—no solids, water, or other liquids. †Data is for infants aged 6 months to 5 years. Those less than 6 months of age were excluded.

INFANT MORTALITY

Based on preliminary data, in 2009, 26,531 infants died before their first birthday, representing an infant mortality rate of 6.42 deaths per 1,000 live births. This represents a decrease of 2.6 percent from the preliminary estimate in 2008 (6.59 deaths per 1,000 live births). The leading causes of infant mortality were congenital malformations, followed by disorders related to short gestation and low birth weight, and Sudden Infant Death Syndrome (data not shown). Although overall there were no changes in the ranking of leading causes of infant death, the infant mortality rate decreased for 2 of 10 leading causes of infant death between 2008 and 2009: maternal complications of pregnancy and unintentional injuries. The infant mortality rates associated with each of these causes declined by 7.5 and 8.5 percent, respectively.

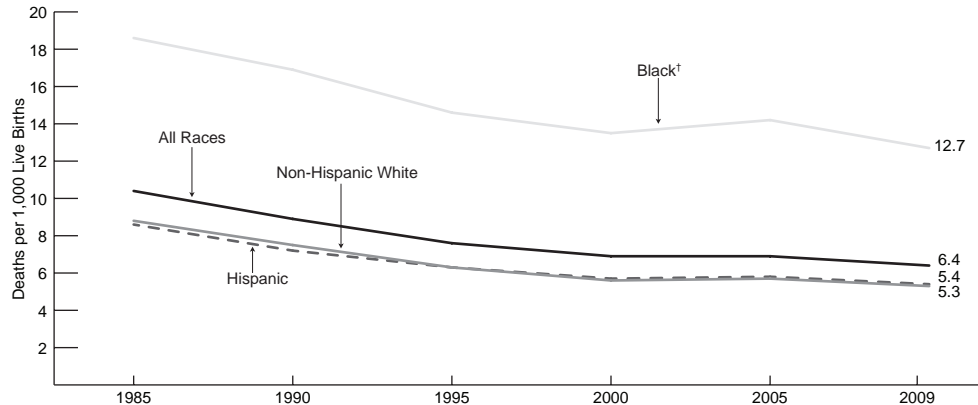
The infant mortality declined substantially during the 20th century resulting in a 93 percent decrease in the overall infant mortality rate between 1915 and 1998.¹ Some factors which contributed to this decline included economic growth, improved nutrition, and new sanitary measures, as well as advances in clinical medicine and access to care.² More recent declines in birth-weight-specific infant mortality rates in the latter part of the 20th century have been attributed, in part, to the approval of synthetic surfactants to reduce the severity of respiratory distress syn-

drome³ and the recommendation that infants be placed on their backs to sleep to prevent Sudden Infant Death Syndrome.⁴

In 2009, the mortality rate among infants born to Black women (including Hispanics) was 12.71 deaths per 1,000 live births, compared to 12.68 per 1,000 live births in 2008; this difference was not statistically significant. Despite the overall decrease in the infant mortality rate, in 2009 the rate for Blacks (including Hispanics) was still 2.4 times the rate among infants born to non-Hispanic White women (5.32 per 1,000 births). The 2009 rate for infants born to non-Hispanic white women reflects a 4.0 percent decrease since the previous year (5.54 infant deaths per 1,000 live births).

Infant Mortality Rates,* by Maternal Race/Ethnicity, 1985-2009**

Source (II.3): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Under 1 year of age. **Data for 2009 are preliminary. †Including Hispanics who identify themselves as Black.

The Maternal and Child Health Block Grant and MCHB's Healthy Start program provide health and support services to pregnant women and infants with the goal of improving children's health outcomes and reducing infant and child mortality.

1 Guyer B, Freedman MA, Strobino DM, and Sondik EJ. *Annual summary of vital statistics: trends in the health of Americans during the 20th century*. Pediatrics. 2000;106:1307-17.

2 Centers for Disease Control and Prevention. *Advancements in public health, 1900-1999: healthier mothers and babies*. MMWR. 1999; 48:849-58.

3 Schoendorf KC and JL Kiely. *Birth weight and age-specific analysis of the 1990 US infant mortality drop: was it surfactant?* Arch Pediatr Adolesc Med. 1997;151:129-134

4 American Academy of Pediatrics Task Force on Infant Positioning and SIDS. *Positioning and SIDS*. Pediatrics. 1992;87:1120-6.

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal. According to preliminary data, in 2009, 17,298 infants died before reaching 28 days of age, representing a neonatal mortality rate of 4.19 deaths per 1,000 live births. Although this represents a 1.9 percent decrease from 4.27 per 1,000 live births in 2008, this change was not statistically significant.

Neonatal mortality is generally related to short gestation and low birth weight, congenital malformations, and conditions originating in the perinatal period, such as maternal complications related to pregnancy or complications experienced by the newborn resulting from birth.¹

Neonatal mortality rates vary by race and ethnicity. Based on preliminary data for 2009, the neonatal mortality rate among infants born to Black women (including Hispanics) was 8.20 per 1,000 live births, more than twice the rate among infants born to non-Hispanic White and Hispanic women (3.43 and 3.62 per 1,000, respectively).

Postneonatal. In 2009, 9,233 infants died between the ages of 28 days and 1 year, representing a postneonatal mortality rate of 2.24 deaths per 1,000 live births. This represents a 3.4 percent decrease since 2008, when the postneonatal mortality rate was 2.32 deaths per 1,000 live births.

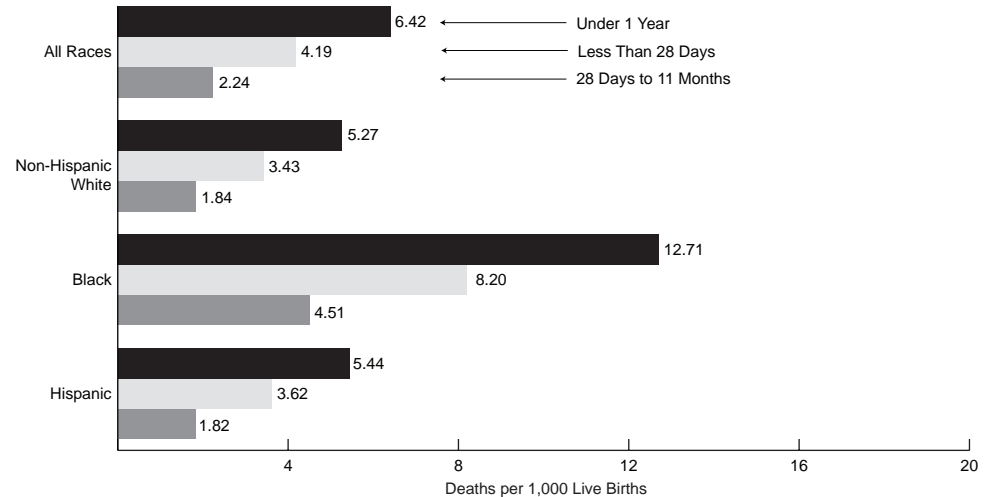
Postneonatal mortality is generally related to Sudden Infant Death Syndrome (SIDS), congenital malformations, and unintentional injuries.¹ Postneonatal mortality varies by race and ethnicity. According to preliminary data in 2009, the highest rate of postneonatal mortality was reported among infants born to

Black (including Hispanic) women (4.51 deaths per 1,000 live births). Rates for infants born to non-Hispanic White and Hispanic women were 1.84 and 1.82 deaths per 1,000 live births, respectively.

1 Centers for Disease Control and Prevention. Quick Stats: Leading Causes of Neonatal and Postneonatal Deaths — United States, 2002. MMWR. 2005; 54(38):966.

Neonatal and Post Neonatal Mortality Rates, by Maternal Race/Ethnicity, 2009*

Source (II.3): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary.

INTERNATIONAL INFANT MORTALITY

In 2007, the U.S. infant mortality rate (6.8 infant deaths per 1,000 live births) was higher than that of many other industrialized nations. Differences in infant mortality rates among industrialized nations may reflect variation in the definition, measurement, and reporting of fetal and infant deaths. However, recent analyses of the differences in gestational age-specific infant mortality indicate that this disparity is most likely related to the high rate of preterm birth in the U.S.¹ Infants born preterm (or less than 37 weeks gestation) have higher rates of death and disability than infants born at term (37 weeks gestation or more).² Although the United States compares favorably with European countries with respect to the survival of infants born preterm, the higher rate of preterm birth in the U.S. overall has a significant impact on the infant mortality rate.

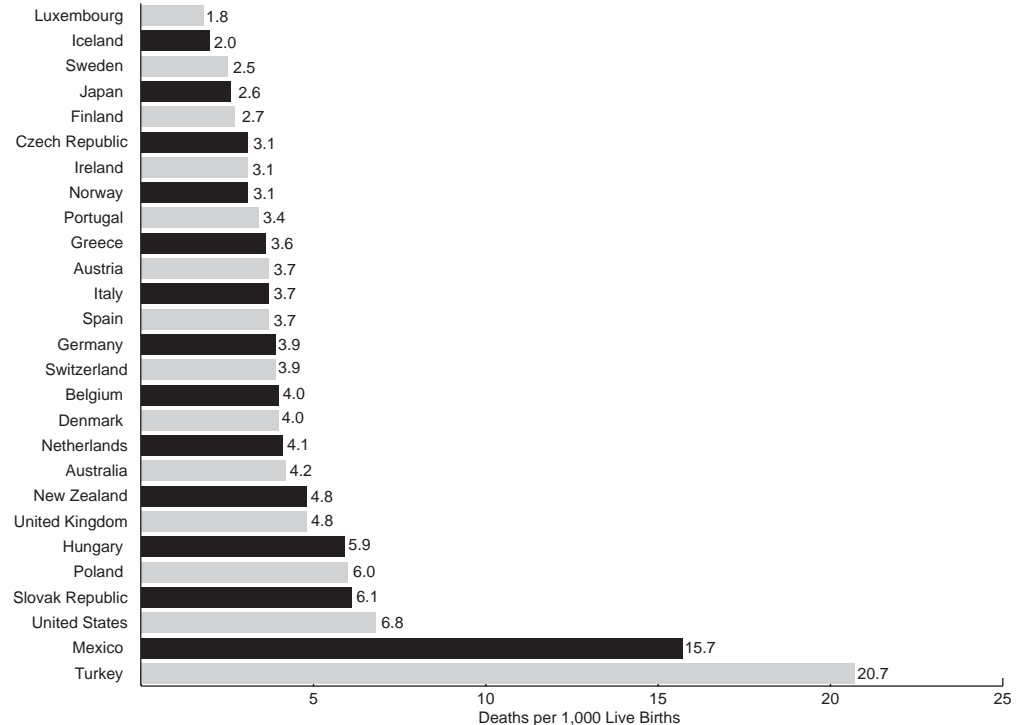
In 2007, the U.S. infant mortality rate was more than twice that of nine other industrialized countries (Luxembourg, Iceland, Sweden, Japan, Finland, Czech Republic, Ireland, Norway, and Portugal). Luxembourg had the lowest rate (1.8 per 1,000), followed by Iceland and Sweden (2.0 and 2.5 deaths per 1,000 live births, respectively).

1 MacDorman MF and Mathews TJ. *Behind international rankings of infant mortality: how the US compares with Europe.* Int J Health Serv. 2010;40(4):577-88.

2 MacDorman, MF, and Mathews, TJ. *Recent Trends in Infant Mortality in the United States.* NCHS Data Brief No. 9. National Center for health Statistics, Hyattsville, MD, 2008.

International Infant Mortality Rates, Selected Countries,* 2007

Source (II.4): The Organization for Economic Co-operation and Development (OECD)



*2007 data were not available for all Organization for Economic Co-operation and Development (OECD) countries.

MATERNAL MORTALITY

Maternal mortality, or death due to maternal causes, includes deaths due to causes related to or aggravated by pregnancy or pregnancy management, and excludes deaths occurring more than 42 days after the end of the pregnancy and deaths of pregnant women due to external causes (such as injury).¹ The rate of maternal mortality in the United States declined dramatically over the last century; however, this trend has reversed somewhat in the last several decades and racial and ethnic disparities persist.²

In 2007, the latest year for which data are available, the maternal mortality rate was 12.7 deaths per 100,000 live births, compared to a low of 6.6 per 100,000 in 1987. This represents

a total of 548 women who died due to maternal causes in 2007. Some of this increase observed over the past decades may be due to changes in the coding and classification of maternal deaths.

The maternal mortality rate among non-Hispanic Black women was approximately 2.7 times the rate for non-Hispanic White women (28.4 versus 10.5 per 100,000), while the maternal mortality rate among Hispanic women was 8.9 deaths per 100,000 live births.

Causes of maternal death are classified as direct, indirect, or unspecified. Some of the most common direct causes are complications related to the puerperium, or period immediately after delivery (2.2 per 100,000), eclampsia and pre-eclampsia (1.5 per 100,000), hemorrhage of preg-

nancy, childbirth, and placenta previa (0.9 per 100,000), and pregnancy with abortive outcome (0.7 per 100,000). Indirect causes occurred at a rate of 3.1 per 100,000, and comprised deaths from pre-existing conditions complicated by pregnancy. The rate of maternal deaths from unspecified causes was 0.5 per 100,000.

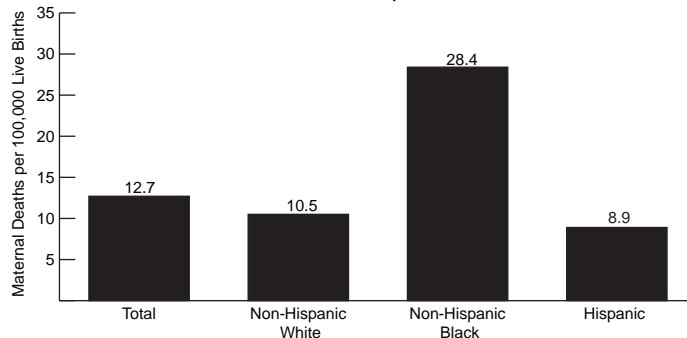
For more information on maternal morbidity, please see *Women's Health USA 2011* available at: <http://www.mchb.hrsa.gov/publications/index.html>.

1 Xu J, Kochanek K, Murphy S, Tejada-Vera B. *Deaths: Final data for 2007. National vital statistics reports; vol 58, no 19. Hyattsville, MD: National Center for Health Statistics. May 2010.*

2 Chang J, Elam-Evans LD, Berg CJ et al. *Pregnancy-Related Mortality Surveillance — United States, 1991—1999. MMWR. 2003; 52(SS02):1-8.4*

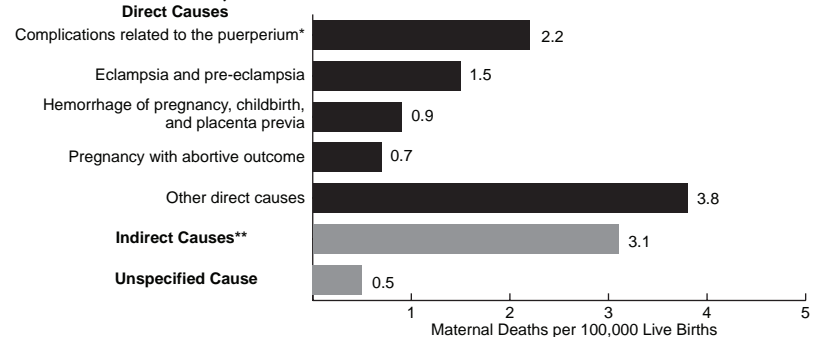
Maternal Mortality Rates, by Race/Ethnicity, 2007

Source (II.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Leading Causes of Maternal Mortality, 2007

Source (II.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Deaths occurring in the period immediately after delivery. **Deaths from pre-existing conditions complicated by pregnancy.



HEALTH STATUS - CHILDREN



VACCINE-PREVENTABLE DISEASES

The number of reported cases of vaccine-preventable diseases among children has generally decreased over the past several decades. In 2008, there were no reported cases of diphtheria, polio, or smallpox in the United States, and no cases of tetanus among children under 5 years of age. There were 5 cases of rubella (German measles) among children aged 0-4 years.

From 2007 to 2008, the number of reported cases of hepatitis A, mumps, and meningococcal disease decreased among children under 5 years of age. The overall incidence of hepatitis A began dropping dramatically once routine vaccination for children living in high-risk areas was recommended beginning in 1996. Furthermore, in 2005, the Centers for Disease Control and Prevention (CDC) instituted the recommendation that all children be immunized for hepatitis A starting at 1 year of age. The latter recommendation was made because two-thirds of cases were occurring in States where the vaccine was not currently recommended. With regard to pertussis (or whooping cough), the number of cases among children aged 0-4 years increased from 2,746 in 2007 to 3,468 in 2008. According to the CDC, pertussis occurs cyclically and decreases

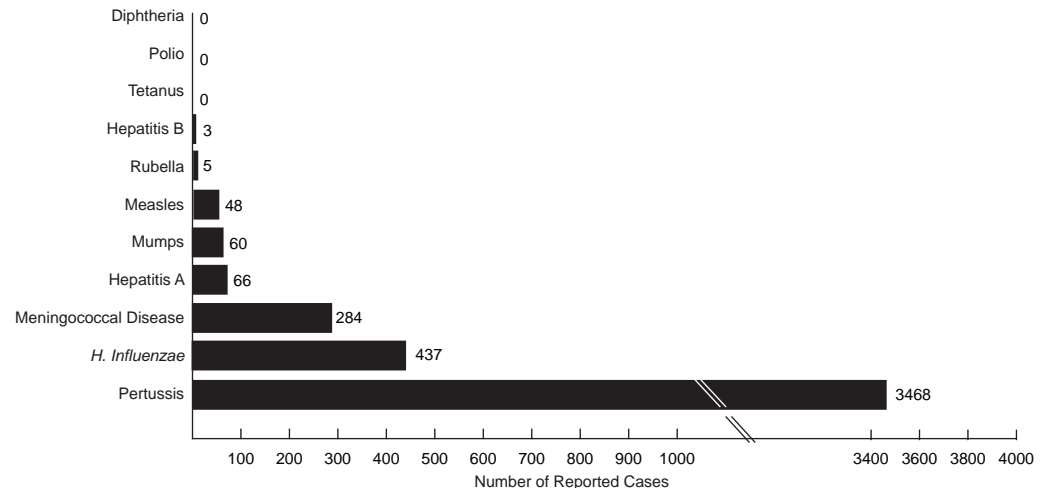
in the incidence of the disease may not be due to increases in immunization rates. The highest reported rate occurred among infants under 6 months of age, a population that is too young to be fully vaccinated. In 2006, the United States experienced a multi-state outbreak of mumps, primarily in Midwestern states. In the following two years, the number of reported cases returned to usual levels; however, beginning in July 2009, another outbreak was documented primarily in New York and New Jersey.¹ Reported cases of

hepatitis B and *H. influenzae* remained relatively unchanged from 2007 to 2008.

1 Centers for Disease Control and Prevention. Mumps Outbreaks. Available at: <http://www.cdc.gov/mumps/outbreaks.html#b>. Accessed March 2011.

Reported Cases of Selected Vaccine-Preventable Diseases Among Children Aged 0-4 Years, 2008

Source (II.6): Centers for Disease Control and Prevention, National Notifiable Diseases Surveillance System



PEDIATRIC HIV AND AIDS

Human immunodeficiency virus (HIV) is a disease that destroys cells that are critical to a healthy immune system. Acquired immunodeficiency syndrome (AIDS) is diagnosed when HIV has weakened the immune system enough that the body has difficulty fighting disease and infections. In 2009, an estimated 166 children younger than 13 years of age were diagnosed with HIV, and 13 were reported to have AIDS. Racial and ethnic minorities are disproportionately affected by HIV. In 2009, non-Hispanic Black children accounted for over three-quarters of diagnosed cases, but represented only

15 percent of the total U.S. population in this age group.

The number of pediatric AIDS cases has declined substantially since 1992, when an estimated 911 cases were reported. A major factor in this decline is the increasing use of antiretroviral therapy before, during, and after pregnancy to reduce perinatal transmission of HIV and the promotion of universal prenatal HIV testing. Perinatal transmission accounts for 91 percent of all AIDS cases among children in the United States. Antiretroviral therapy during pregnancy can reduce the transmission rate to

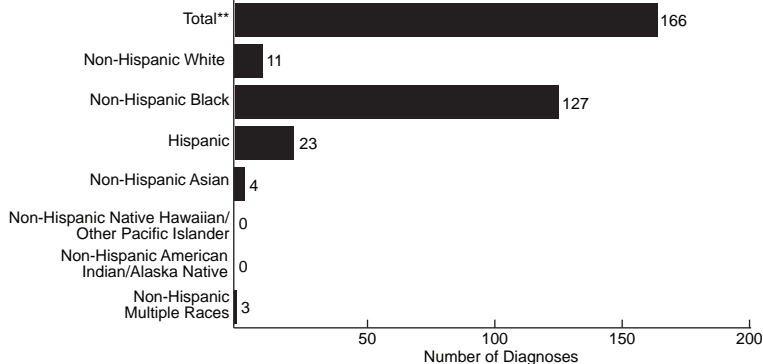
2 percent or less, while without treatment the transmission rate is 25 percent.¹

At the end of 2008, 660,062 adults and adolescents and 3,022 children under age 13 years were living with HIV while 479,161 adults and adolescents, and 707 children under age 13 years were living with AIDS. Of the 1,108,611 AIDS cases cumulatively diagnosed through 2009, 9,448 were among children under age 13 years (data not shown).

1 Centers for Disease Control and Prevention. One Test Two Lives. Available at: <http://www.cdc.gov/hiv/topics/perinatal/1test2lives/default.htm>. Accessed April 2011.

Estimated Numbers of Diagnoses of HIV Infection* Reported in Children Under Age 13, by Race/Ethnicity, 2009

Source (II.7): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System

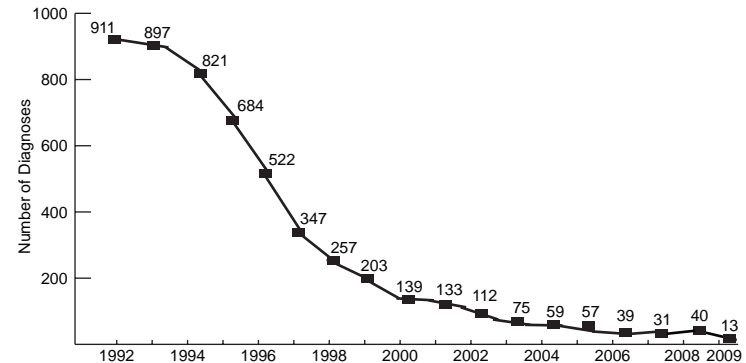


*Includes persons with a diagnosis of HIV infection regardless of stage of disease at the time of diagnosis.

**The total was estimated independently of values for each subpopulation; therefore, the sum of all races/ethnicities does not equal the overall total.

Estimated Numbers of AIDS Diagnoses in Children Under Age 13, by Year of Diagnosis, 1992–2009

Source (II.7): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



HOSPITALIZATION

In 2009, there were over 3.1 million hospital discharges among people aged 1–21 years, equaling 3.6 hospital discharges per 100 children, adolescents and young adults. While injuries are the leading cause of death among this age group, they were not the most common cause of hospitalization. In 2009, diseases of the respiratory system, including asthma and pneumonia, were the most common causes of hospitalization among children aged 1–4 and 5–9 years. Among children aged 1–4 years, diseases of the respiratory system accounted for nearly 40 percent of discharges; the same was true for about one-quarter of 5–9 year-olds. Mental disorders were the most common cause of hospitalization among children aged 10–14 years (22.5 percent of discharges) and the second most common cause among adolescents aged 15–19 years (15.7 percent of discharges) and young adults aged 20–21 years (8.4 percent). Among adolescents aged 15–19 years and young adults aged 20–21 years, labor and delivery (among females) was the most common cause of hospitalization resulting 49.6 and 62.3 percent of discharges, respectively.

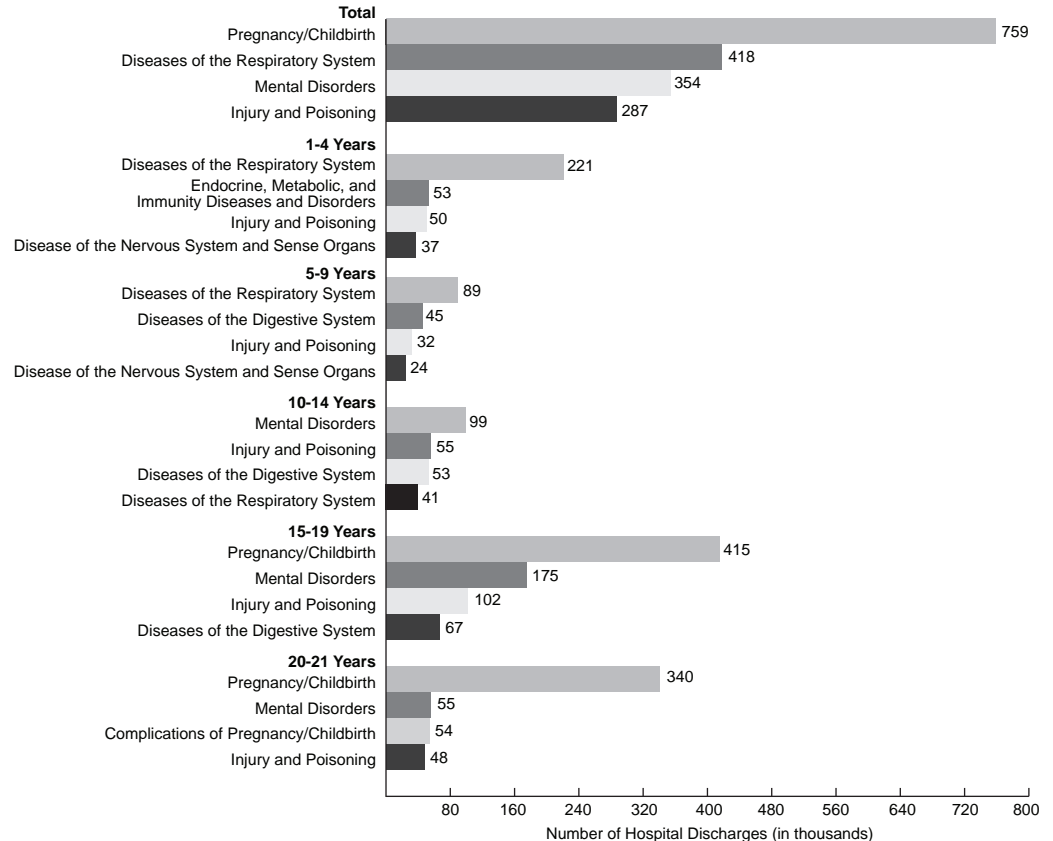
Between 1990 and 2009, overall hospital discharge rates for children aged 1–14 years did not change significantly. However, there was a change in the rates for some of the most common individual categories of discharges: the rate of discharges for diseases of the respiratory

system increased by 19.6 percent between 1990 and 2009, while discharges related to injury and

poisoning decreased by 31.5 percent during the same period.

Major Causes of Hospitalization, by Age Group, 2009

Source (II.8): Centers for Disease Control and Prevention, National Hospital Discharge Survey



CHRONIC HEALTH CONDITIONS

In 2007, the parents of 22.3 percent of children reported that their child had one or more of 16 chronic physical or mental health conditions. The five most commonly reported conditions were asthma, learning disabilities, attention deficit or attention deficit hyperactivity disorder (ADD/ADHD), speech problems, and oppositional defiant or conduct disorder. The least commonly reported conditions addressed in the survey were brain injury or concussion and Tourette syndrome.

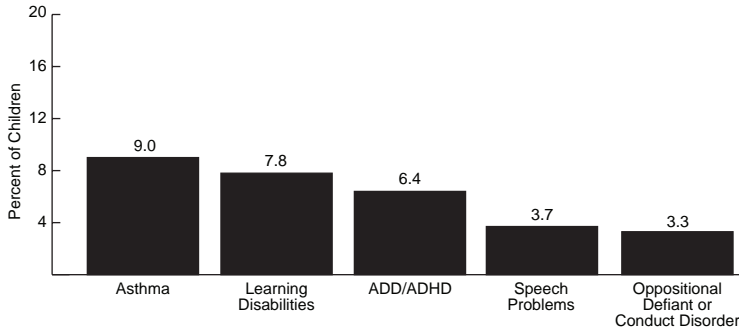
The proportion of children with one or more conditions varied by race/ethnicity. Nearly 30

percent of non-Hispanic Black children had one or more chronic conditions while the same was true for 18.3 percent of Hispanic children and 22.5 percent of non-Hispanic White children. The proportion of children with chronic conditions was also greater among those living in households with incomes less than 100 percent or between 100-199 percent of the Federal poverty level (\$20,650 for a family of four in 2007), with 27.0 and 24.2 percent of poor and near-poor children, respectively, having at least one reported condition compared to 18.9 percent of children living in families with incomes of 400 percent or more of the Federal poverty level (data not shown).

Among children with at least one of these 16 health conditions, 47.8 percent were reported to have one or more moderate or severe conditions. Of the 9.0 percent of children with asthma, the majority (71.3 percent) had parents who reported the condition to be mild, while 23.1 percent had a condition reported to be moderate and 5.6 percent had a condition reported to be severe. Parent-reported severity of asthma varied by race/ethnicity: 10.3 percent of non-Hispanic Black children were severely affected by their asthma, followed by 6.5 percent of Hispanic children and 3.1 percent of non-Hispanic White children.

Five Most Common Chronic Conditions* Among Children Aged 0-17 Years, 2007

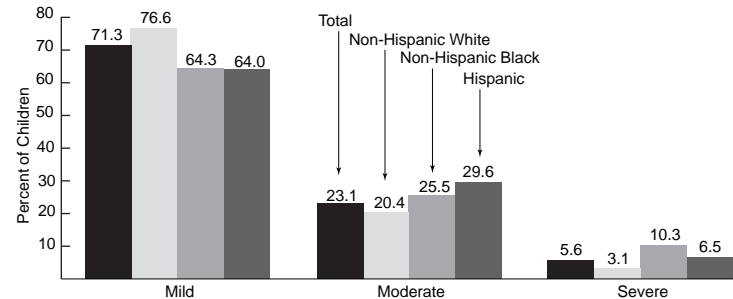
Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Based on parent-report that a doctor or other health care provider ever told them that their child had a particular condition.

Children Aged 0-17 Years with Asthma, by Condition Severity* and Race/Ethnicity, 2007

Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Based on parent-report.

ABUSE AND NEGLECT

State child protective services (CPS) agencies received approximately 3.3 million referrals, involving an estimated 6.0 million children, alleging abuse or neglect in 2009. More than 58.3 percent of these reports were made by professionals, including teachers, police officers, lawyers, and social services staff. Nonprofessionals, including parents, neighbors, friends, other relatives, and anonymous reporters made 28.1 percent of the reports; other and unknown sources submitted the remainder of reports (13.6 percent; data not shown).

CPS investigations determined that an estimated 702,000 individual children were victims of abuse or neglect in 2009, equaling a victimiza-

tion rate of 9.3 per 1,000 children in the population (data not shown). Neglect was the most common type of maltreatment (experienced by 78.3 percent of victims), followed by physical abuse (17.8 percent), sexual abuse (9.5 percent), psychological maltreatment (7.6 percent), and medical neglect (2.4 percent). About 10 percent of victims experienced other types of maltreatment including abandonment, threats of harm, or congenital drug addiction. A child may have suffered from multiple forms of maltreatment and was counted once for each maltreatment type.

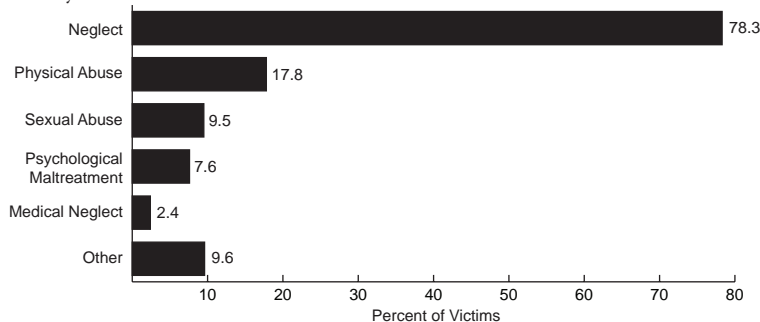
In 2009, children aged 0-3 years accounted for 33.4 percent of all victims. Approximately one-quarter of victims were between the ages of 4 and

7 years, 18.8 percent were aged 8-11 years, 17.8 percent were aged 12-15 years, and 6.3 percent were aged 16-17 years. Victimization was split between the sexes with males accounting for 48.2 percent and females accounting for 51.1 percent (the remainder were unknown; data not shown).

Overall, 80.9 percent of perpetrators of abuse or neglect were parents of the victim (either alone or in conjunction with another person). Additional categories of perpetrators included other relatives (6.3 percent), unmarried partners of parents (4.3 percent), and professionals such as childcare workers and residential facility staff (0.8 percent). Other types of perpetrators included foster parents, friends and neighbors, and legal guardians (data not shown).

Abuse and Neglect Among Children Under Age 18, by Type of Maltreatment,* 2009

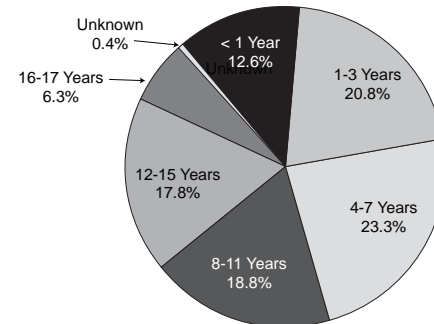
Source (II.9): Administration for Children and Families, National Child Abuse and Neglect Data System



*A child may have suffered from multiple forms of maltreatment and was counted once for each maltreatment type.

Child Abuse and Neglect Victims, by Age, 2009

Source (II.9): Administration for Children and Families, National Child Abuse and Neglect Data System



CHILD MORTALITY

According to preliminary data in 2009, 10,076 children aged 1-14 years died of various causes, which was a decrease of 335 cases since the previous year. The overall mortality rate among children aged 1-4 years was 26.1 per 100,000 children in that age group, and the rate among children aged 5-14 years was 13.9 per 100,000.

Unintentional injury continued to be the leading cause of death among children in both age groups, accounting for 32.5 percent of all deaths among 1- to 4-year-olds and 29.6 percent of deaths among 5- to 14-year-olds. Among children aged 1-4 years, congenital anomalies (or birth defects) were the second most common cause of death (10.9 percent of deaths), while among children aged 5-14 years, cancer was the second leading cause of death (15.9 percent of deaths).

Between 1970 and 2008, the leading causes of child mortality shifted. The percentage of deaths due to homicide increased from 2 to 9 percent among 1- to 4-year-olds and from 2 to 6 percent among 5- to 14-year-olds. Conversely, the proportion of deaths due to pneumonia and influenza declined from 9 to 3 percent among 1- to 4-year-olds and from 4 to 2 percent among 5- to 14-year-olds during the same time period (data not shown).¹

In 2009, mortality rates were higher among males than females in both age groups. Among

children aged 1-4 years, the mortality rate for males was 28.8 per 100,000 compared to 23.4 per 100,000 among females of the same age; rates among 5- to 14-year-old children were 15.6 per 100,000 and 12.1 per 100,000 for males and females, respectively (data not shown). There are also racial/ethnic disparities in child mortality, with non-Hispanic Black children experiencing higher mortality rates than children of other racial/ethnic groups. Among children aged 1-4 years, the rate was 41.2 per 100,000 for non-Hispanic Blacks, compared to rates of 23.2 and 23.9 per 100,000 for Hispanics and non-His-

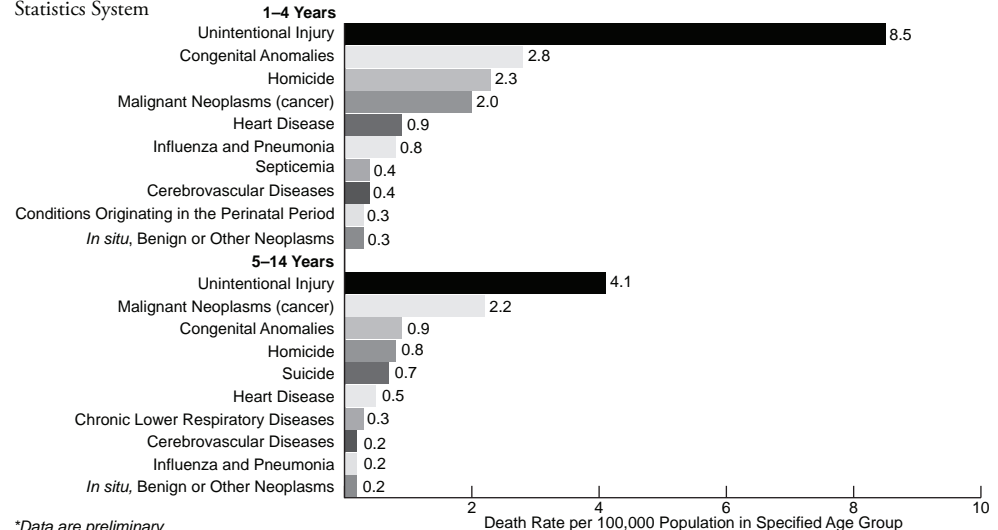
panic Whites, respectively. Among children aged 5-14 years, rates were 21.0 per 100,000 for non-Hispanic Blacks, 13.1 per 100,000 for Hispanics, 12.2 for non-Hispanic Whites, 10.9 for Asian or Pacific Islanders,² and 20.2 for American Indian/Alaskan Native children (data not shown).

1 Singh GK. Child Mortality in the United States, 1935-2007: Large Racial and Socioeconomic Disparities Have Persisted Over Time. A 75th Anniversary Publication. Health Resources and Services Administration, Maternal and Child Health Bureau. Rockville, MD: US Department of Health and Human Services; 2010.

2 Separate estimates for Asians and Native Hawaiian or Other Pacific Islanders not available.

Leading Causes of Death Among Children Aged 1-14 Years, 2009*

Source (II.3): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data are preliminary.

HEALTH STATUS - ADOLESCENTS



SEXUAL ACTIVITY AND EDUCATION

In 2009, 46.0 percent of high school students reported having had sexual intercourse at least once, while the remaining 54.0 percent were abstinent. Sexual activity increased with grade level: 31.6 percent of 9th grade students reported having had sexual intercourse, compared to 40.9 percent of 10th graders, 53.0 percent 11th graders, and 62.3 percent of 12th graders. No significant difference was observed between males and females with respect to the proportion who reported sexual activity within each grade level. However, males are significantly more likely to report having had sexual

intercourse for the first time before age 13 than females (data not shown).

Contraceptive use also varies significantly by sex. Overall, 68.6 percent of males and 53.9 percent of females reported condom use at last intercourse. Use of a hormonal contraceptive (by self or partner) was less common than condom use and was reported by 18.3 percent of males and 27.4 percent of females. Overall, fewer than 9 percent of adolescents used both a condom and a form of hormonal contraception during last sexual intercourse.

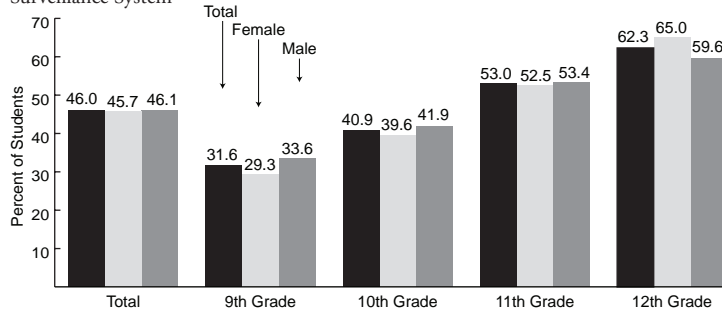
According to data from the National Survey of Family Growth, 96 percent of females and 97 percent of males received some form of for-

mal sex education before the age of 18 (data not shown).¹ This includes information on topics such as how to say no to sex, methods of birth control, sexually transmitted diseases, and/or how to prevent HIV/AIDS. By individual topic, formal sex education on sexually transmitted diseases was the most prevalent (92 percent of males and 93 percent of females), while methods of birth control was the least common (62 percent of males and 70 percent of females).

1 Martinez G, Abma J, Copen C. Educating teenagers about sex in the United States. NCHS data brief, no 44. Hyattsville, MD: National Center for Health Statistics. 2010.

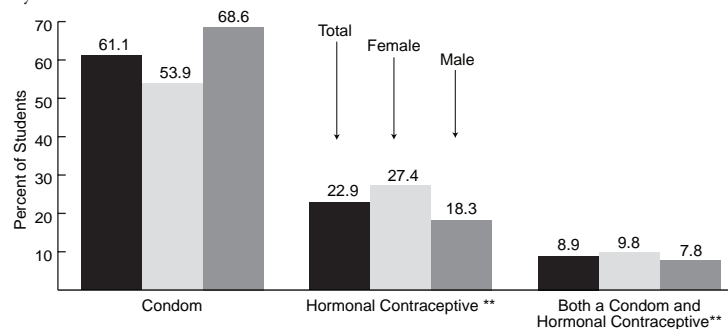
High School Students Who Have Ever Had Sexual Intercourse, by Grade Level and Sex, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



Contraceptive Method Used* Among Currently Sexually Active, High School Students, by Sex and Type of Method, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Used during last sexual intercourse by student or their partner. **Hormonal contraceptives refers to either birth control pills or Depo-Provera.

ADOLESCENT CHILDBEARING

According to preliminary data, the birth rate among adolescent females aged 15–19 years decreased to 39.1 per 1,000 females in 2009. This continues the general decline in teen birth rates since the most recent peak in 1991, when the rate was 61.8 per 1,000 females, and represents a decline of nearly 37 percent over that period. The birth rate among adolescents aged 10–14 years was 0.5 births per 1,000 females, the lowest rate ever reported. Teenage birth rates were highest among adolescents aged 18–19 years (66.2 per 1,000), and this age group

experienced the smallest decline since 1991 (30 percent; data not shown).

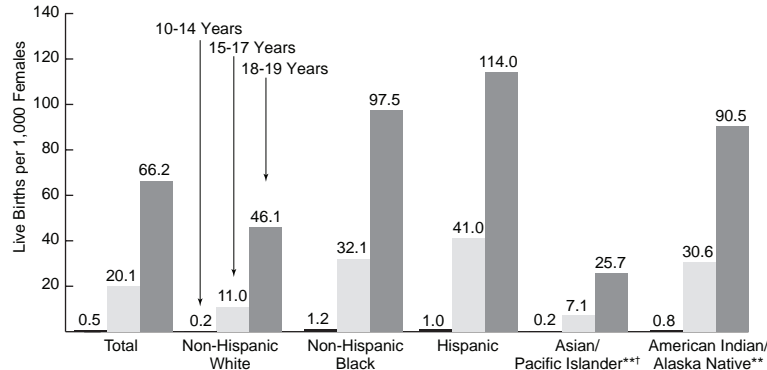
Among adolescents aged 10–14 years, non-Hispanic Black and Hispanic females had the highest birth rates in 2009 (1.2 and 1.0 per 1,000 population, respectively). Non-Hispanic White and Asian/Pacific Islander females had the lowest birth rates among those aged 10–14 years (both 0.2 per 1,000). The birth rate among American Indian/Alaskan Native adolescents aged 10–14 years was 0.8 per 1,000.

Among adolescents aged 15–19 years, Asian/Pacific Islander females had the lowest birth

rate in 2009 (14.6 per 1,000), followed by non-Hispanic White females (25.6 per 1,000). Hispanic females had the highest birth rate in this age group (70.1 per 1,000). However, this estimate represents a 10 percent decline since 2008 and the lowest rate ever reported for this group in the two decades for which rates for Hispanic teenagers are available. Non-Hispanic Black females had the second highest birth rate among those aged 15–19 years (59.0 per 1,000), followed by American Indian/Alaska Native teens (55.5 per 1,000).

Birth Rates Among Adolescent Females Aged 10-19 Years, by Age and Race/Ethnicity, 2009*

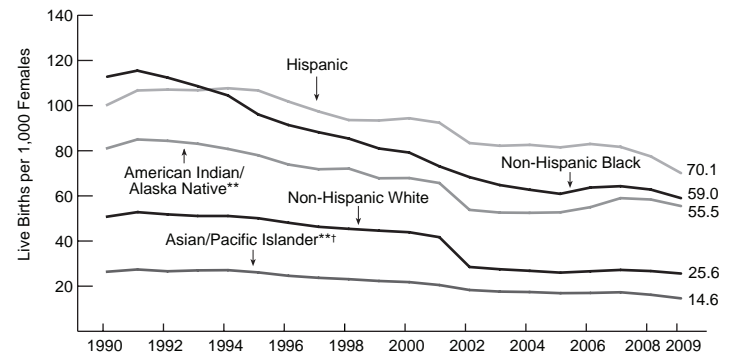
Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary. **May include Hispanics. †Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

Birth Rates Among Adolescent Females Aged 15-19, by Race/Ethnicity, 1990-2009*

Source (II.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 2009 are preliminary. **May include Hispanics. †Separate estimates for Asians and Native Hawaiians and Other Pacific Islanders were not available.

SEXUALLY TRANSMITTED INFECTIONS

In general, adolescents and young adults are at much higher risk than older adults of contracting sexually transmitted infections (STIs), such as chlamydia, gonorrhea, and genital human papillomavirus (HPV). Although young people aged 15–24 years represent only one-quarter of the sexually experienced population, they acquire nearly half of all new STIs.¹

Chlamydia continues to be the most common reportable STI among adolescents and young adults. There were 2,000 chlamydial infections per 100,000 adolescents aged 15–19 years and 2,165 per 100,000 young adults aged 20–24 years in 2009. Gonorrhea was less common, with

rates of 405 and 479 per 100,000 in these age groups, respectively. Rates vary by race/ethnicity: among adolescents aged 15–19 years, the highest rates of chlamydia was reported among non-Hispanic Blacks (6,765 per 100,000), followed by American Indian/Alaska Natives (2,718 per 100,000). Rates of gonorrhea were also highest among these two groups.

Unlike chlamydia and gonorrhea, HPV is not required to be reported to the CDC. However, a recent study indicated that approximately one-quarter of females aged 14–19 years and nearly 45 percent of those aged 20–24 years are infected with HPV.² A vaccine for certain types of HPV was approved in 2006 for use in females aged 9–26 years.³ In 2009, 44.3 percent of females

aged 13–17 years had received at least one dose of the three-dose series.⁴

1 Weinstock H, Berman S, Cates W Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health.* 2004;36(1):6-10.

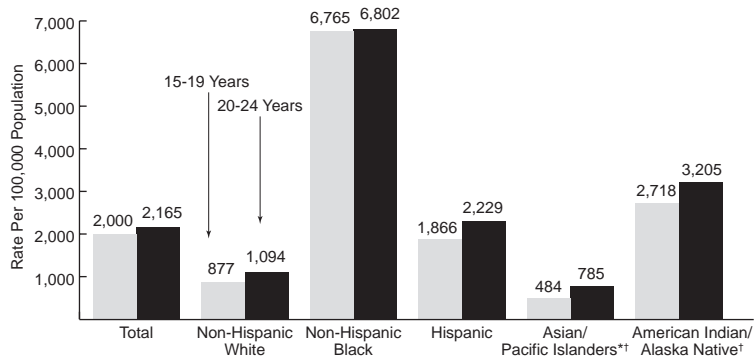
2 Dunne EF, Unger ER, Sternberg M, McQuillan G, Swan DC, Patel SS, Markowitz LE. Prevalence of HPV infection among females in the United States. *JAMA.* 2007 Feb;297(8):876-8.

3 Centers for Disease Control and Prevention, Division of STD Prevention. HPV and HPV vaccines: information for healthcare providers. June 2006. Available at: <http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine-hcp.htm>. Accessed August 2011.

4 Centers for Disease Control and Prevention. National, state, and local area vaccination coverage among adolescents aged 13–17 years—United States, 2009. *MMWR* 2010;59: 1018-23.

Reported Chlamydia Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity, 2009

Source (II.11): Centers for Disease Control and Prevention, STD Surveillance System

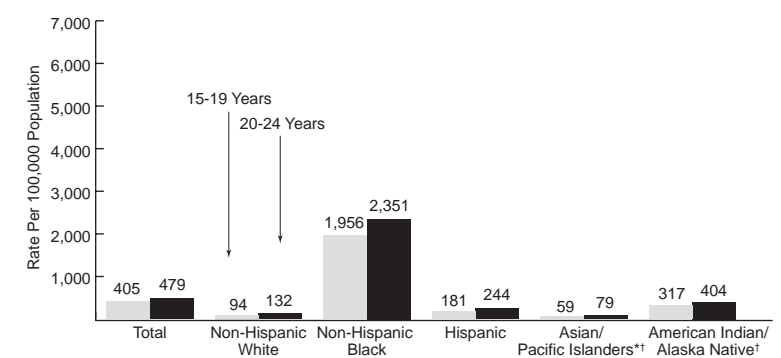


*Separate estimates for Asians and Native Hawaiian and Other Pacific Islanders not available.

†May include Hispanics.

Reported Gonorrhea Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity, 2009

Source (II.11): Centers for Disease Control and Prevention, STD Surveillance System



*Separate estimates for Asians and Native Hawaiian and Other Pacific Islanders not available.

†May include Hispanics.

ADOLESCENT AND YOUNG ADULT HIV AND AIDS

Human immunodeficiency virus (HIV) is a disease that destroys cells that are critical to a healthy immune system. Acquired immunodeficiency syndrome (AIDS) is diagnosed when HIV has weakened the immune system enough that the body has difficulty fighting disease and infections. In 2009, an estimated 8,294 people aged 13–24 years were diagnosed with HIV, representing 19.7 percent of all cases. Between 2006 and 2009, the rate of diagnosed HIV infection decreased for younger adolescents (aged 13–14 years) while increasing for those aged 15–24 years. In 2009, the rates of diagnosed HIV infection among adolescents aged 13–14 years and 15–19 years were 0.3 and 12.0 per 100,000 population, respectively. Among young adults aged 20–24 years the rate was 36.9 per 100,000 – the highest rate of any age group (data not shown).

By 2009, an estimated 51,455 adolescents and young adults had been diagnosed with AIDS, representing 4.6 percent of AIDS diagnoses. In 2008, the death rates for adolescents and young adults with AIDS remained stable with an estimated 205 deaths reported for individuals with an AIDS diagnosis in this population. Since the beginning of the epidemic through 2008, an estimated 10,682 persons aged 13–24 years have died with the disease.

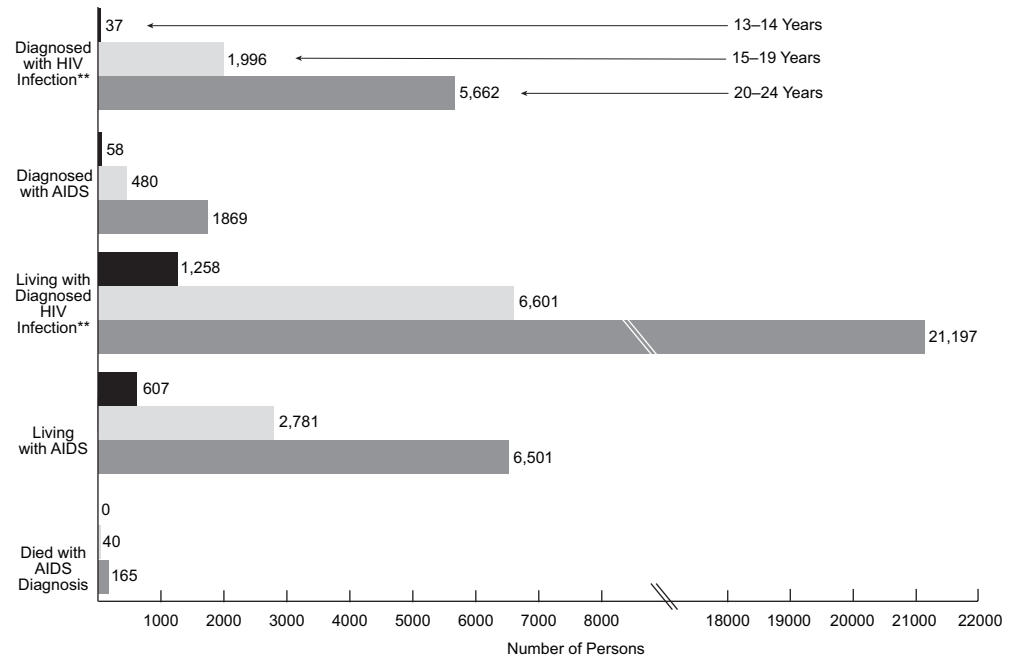
Death rates among adolescents and young adults with a diagnosis of HIV infection or AIDS remained stable between 2006–2008.¹ In 2008, an estimated 29,056 people aged 13–24 years were living with HIV, representing 4.4 percent of all cases. Overall, the number of adolescents and

young adults living with HIV increased nearly 17 percent between 2006 and 2008.

1 Centers for Disease Control and Prevention. HIV Surveillance Report, 2009; vol. 21. February 2011. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Accessed April 2011.

Selected Data on HIV* and AIDS Among Adolescents and Young Adults, by Age, 2008

Source (II.7): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



*All HIV estimates reflect diagnoses. **Data from 40 states with confidential name-based HIV infection reporting. Includes persons with a diagnosis of HIV infection regardless of stage of disease at the time of diagnosis.

PHYSICAL ACTIVITY

Data from the 2009 Youth Risk Behavior Surveillance System showed that 18.4 percent of high school students were physically active for at least 60 minutes on each of the 7 previous days. This is consistent with the U.S. Department of Health and Human Services' recommendation that children and adolescents get one hour or more of physical activity every day, most of which should be moderate- to vigorous-intensity aerobic activity.

Overall, 23.1 percent of students did not participate in 60 or more minutes of physical activity on any day in the preceding week. The rate was higher for females than males (29.9 versus 17.0 percent) and for non-Hispanic Black and Asian children (32.1 and 31.1 percent, respectively) than non-Hispanic Whites (20.3 percent; data not shown).

Participation in recommended levels of physical activity varied by sex and grade level. Among high school students in all grades, a smaller proportion of females reported 60 minutes of physical activity on each of the previous seven days than males. Among 9th graders, 13.6 percent of females met recommended levels of physical activity compared to 28.0 percent of their male counterparts. By 12th grade, only 8.6 percent of females met the recommended levels compared to 21.9 percent of males in the same grade.

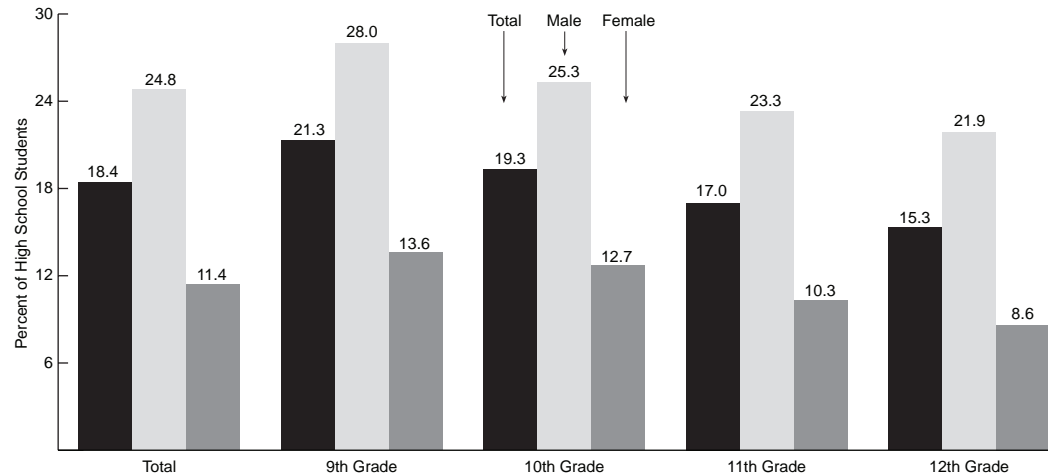
Nationwide, 56.4 percent of high school students attended physical education (PE) classes at least one day per week in 2009. The rate drops dramatically with increasing grade: 72.4 percent of 9th grade students attended PE class, compared to 43.8 percent of 12th grade students. Overall, only 33.3 percent of students attended daily PE classes in 2009 (data not shown).

In 2009, 58.3 percent of high school students reported playing on at least one sports team in the past year. This was more common among younger children than older children (61.6 percent of 9th graders compared to 51.1 per-

cent of 12th graders). Sex differences were also observed in sports participation. Overall, just over half of high-school females reported playing on at least one sports team in the past year, compared to 63.8 percent of high school males. These differences increased with age: while 56.6 percent of 9th grade females reported sports participation in 2009, only 44.1 percent of 12th grade females did so. Among males, the rates of past-year sports team participation declined from 65.9 percent among 9th graders to 57.9 percent among 12th graders (data not shown).

Physical Activity* Among High School Students, by Grade Level and Sex, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Met recommended levels of physical activity, which is one hour or more of physical activity every day, most of which should be moderate- to vigorous-intensity aerobic activity.



SEDENTARY BEHAVIORS

The American Academy of Pediatrics recommends that parents limit children's media time to 1-2 hours per day.¹ This includes time spent watching TV or videos as well as time spent playing video games. In 2007, 7.9 percent of children aged 1-5 years did not watch any TV or videos on an average weekday while 37.7 percent watched 1 hour or less, and 54.4 percent watched more than 1 hour. Among school-aged children (6-17 years), 5.8 percent of children did not spend any time on an average weekday watching TV or videos or playing video games while 44.1 percent spent 1 hour or less, and 50.1 percent spent more than 1 hour.

Among preschool aged children, the amount of weekday media use varied by poverty. Children living in households with incomes of less than 100 percent of the Federal poverty level (\$20,650 for a family of four in 2007) were most likely to engage in 4 or more hours of media use per day (19.1 percent) while only 6.6 percent of children living in households with incomes 400 percent or greater of the poverty level reported 4 or more hours of media use per weekday. A similar pattern was observed for school-aged children (data not shown).

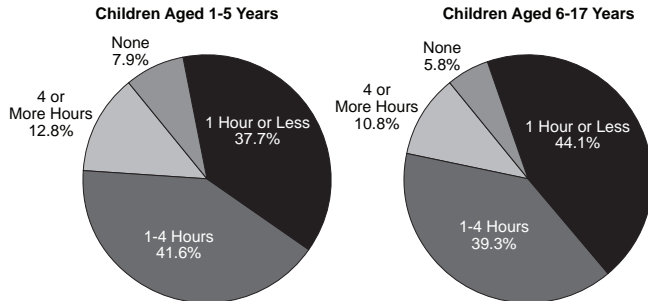
Media use among school-aged children varied by age and sex. While the proportions of

males and females engaged in each level of media use were similar among children aged 6-11 years, females aged 12-17 were more likely to report lower levels of weekday media use than their male counterparts. Nearly 8 percent of 12-17 year old girls did not engage in any weekday media use compared to 4.7 percent of boys of the same age, and males in this age group were more likely than their female counterparts to engage in 4 or more hours of media use (14.7 percent and 10.1 percent, respectively).

1 Committee on Public Education. Children, Adolescents, and Television. Pediatrics. February 1, 2001 2001;107(2):423-426.

Media Use* Among Children 1-5 and 6-17 Years of Age, 2007

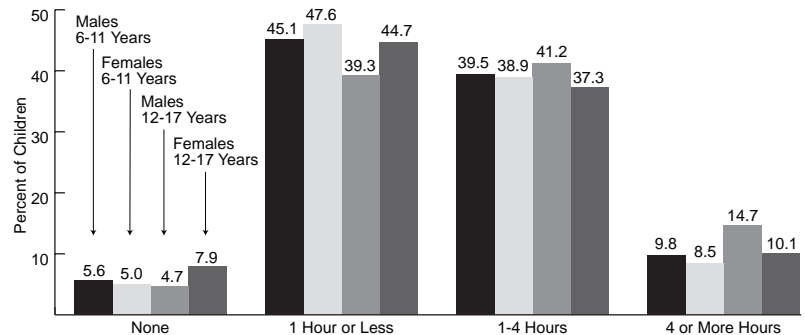
Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*For children 1-5 years of age, this is the number of hours spent watching TV or videos on an average weekday; for children 6-17 years, this is the number of hours spent watching TV or videos or playing video games on an average weekday.

Media Use* Among Children Aged 6-17, by Age and Sex, 2007

Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*This is the number of hours spent watching TV or videos or playing video games on an average weekday.

OVERWEIGHT AND OBESITY

Body mass index (BMI) is the ratio of weight to height, which is used to define weight status. In children, BMI is used in conjunction with age and sex, since both of these factors affect body composition. Children who fall between the 85th and 94th percentile of BMI-for-age are considered overweight, while children who are in the 95th percentile or above are considered obese; those who fall below the 5th percentile are considered underweight. Those between the 5th and 84th percentile are considered to be normal weight. In 2007, 15.3 percent of children aged 10-17 years were overweight and 16.4 percent were obese based on parent-reported height and weight. Obesity is a serious health concern for

children—obese children are more likely to have risk factors for cardiovascular disease, such as high blood pressure, high cholesterol, and Type 2 diabetes. Obese children are also at increased risk of obesity in adulthood, which is associated with a host of serious health consequences.¹

Weight status among children varies by a number of factors including household poverty.² In 2007, 27.4 percent of children living with household incomes below 100 percent of the Federal poverty level (\$20,650 for a family of four in 2007) were obese, compared to only 10.0 percent of children living in households with incomes of 400 percent or more of the Federal poverty level.

The prevalence of obesity among children

increased sharply between 1976 and 2008. The obesity prevalence for male children nearly quadrupled from 5.5 percent in 1976-1980 to 21.0 percent in 2007-2008. For female children, the obesity prevalence tripled from 5.8 percent in 1976-1980 to 17.3 percent in 2007-2008.³

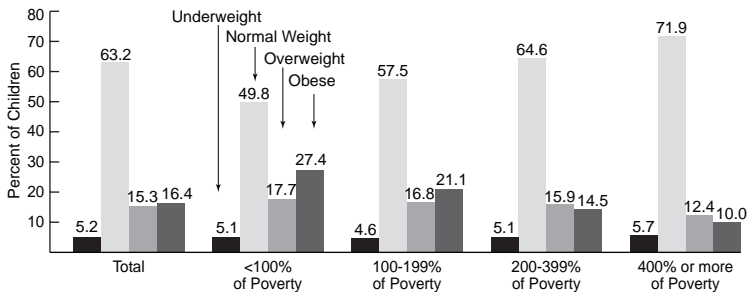
1 Centers for Disease Control and Prevention. *Childhood overweight and obesity*. Available at: <http://www.cdc.gov/obesity/childhood/index.html>. Accessed February 2011.

2 Gopal SK and Kogan MD. *Childhood Obesity in the United States, 1976-2008. A 75th Anniversary Publication*. Health Resources and Services Administration, Maternal and Child Health Bureau. Rockville, MD: US Department of Health and Human Services; 2010.

3 Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2010*. Available at: <http://childstats.gov/americaschildren/index.asp>. Accessed June 2011.

Weight Status* Among Children Aged 10-17 Years, by Poverty,** 2007

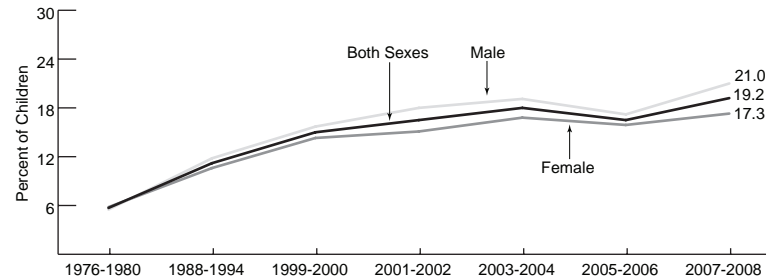
Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Underweight is a BMI-for-age under the 5th percentile, normal weight is a BMI-for-weight between the 5th and 84th percentile, overweight is a BMI-for-age between the 85th and 94th percentile, and obesity is a BMI-for-age in the 95th percentile or above; based on parent-reported height and weight. **The U.S. Department of Health and Human Services poverty level for a family of four was \$20,650 in 2007.

Obesity* Among US Children Aged 6-17, by Sex, 1976-2008

Source (II.12): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Obesity is a BMI-for-age in the 95th percentile or above; based on parent-reported height and weight.

MENTAL HEALTH

In 2009, 8.1 percent or 2.0 million adolescents aged 12–17 years experienced at least one major depressive episode (MDE), which is defined as having at least 2 weeks of depressed mood or loss of interest or pleasure in daily activities, plus a majority of specific depression symptoms, such as altered sleeping patterns, fatigue, and feelings of worthlessness.¹ Females were more likely than males to experience MDE (11.7 percent versus 4.7 percent). Occurrence of MDE increased with age, from 3.6 percent among children age 12 years to 10.9 percent among children age 17 (data not shown).

Among adolescents experiencing MDE in

2009, over one-half (1.4 million) also experienced severe impairment defined by the degree to which activities and roles, such as completing chores at home, going to school or work, or maintaining close family relationships are affected. MDE with severe impairment was more common among older adolescents and females (data not shown).

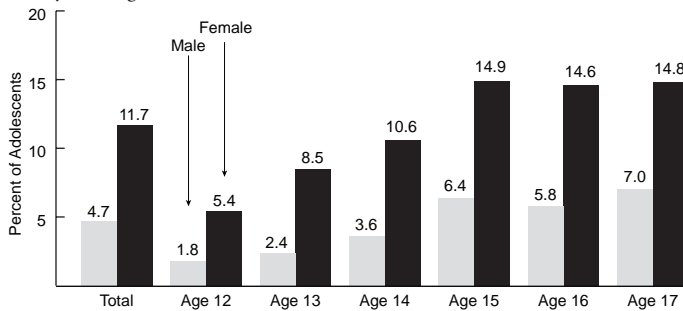
In 2009, adolescents aged 12 to 17 with past-year MDE were more likely than those without MDE to have used illicit drugs in the past year (35.7 compared to 18.0 percent). Adolescents with past-year MDE were also more likely to report daily cigarette and heavy alcohol use in the past month compared with those without past-

year MDE. Among adolescents with past-year MDE who used illicit drugs, nearly one-quarter (24.2 percent) reported using marijuana or hashish and nearly one-fifth (19.2 percent) reported non-medical use of psychotherapeutics, including pain relievers, tranquilizers, stimulants and sedatives. Among adolescents who did not experience past-year MDE, the proportion who reported using these substances was 12.6 percent and 6.6 percent, respectively (data not shown).

1 Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

Occurrence of Major Depressive Episode (MDE)* in the Past Year Among Adolescents Aged 12-17 Years, by Age and Sex, 2009

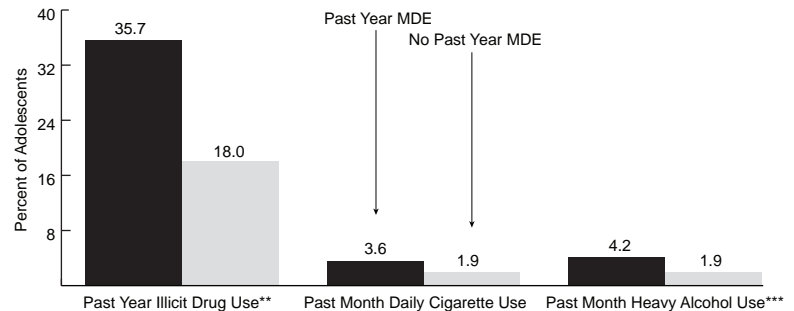
Source (II.13): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of pleasure in daily activities and had a majority of specific depression symptoms.

Substance Use among Adolescents Aged 12-17, by Past-Year Major Depressive Episode (MDE)*, 2009

Source (II.13): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of pleasure in daily activities and had a majority of specific depression symptoms.

Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. *Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

SUICIDE

In 2007, the latest year for which mortality data were available, suicide was the third leading cause of death among persons aged 15-24 years, 9.7 deaths per 100,000 population.¹ Suicide mortality among this age group increased by over 70 percent between 1969 and 1994; however, there was a downward trend between the years of 1994 and 2007. The overall rise in suicide rates between 1969 and 2007 occurred disproportionately, with a larger increase among White youth aged 15-24 years than among Black youth.²

In 2009, data from the Youth Risk Behavior Surveillance System showed that 13.8 percent of all high school students had considered attempting suicide during the 12 months prior to the survey. Female students in the 9th grade were

the most likely to consider suicide (20.3 percent) while 9th- and 10th-grade males were the least likely (10.0 percent). Female students were significantly more likely to consider suicide as compared to males within each grade level; 13.6 percent of 12th grade females had considered suicide in the prior year. No significant difference by grade level was found among male students.

In 2009, 6.3 percent of high school students reported having attempted suicide in the past 12 months. Overall, females (8.1 percent) were more likely to report at least one suicide attempt than males (4.6 percent; data not shown). The proportion of students who reported having attempted suicide also varied by race/ethnicity. Non-Hispanic Asian and White students were least likely to report attempting suicide (4.0 percent and 5.0

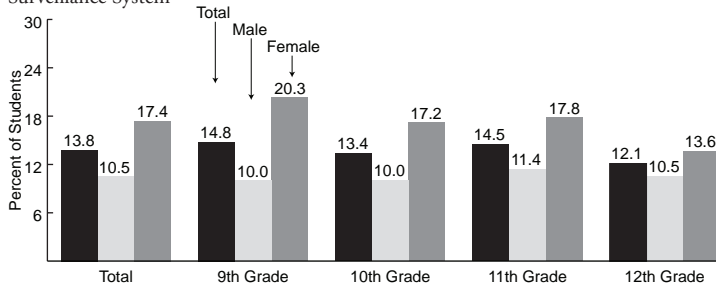
percent, respectively) while non-Hispanic Native Hawaiian/Other Pacific Islander students and non-Hispanic students of more than one race were the most likely to report at least one attempt in the past year (11.9 percent and 12.4 percent, respectively). Female students were significantly more likely to report attempted suicide among non-Hispanic Black, White, and Hispanic students; no sex differences were observed for other racial/ethnic groups (data not shown).

1 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available at: <http://www.cdc.gov/ncipc/wisqars>. Accessed March, 2011.

2 Singh GK. Youth Mortality in the United States, 1935-2007; Over Seven Decades of Progress and Disparities. A 75th Anniversary Publication. Health Resources and Services Administration, Maternal and Child Health Bureau. Rockville, Maryland: U.S. Department of Health and Human Services; 2010.

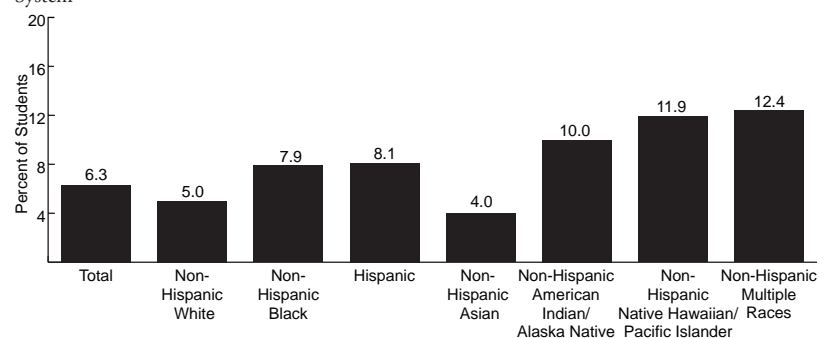
High School Students Who Considered Attempting Suicide in the Past 12 Months, by Grade Level and Sex, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



High School Students Who Attempted Suicide in the Past 12 Months, by Race/Ethnicity and Sex*, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



VIOLENCE

Physical violence among adolescents occurs in multiple forms and is a critical public health issue in the United States. Instances of violence include homicide, which was the second leading cause of death among all persons aged 15–24 years in 2007 (the latest year for which data are available).¹

Results from the Youth Risk Behavior Surveillance System show that, in 2009, 11.1 percent of high school students reported being in a physical fight on school property during the preceding 12 months. Males were more than twice as likely as females to report having been

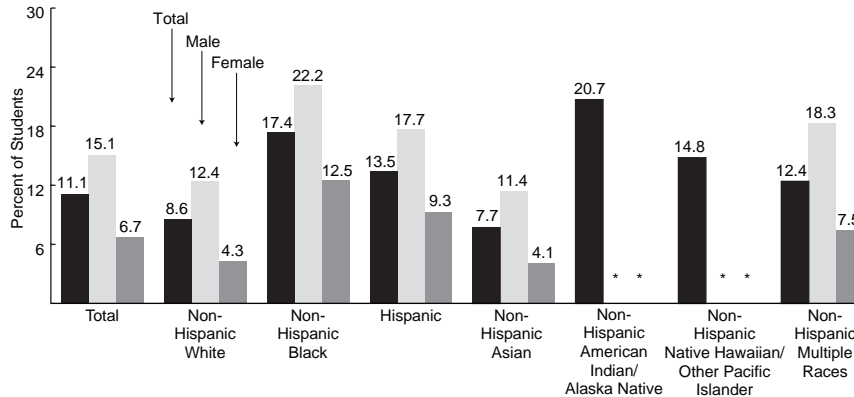
in a fight (15.1 percent versus 6.7 percent). This disparity was most pronounced among non-Hispanic Whites, where males were almost three times as likely as females to have been in a fight (12.4 percent versus 4.3 percent), although significant sex differences were observed across all racial/ethnic groups. Overall, non-Hispanic White and Asian students were least likely to report having been in a fight (8.6 percent and 7.7 percent, respectively) while over one-fifth of non-Hispanic American Indian/Alaska Native students reported having been in a physical fight on school property in the past year.

Approximately 1 out of every 10 high school students reported that they were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend at least once in the past 12 months. The prevalence of dating violence was similar across grade levels and among males and females, with one exception. Males in the 11th grade were slightly more likely to report having been victims of dating violence (11.5 percent) than females in the same grade level (9.1 percent; data not shown).

1 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available at: <http://www.cdc.gov/ncipc/wisqars>. Accessed July 2011.

High School Students in a Physical Fight on School Property in the Past 12 Months, by Sex and Race/Ethnicity*, 2009

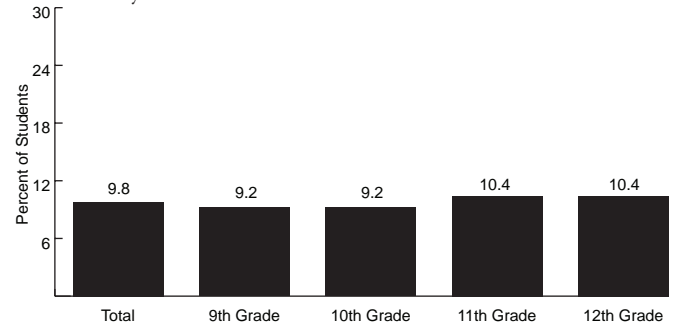
Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Data for American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders do not meet standards for reliability or precision.

High School Students Experiencing Dating Violence* in the Past 12 Months, by Grade and Sex, 2009

Source (II.10): Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System



*Dating violence was defined as having been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend.

BULLYING

Bullying is defined as aggressive behavior that is intentional, repeated over time, and involves an imbalance of power or strength. Bullying may damage children's self-esteem, cause higher rates of loneliness and depression, and affect academic success. Bullying can also have physical effects, such as an increase in headaches, sleeping problems, and stomach ailments. Children who engage in bullying may be more likely to get into physical altercations, use drugs and alcohol, and get into trouble with the law. Even children who witness bullying can be negatively affected.¹

In 2009, 19.9 percent of high school students reported that they had been bullied on school

property in the past year. The likelihood of a child being bullied varied by a number of factors including sex, race/ethnicity, and grade level. Females were more likely than males to have been bullied (21.2 percent versus 18.7 percent) while nearly one-quarter of 9th graders reported being bullied compared to 13.5 percent of 12th graders (data not shown). Overall, non-Hispanic American Indian/Alaska Native children were most likely to report having been bullied (33.8 percent), while non-Hispanic Black children were least likely (13.7 percent).

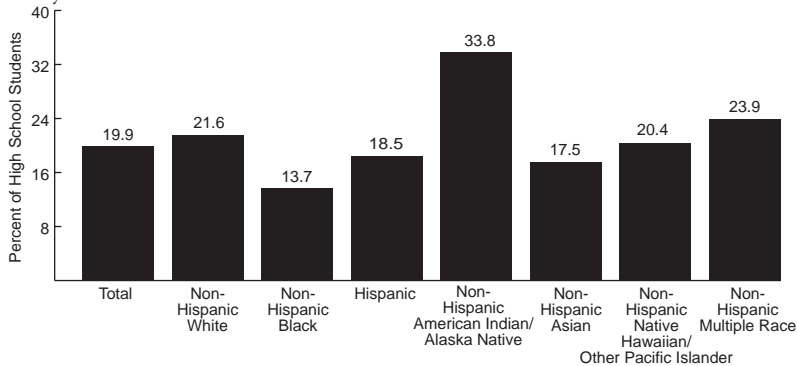
Violence, such as bullying, can prevent children from attending school for fear of their safety. In 2009, 5.0 percent of high school

students reported that they did not go to school on at least one day during the past month because they felt unsafe at school or on their way to or from school. Non-Hispanic American Indian/Alaska Native and Hispanic students were more than twice as likely to miss school because of safety concerns as non-Hispanic White children (8.7 and 8.1 percent, respectively, versus 3.5 percent) while non-Hispanic Native Hawaiian or Other Pacific Islander children were more than three times as likely (10.6 percent).

1 U.S. Department of Health and Human Services. Stop Bullying Now. Available at: <http://www.stopbullying.gov/>. Accessed March 2011.

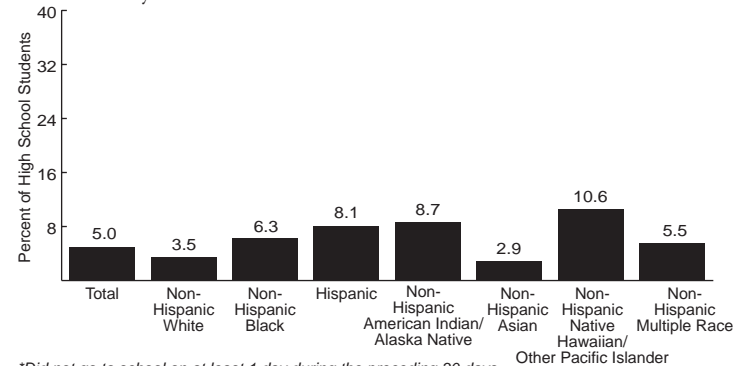
High School Students Who Were Bullied on School Property in the Past Year, by Race/Ethnicity, 2009

Source (II.10): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



High School Students Who Felt Unsafe at School,* by Race/Ethnicity, 2009

Source (II.10): Centers for Disease Control and Prevention, High School Youth Risk Behavior Survey



*Did not go to school on at least 1 day during the preceding 30 days because he/she felt unsafe at school or on the way to or from school.

SOCIAL SKILLS

Cultivating social skills is a significant component of a child's development and begins at an early age. Social skills include the ability to communicate and empathize with others and remain important throughout a child's lifetime.

Parents of children aged 6-17 years were asked if their child had never, rarely, sometimes, usually, or always exhibited each of the following behaviors in the past month: showed respect for teachers and neighbors; got along well with other children; tried to understand other people's feelings; and tried to resolve conflict with classmates, family, or friends. The preva-

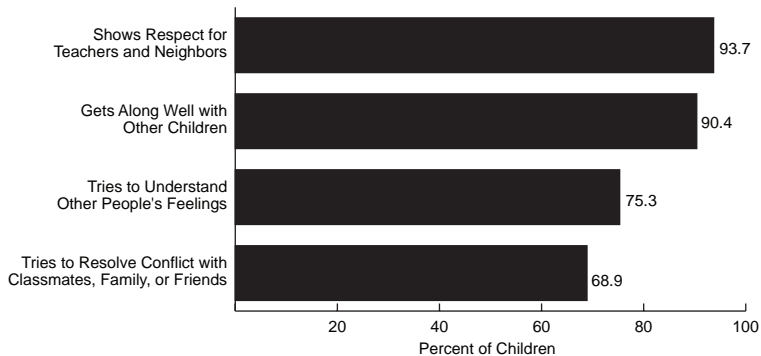
lence of individual social skills varied greatly. Parents of over 90 percent of children reported that they usually or always showed respect for teachers and neighbors, and got along well with other children. In comparison, 75.3 percent of children were reported to have tried to understand other people's feelings, and 68.9 percent were reported to have tried to resolve conflict with classmates, family, or friends. While most children displayed positive social skills to some degree, children were considered to consistently display social skills if parents responded "usually" or "always" to two or more of these ques-

tions. Overall, 93.6 percent of children were reported as having consistently exhibited two or more positive social skills (data not shown).

The display of specific social skills varied by the child's sex. Among children aged 6-17 years, 72.5 percent of females tried to resolve conflicts with classmates, family, or friends compared to 65.4 percent of males; however, this behavior increased in both sexes with age.

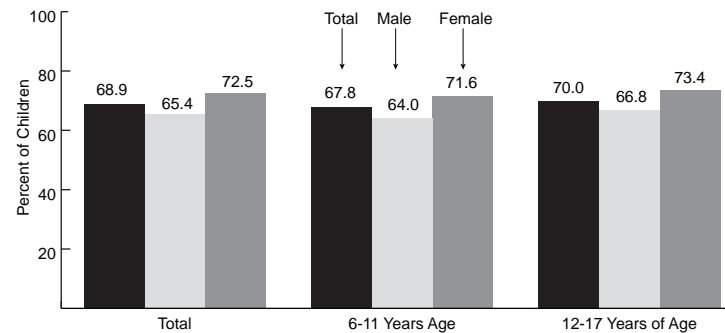
Children Aged 6-17 Years Usually or Always Exhibiting Social Skills, by Type of Social Skill, 2007

Source (II.14): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



Children Aged 6-17 Years Who Usually or Always Try to Resolve Conflicts,* by Age and Sex, 2007

Source (II.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*With classmates, family, or friends.

CIGARETTE SMOKING

In 2009, cigarette smoking among adolescents reached the lowest levels recorded in the past 34 years, according to the annual Monitoring the Future study. Between 2009 and 2010, there was a non-significant increase in the overall percentage of high school students to have smoked cigarettes in the past 30 days from 12.7 percent in 2009 to 12.8 percent in 2010. This increase in current cigarette use occurred among both 8th and 10th graders, from 6.5 percent to 7.1 percent and 13.1 percent to 13.6 percent, respectively. During this same period a small decline was observed among 12th graders (20.1 percent to 19.2 percent).¹

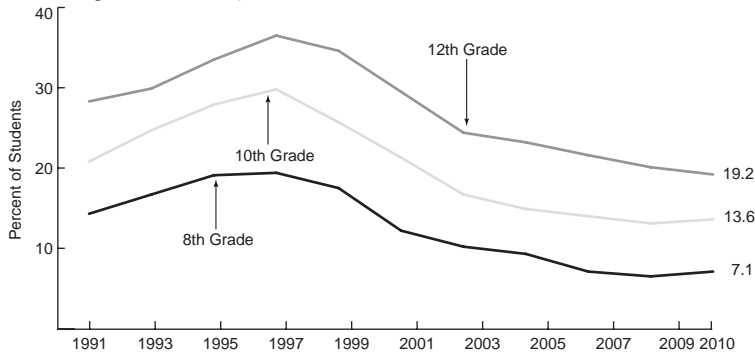
The percent of teens who report smoking in the past month began a rapid increase in the early 1990s, with the rates among 8th and 10th grade students reaching a peak in 1996 (at 21.0 and 30.4 percent, respectively), and the rate among 12th grade students peaking a year later (36.5 percent). These increases occurred in virtually every sociodemographic group: male and female, those with and without plans for college attendance, those living in all four regions of the country, and those of different racial and ethnic groups. Since peaking in the mid-1990s, overall rates of smoking in the past month have dropped 66 percent among 8th grade students, 55 percent among 10th grade students, and 47 percent among 12th grade students.

Despite a population-wide decline, certain subgroups of adolescents were still more likely than others to smoke. In 2009-2010, non-Hispanic White students were the most likely to report smoking in the past month, followed by Hispanic students. Also, males were more likely than females to smoke, and adolescents without plans to attend a four-year college program are more likely to smoke than their college-bound peers (data not shown).

¹ Johnston, LD, O'Malley, PM, Bachman, JG, & Schulenberg, JE (December 14, 2010). "Smoking stops declining and shows signs of increasing among younger teens." *University of Michigan News Service*. 2010. Available at: <http://www.monitoringthefuture.org>. Accessed July 2011.

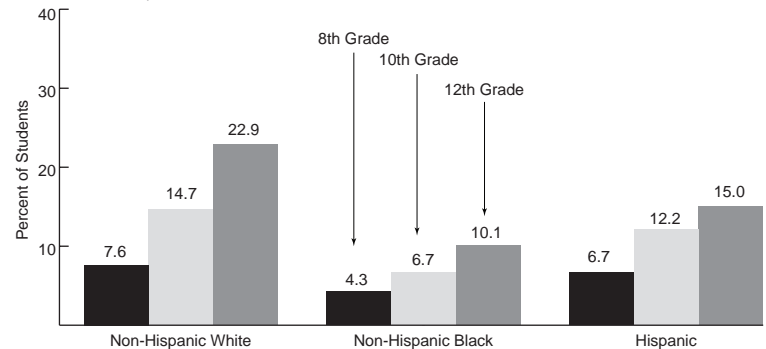
Cigarette Use Among Students in the Past 30 Days, by Grade Level, 1991-2010

Source (II.15): National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Study



Cigarette Use Among Students in the Past 30 Days, by Grade Level and Race/Ethnicity, 2009-2010*

Source (II.16): National Institutes of Health, National Institute on Drug Abuse, Monitoring the Future Study



*To derive percentages for each racial subgroup, data for 2009 and 2010 have been combined to increase subgroup sample sizes and thus provide more stable estimates.

SUBSTANCE ABUSE

In 2009, 10.0 percent of adolescents aged 12–17 years reported using illicit drugs in the past month, representing a significant increase since the previous year. Illicit drug use varied by age, with 3.6 percent of youth aged 12–13 years reporting drug use in the past month, compared to 9.0 percent of youth aged 14–15 years and 16.7 percent of youth aged 16–17 years. There was also variation by race/ethnicity, with rates ranging from 5.5 percent among non-Hispanic Asian youth to 14.6 percent among non-Hispanic American Indian/Alaska Native youth. Rates for non-Hispanic White, non-Hispanic Black, and Hispanic youth were 9.6 percent, 10.8 percent, and 11.4 percent, respectively (data not shown).

Marijuana is consistently the most commonly used illicit drug among adolescents, with 7.3 percent reporting past-month use in 2009. This was followed by nonmedical use of prescription-type psychotherapeutics, such as pain relievers, tranquilizers, stimulants, and sedatives (3.1 percent). Marijuana was the most commonly used drug among adolescents aged 14–15 and 16–17 years (6.3 percent and 14.0 percent, respectively) compared to less than 1 percent among adolescents aged 12–13 years (data not shown).

Illicit drug use is associated with other health risk behaviors. In 2009, 52.8 percent of adolescents who reported cigarette use in the past month also reported illicit drug use, compared to

only 5.9 percent of adolescents who did not report smoking. Adolescents who reported alcohol use in the past month were also more likely to use illicit drugs than adolescents who did not report alcohol use: 70 percent of heavy drinkers (i.e., adolescents who consumed five or more drinks on the same occasion on each of 5 or more days in the past 30 days), also used illicit drugs (data not shown).

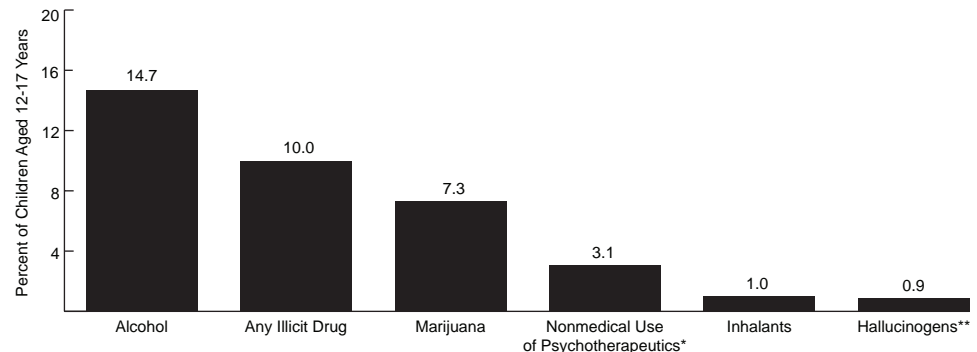
Alcohol continues to be the most commonly used drug among adolescents, with 14.7 percent reporting past-month use in 2009. Rates of past month alcohol use varied by race/ethnicity, with rates ranging from 6.5 percent among non-Hispanic Asian youth to 16.1 percent non-Hispanic White youth (data not shown).

In 2009, 30.7 percent of adolescents perceived smoking marijuana once a month to be a great risk, while 49.5 percent perceived the same risk regarding cocaine use. Smoking one or more packs of cigarettes a day was considered a great risk by 65.8 percent of adolescents. Drinking five or more drinks once or twice per week was considered a great risk by 39.9 percent of adolescents (data not shown).

While 14.3 percent of adolescents were approached by someone selling drugs in the past month, nearly 50 percent reported that marijuana would be fairly or very easy to obtain; 22.1 percent reported the same for crack, 20.9 percent for cocaine, 13.5 percent for LSD, and 12.9 percent for heroin (data not shown).

Past Month Drug Use Among Adolescents Aged 12-17 Years, by Drug Type, 2009

Source (II.13): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Includes non-medical use of pain relievers, sedatives, stimulants, and tranquilizers; does not include over-the-counter substances.

**Includes LSD, PCP, and Ecstasy.

ADOLESCENT MORTALITY

In 2007, the latest year for which data are available, 13,299 adolescents aged 15 to 19 years died of various causes, representing a rate of 61.9 per 100,000. Unintentional injury was the leading cause of death, followed by homicide, suicide, cancer, and heart disease. Together, these causes account for 84.3 percent of deaths in this age group, although nearly half of all adolescent deaths are attributable to unintentional injury.

The mortality rate of males in this age group was notably higher than that of females (86.9 versus 35.7 per 100,000, respectively; data not shown). While unintentional injuries account for about half of deaths among both males and females, the proportion of deaths due to homicide, suicide, and cancer vary by sex. One-fifth of

deaths among adolescent males were homicides, compared to 7.8 percent of deaths among females. Similarly, 12.8 percent of adolescent male deaths were attributed to suicide, compared to 7.4 percent of adolescent female deaths.

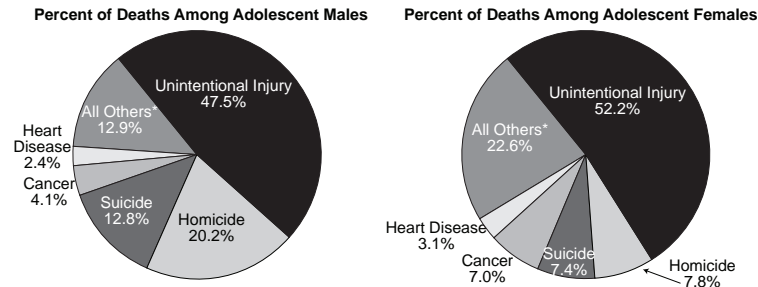
Racial and ethnic disparities also exist, with non-Hispanic Black adolescents experiencing a mortality rate of 85.7 per 100,000, compared to rates of 58.0 and 57.9 per 100,000 among non-Hispanic Whites and Hispanics, respectively (data not shown). In 2007, unintentional injury was the leading cause of death among adolescents of all racial/ethnic groups, except non-Hispanic Blacks. Nearly 45 percent of adolescent deaths among non-Hispanic Blacks were homicides, compared to nearly one-quarter of deaths among

Hispanic adolescents and 4.5 percent of deaths among non-Hispanic White adolescents (data not shown).

Of the 6,493 adolescent deaths in 2007 due to unintentional injuries, motor vehicle traffic was the leading cause death (70.7 percent), followed by poisoning (12.9 percent). However, of the 10,415 deaths due to both unintentional and intentional (or violence-related) injuries, motor vehicle traffic accounted for 44.1 percent of deaths, while homicide by firearm was the second leading cause of injury death, accounting for 18.2 percent of adolescent deaths of this nature. Firearms accounted for 85.3 percent of homicide deaths and 42.5 percent of suicide deaths among adolescents (data not shown).

Leading Causes of Death Among Adolescents Aged 15-19 Years, by Sex, 2007

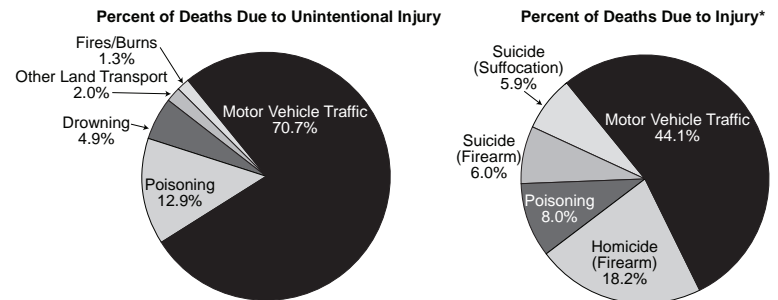
Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Includes congenital anomalies, cerebrovascular diseases, chronic lower respiratory disease (males), pregnancy and childbirth (females), diabetes (males), influenza and pneumonia (females), septicemia, and all other causes not specified.

Deaths Due to Unintentional and Intentional Injury Among Adolescents Aged 15-19 Years, 2007

Source (II.17): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Includes unintentional injury, intentional injury, such as homicide and suicide, and injury deaths of undetermined intent.



HEALTH SERVICES FINANCING AND UTILIZATION

The availability of and access to quality health care directly affects the health of the population. This is especially true of those at high risk due to low socioeconomic status or chronic medical conditions.

Children may receive health coverage through a number of sources, including private insurance, either employer-based or purchased directly, and public programs, such as Medicaid or the Children's Health Insurance Program (CHIP). Eligibility for public programs is based on a family's income compared to the Federal poverty level. Nearly every state has CHIP programs that help to expand coverage to children who would otherwise be uninsured. Despite the progress achieved through public programs, approximately 7.5 million children remain uninsured in the United States.

This section presents data on the health insurance status and utilization of health services within the maternal and child population. Data are summarized by source of payment, type of care, and place of service delivery.

HEALTH CARE FINANCING

In 2009, approximately 7.5 million U.S. children under 18 years of age had no health insurance coverage, representing 10.0 percent of the population. More than one-third of children were insured through public programs such as Medicaid and the Children's Health Insurance Program (36.8 percent), and 60.4 percent were covered by private insurance.

Children's insurance status varies by race and ethnicity. In 2009, 74.0 percent and 70.9 percent of non-Hispanic White and non-Hispanic Asian children, respectively, and 70.8 percent of Asian children had private coverage, while the same was true of only 47.1 percent of non-Hispanic Native Hawaiian and Other Pacific Islander children, 43.7 percent of non-Hispanic Black children,

41.8 percent of non-Hispanic American Indian and Alaska Native children, and 36.8 percent of Hispanic children. Over half of non-Hispanic Black, American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islander children were publicly insured.

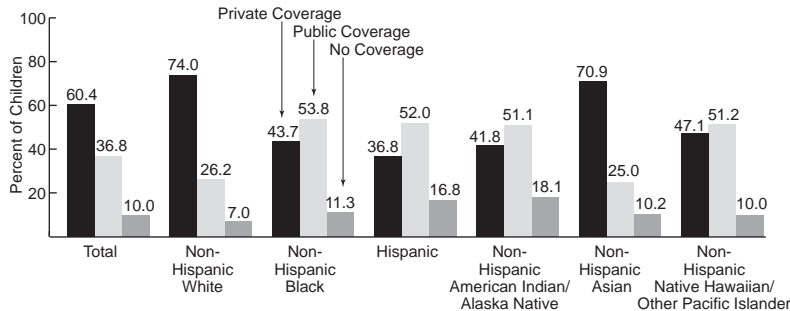
As family income increases, private health insurance coverage among children rises and the proportions of children with public coverage and no coverage decrease. In 2009, children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009) were most likely to have public coverage (74.8 percent) while similar proportions of poor and near-poor (incomes between 100-199 percent of the

poverty threshold) children were uninsured (15.1 percent and 14.8 percent, respectively). Children with family incomes of 300 percent or more of the poverty threshold were most likely to have private coverage (89.0 percent), and least likely to have public coverage (12.2 percent) or to be uninsured (4.7 percent).

In 1997, the Children's Health Insurance Program (CHIP) was created in response to the growing number of uninsured children in low-income working families. Although designed to cover children with family incomes below 200 percent of the poverty level, many States have expanded eligibility to children with higher family incomes.

Health Insurance Coverage Among Children Under Age 18, by Race/Ethnicity and Type of Coverage,* 2009

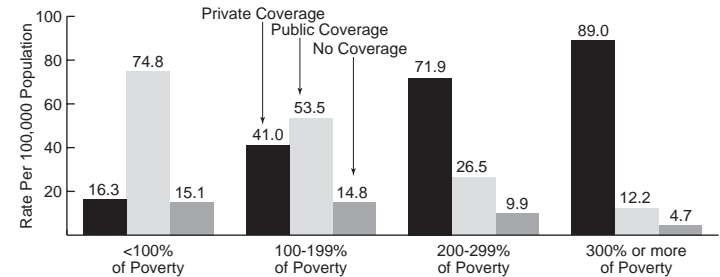
Source (III.1): U.S. Census Bureau, Current Population Survey



*Totals equal more than 100 percent because children may have more than one source of coverage.

Health Insurance Coverage Among Children Under Age 18, by Poverty Status* and Type of Coverage,** 2009

Source (III.1): U.S. Census Bureau, Current Population Survey



*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009. **Totals equal more than 100 percent because children may have more than one source of coverage.

LEVELS OF INSURANCE

While most children have some type of health insurance, it may not always meet their needs. The 2007 National Survey of Children's Health asked parents about their child's health insurance coverage and related costs and benefits. Based on both insurance status and benefits, four levels of insurance were defined: full and adequate coverage; full and inadequate coverage (or underinsurance); gaps in coverage (child had periods of no insurance coverage in the past year); and uninsured (child was never insured in the past year).¹ Overall, 65.7 percent of children were fully insured in 2007, 19.3 percent were underinsured (i.e., covered but did not receive

the level of benefits necessary to meet their needs), 10.4 percent had gaps in coverage, and 4.7 percent were consistently uninsured during the past year.

The proportion of children with different levels of insurance coverage varied by a number of factors. Children aged 0-5 years were most likely to have full and adequate insurance coverage (69.3 percent) compared to children aged 6-11 years (64.0 percent) and aged 12-17 years (63.9 percent; data not shown). Hispanic children were most likely to be uninsured (12.1 percent) and to have gaps in their past-year coverage (16.1 percent). Non-Hispanic White and multiracial children had the highest rates of

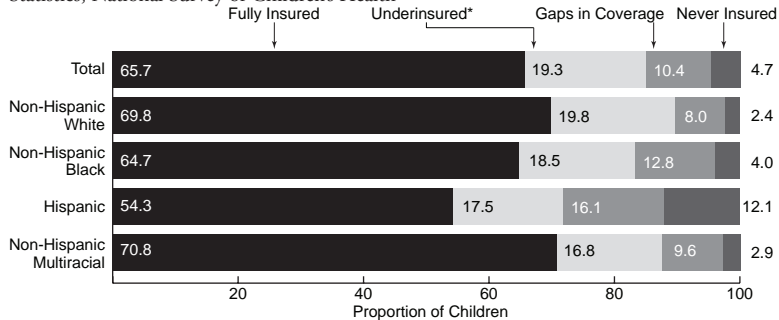
full and adequate insurance coverage (69.8 and 70.8 percent, respectively).

Underinsurance was most commonly reported among children living in households with incomes 200-399 percent of the Federal poverty level (\$20,650 for a family of four in 2007) and least commonly reported among children living in households with incomes below the poverty line (22.8 versus 14.1 percent). Underinsurance was also more common among children in fair or poor health and those with special health care needs (data not shown).

1 Kogan MD, Newacheck PW, Blumberg SJ, Ghandour RM, Singh GK, Strickland BB, van Dyck PC. Underinsurance among children in the United States. N Engl J Med. 2010 Aug 26;363(9):841-51.

Levels of Insurance Among Children Aged 0-17 Years, by Race/Ethnicity 2007

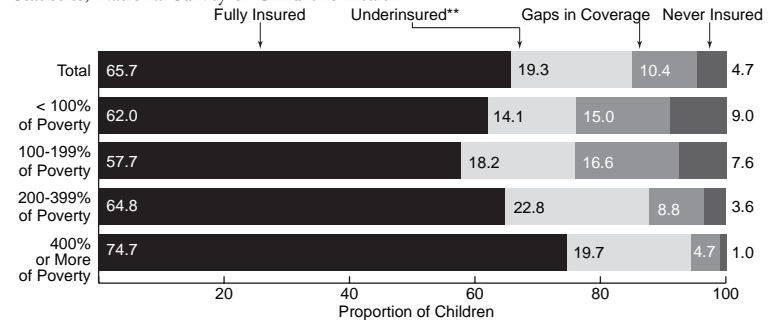
Source (III.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Fully insured but did not receive the level of benefits necessary to meet their needs, based on parent report.

Levels of Insurance Among Children Aged 0-17 Years, by Poverty*, 2007

Source (III.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$20,650 in 2007.

**Fully insured but did not receive the level of benefits necessary to meet their needs, based on parent report.

VACCINATION COVERAGE

The Healthy People 2020 objective for childhood immunization is to achieve 90 percent coverage for each of the universally recommended vaccines among young children. In 2009, 70.5 percent of children 19–35 months of age received each of six vaccines in a modified series of recommended vaccines (4:3:1:3:1:4). This series includes four doses of diphtheria, tetanus, and pertussis vaccine (DTP/DT/DTaP); three doses of poliovirus vaccine; one dose of measles, mumps, and rubella vaccine (MMR); three doses of the Hepatitis B vaccine (HepB); one dose of the varicella (chicken pox) vaccine; and four doses of the pneumococcal conjugate vaccine (PCV). Estimates presented in previous editions of Child Health USA have focused on receipt of a 7-vaccine series which also included three doses of *Haemophilus influenzae* type b vaccine (Hib). However, because of changes in measurement of the Hib vaccine and the vaccine shortage that occurred from December 2007 to September 2009, coverage estimates included here are based on the modified series that excludes Hib.

For some vaccines, the proportion of children covered varied by poverty status. Children living in households with family incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in

2008) had significantly lower rates of vaccine coverage for diphtheria, tetanus, and pertussis (80.1 percent compared to 85.7 percent of children living in households with family incomes above the poverty threshold) as well as for the four recommended doses of pneumococcal conjugate vaccine (74.8 percent versus 83.2 percent). Although no difference was observed in the proportion of children receiving three

doses of the Hepatitis B vaccine by poverty status, coverage for the Hepatitis B birth dose (one dose within the first three days of life) was higher among children living below poverty than for those living at or above poverty (63.2 percent versus 59.4 percent; data not shown). No statistically significant difference was observed in the proportion of children receiving the modified 6-vaccine schedule by poverty status.

Vaccination Rates Among Children Aged 19-35 Months, by Poverty,* 2009

Source (III.3): Centers for Disease Control and Prevention, National Immunization Survey

Vaccine	Total	< 100% Poverty	≥ 100% Poverty
4:3:1:3:x:1:4 Modified Series**	70.5	75.5	78.5
4+DTAP	83.9	80.1	85.7
3+Polio	92.8	92.0	93.3
1+MMR	90.0	88.8	90.6
2+ or 3+Hib***	83.6	90.1	93.1
3+HepB	92.4	92.3	92.7
1+ Varicella	89.6	89.0	90.2
4+ PCV	80.4	74.8	83.2

*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$22,025 in 2008. **Excludes Hib, due to the 2007–2009 shortage. ***Depending on product type received

Recommended Immunization Schedule for Children Aged 0-6 Years, United States, 2011

Source (III.4): Department of Health and Human Services, Centers for Disease Control and Prevention

Range of recommended ages Certain high-risk groups

	Birth	1mo	2mo	4mo	6mo	12mo	15mo	18mo	19-23mo	2-3yr	4-6yr
Hepatitis B¹	HepB	HepB		HepB							
Rotavirus²			RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis³			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b⁴			Hib	Hib	Hib ⁴	Hib					
Pneumococcal⁵			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus⁶			IPV	IPV		IPV					IPV
Influenza⁷						Influenza (yearly)					
Measles, Mumps, Rubella⁸						MMR		see footnote 8			MMR
Varicella⁹						Varicella		see footnote 9			Varicella
Hepatitis A¹⁰						HepA (2 doses)				HepA Series	
Meningococcal¹¹											MCV

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices

statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.

- Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See MMWR 2010;59(No. RR-11).
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See MMWR 2010;59(No. RR-8):33-34.

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The National Survey of Children with Special Health Care Needs (CSHCN) asked the parents of CSHCN whether their child had insurance in the past 12 months and what kind of insurance they had. Overall, 91.2 percent of CSHCN were reported to have been insured for all of the previous 12 months, while the remaining 8.8 percent were uninsured for all or some part of the year. At the time of the interview, almost 97 percent of CSHCN were reported to have some type of insurance: 59.1 percent had private insurance provided through an em-

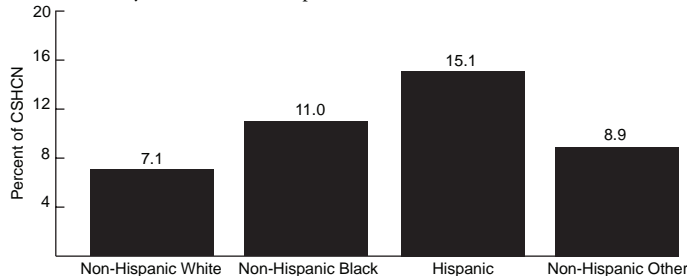
ployer or obtained directly from an insurance company and 28.1 percent had public insurance, such as Medicaid, the Children's Health Insurance Program (CHIP), or military health care. Another 7.4 percent of CSHCN had both private and public insurance, and 3.5 percent were uninsured at the time of the interview (data not shown).

The percentage of CSHCN without insurance in 2005-06 varied by race/ethnicity and family income. Hispanic CSHCN were most likely to have been uninsured at some point during the prior year (15.1 percent), followed by non-Hispanic Black children (11.0 per-

cent), non-Hispanic CSHCN of other races (8.9 percent) and non-Hispanic White children (7.1 percent). CSHCN living in poor and near poor families—or those with family incomes below 100 percent of the Federal poverty level (\$19,350 for a family of four in 2005) and between 100 and 199 percent of the Federal poverty level—were most likely to be uninsured at some point in the prior year (14.2 and 14.1 percent, respectively). In contrast, the same was true for 7.1 percent of CSHCN living in families with incomes 200-399 percent of poverty and 2.9 percent of CSHCN living in households with family incomes of 400 percent or more of poverty.

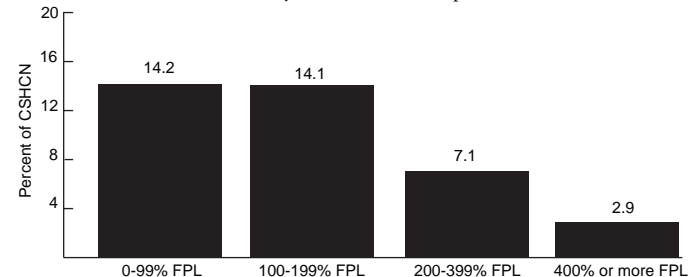
Percent of CSHCN Ever Uninsured in the Past 12 Months, by Race/Ethnicity, 2005-06

Source (III.5): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children with Special Health Care Needs



Percent of CSHCN Ever Uninsured in the Past 12 Months, by Poverty Level,* 2005-06

Source (III.5): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children with Special Health Care Needs



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$19,350 in 2005.

MENTAL HEALTH TREATMENT

In 2009, 2.9 million, or 12.0 percent of adolescents aged 12 to 17 received past-year treatment or counseling for problems with emotions or behavior (not including problems caused by drug or alcohol use) in a specialty mental health setting, including both inpatient¹ and outpatient² care (data not shown). A similar proportion of adolescents received mental health services in an educational setting³ (12.1 percent) while 2.5 percent received services from a pediatrician or other family doctor in a medical setting, and less than 1 percent received mental health services in a juvenile justice setting. About 5 percent of adolescents received mental health services in both a specialty mental health setting and either an educational or a medical setting.

A greater proportion of females received specialty mental health services (14.0 percent) than males (10.1 percent; data not shown). Few racial and ethnic differences in service site for past-year treatment were observed with two notable exceptions: Asians were less likely to receive services in a specialty mental health setting compared to non-Hispanic White and Black children (6.6 percent versus 12.8 and 12.2 percent, respectively) and non-Hispanic Black children were more likely to receive services in an educational setting (16.4 percent) than children of other racial/ethnic groups (data not shown).

The most commonly reported reason for service use was feeling depressed. This was true for nearly half of adolescents who received services in either a specialty mental health or medical

setting, and over one-third of those who received services in an educational setting. Overall, reasons for treatment or counseling varied by service site. For example, problems with home/family was reported as the reason for seeking services by 27.8 percent of those seeking care in a specialty mental health setting compared to 17.8 and 11.9 percent of those treated in educational and medical settings, respectively.

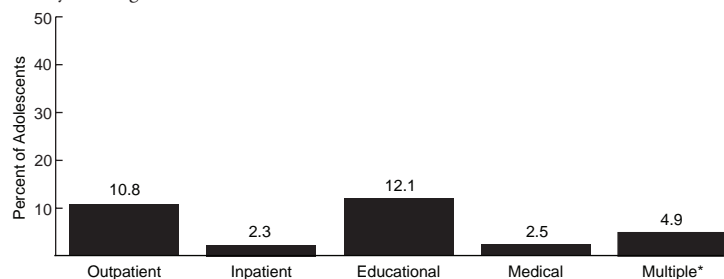
1 Includes treatment/counseling from an overnight or longer stay in a hospital, residential treatment center, or foster care or therapeutic foster care home.

2 Includes treatment/counseling from a private therapist, psychologist, psychiatrist, social worker, or counselor; mental health clinic or center; partial day hospital or day treatment program; or in-home therapist, counselor, or family preservation worker.

3 Includes treatment/counseling from a school social worker, school psychologist, or school counselor.

Past-Year Mental Health Service Use Among Adolescents Aged 12-17, by Service Site, 2009

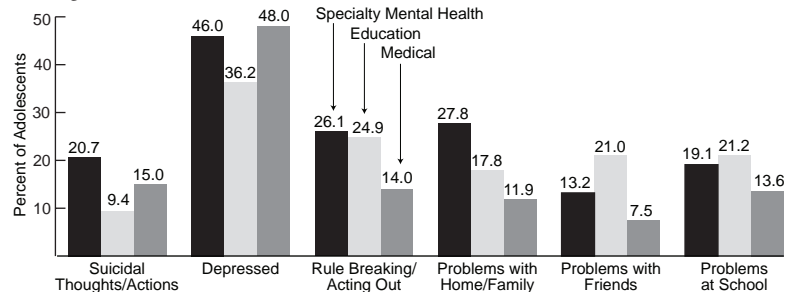
Source (III.6): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Inpatient or Outpatient services in addition to services received in either an educational or medical setting.

Selected Reasons* for Mental Health Service Use Among Adolescents Aged 12-17,** by Service Site, 2009

Source (III.6): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Respondents could report multiple reasons. **Among adolescents who received past-year mental health treatment or counseling.

DENTAL CARE

According to the Centers for Disease Control and Prevention, dental caries (tooth decay) is the most common chronic disease among children in the United States. Untreated tooth decay causes pain and infections, which may affect children's ability to eat, speak, play, and learn.¹ Tooth decay, however, is preventable with proper dental care. For this reason, the American Dental Association recommends that children have their first dental checkup within 6 months of the eruption of the first tooth or at 12 months of age, whichever comes first.²

In 2009, 78.4 percent of children aged 2–17 years received dental care in the past year while 15.0 percent had not received such care in more than 2 years. Receipt of dental care varied by

a number of factors, including insurance status and poverty. Over 80 percent of children with private health insurance coverage received past-year dental care, as did 76.6 percent of children with public insurance, and only 51.6 percent of uninsured children. Poor and near poor children, or those living in households with incomes at or below 100 or 200 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008), were less likely than children living in households with incomes above 200 percent of the poverty threshold to have received past-year dental care (71.5 and 75.6 percent, respectively, compared to 82.2 percent; data not shown).

Similar patterns were observed for unmet dental care needs. Overall, 7.1 percent of children

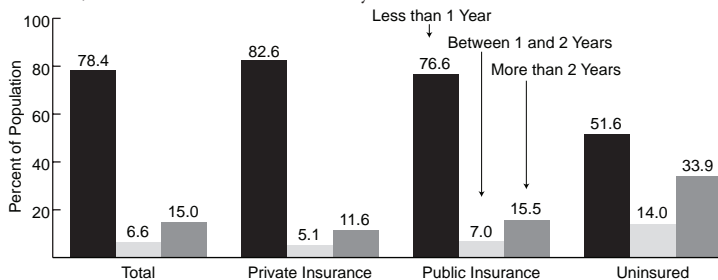
had unmet dental care needs in 2009. However, the proportion of children with unmet needs was substantially higher among those who were uninsured (27.8 percent) compared to those with either private (4.4 percent) or public (6.7 percent) insurance. Similar proportions of poor and near poor children, about 10 percent, had unmet dental needs compared to 4.5 percent of children living in households with incomes above 200 percent of the poverty threshold (data not shown).

1 Centers for Disease Control and Prevention, Division of Oral Health. *Children's Oral Health*. Available at: <http://www.cdc.gov/OralHealth/topics/child.htm>. Accessed April 2011.

2 American Dental Association. *For the patient: baby's first teeth*. *JADA* 2002;133:255.

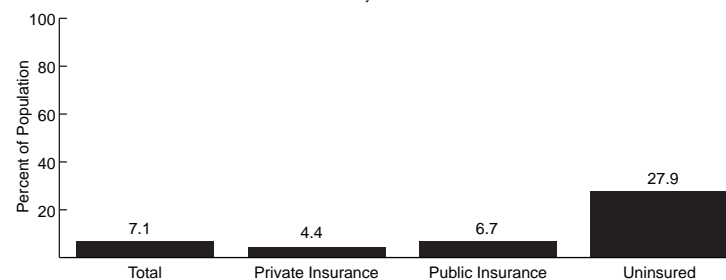
Time Since Last Dental Contact Among Children Aged 2-17 Years, by Insurance Status and Type, 2009

Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Unmet Dental Need* Among Children Aged 2-17 Years in Past 12 Months, by Insurance Status and Type, 2009

Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Based on parent report that services were needed but were not affordable.

WELL-CHILD VISITS

In 2009, 78.0 percent of children under 18 years of age were reported by their parents to have had a preventive, or “well-child”, medical visit in the past year. The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence. Well-child visits offer an opportunity not only to monitor children’s health and provide immunizations, but also to assess a child’s be-

havior and development, discuss nutrition, and answer parents’ questions.

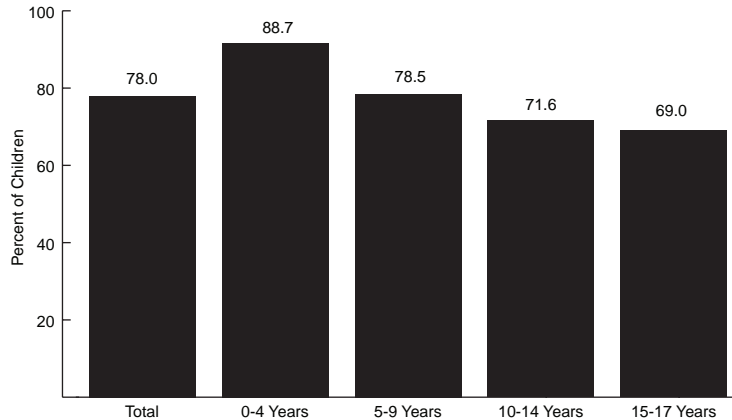
The proportion of children receiving well-child visits declines with age. In 2009, 88.7 percent of children 4 years of age and younger received a preventive visit in the past year, compared to 78.5 percent of children 5–9 years of age, 71.6 percent of children 10–14 years of age, and 69.0 percent of children 15–17 years of age.

Receipt of preventive medical care also varies by race and ethnicity. In 2009, non-Hispanic

Black children were significantly more likely to have received a well-child visit in the past year (83.6 percent) than non-Hispanic White and Hispanic children (77.6 percent and 74.9 percent, respectively). Non-Hispanic American Indian/Alaskan Native children had the lowest reported rate of preventive care in the past year (72.1 percent), but this was not statistically different than estimates for other racial/ethnic groups.

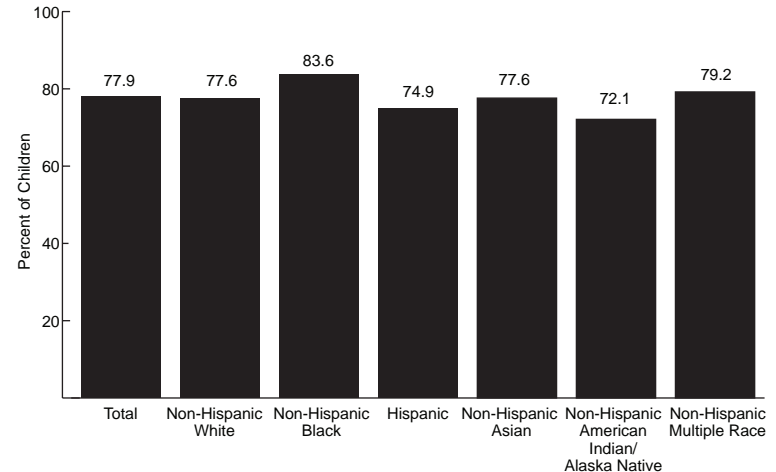
Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Age, 2009

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Race/Ethnicity, 2009

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



HEALTH CARE VISITS

In 2009, 10.1 percent of children under 18 years of age had not seen a physician or other health care professional in the past year for either sick or routine care (not including overnight hospitalization, emergency department visits, home health care, or dental care). Older children were more likely than younger children to go 12 months without seeing a health care provider. Nearly 15 percent of children aged 15–17 years had not seen a health care provider in the past year, compared to less than 5.0 percent of children under 5 years of age.

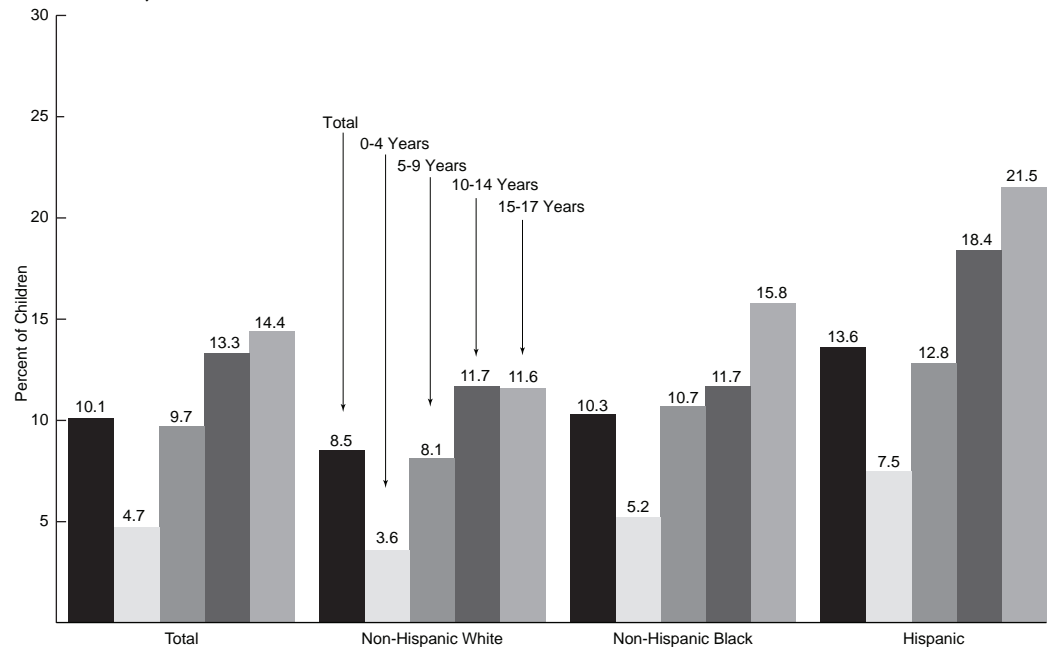
Health care visits also varied by race/ethnicity. In 2009, 13.6 percent of Hispanic children had not seen a physician or other health professional in the past year, compared to 8.5 percent of non-Hispanic White children and 10.3 percent of non-Hispanic Black children. Across all age groups, Hispanic children were the least likely to have seen a health care provider, and non-Hispanic White children were the most likely to have seen one; however, not all observed differences were statistically significant. Differences were most pronounced among older children: Among children aged 15–17, 11.6 percent of non-Hispanic White children had not seen a health professional in the past year compared to 21.5 percent of Hispanic children.

The proportion of children going without health care also varied by poverty level. In 2009, 13.2 percent of children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954

for a family of four in 2009) had not seen a physician or other health professional in the past year, compared to 5.4 percent of children living in households with incomes of 400 percent or more of the poverty threshold (data not shown).

Child Reported to Have Not Seen a Physician or Other Health Care Professional* in the Past 12 Months, by Age and Race/Ethnicity, 2009

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Does not include overnight hospitalizations, emergency department visits, home health care, and dental care.

USUAL PLACE FOR SICK CARE

In 2009, a doctor's office or health maintenance organization (HMO) was the usual place for sick care (not including routine or preventive care) for 74.5 percent of children in the United States, a proportion that varies by poverty status and race/ethnicity. Children living in households with incomes above the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009) were more likely to visit a doctor's office or HMO for sick care than children living in households with incomes below the poverty threshold (78.6 percent versus 57.3 percent). Children living in households with incomes below the poverty threshold were more likely than children living in households with

higher incomes to go to a clinic or health center (39.4 percent versus 19.9 percent).

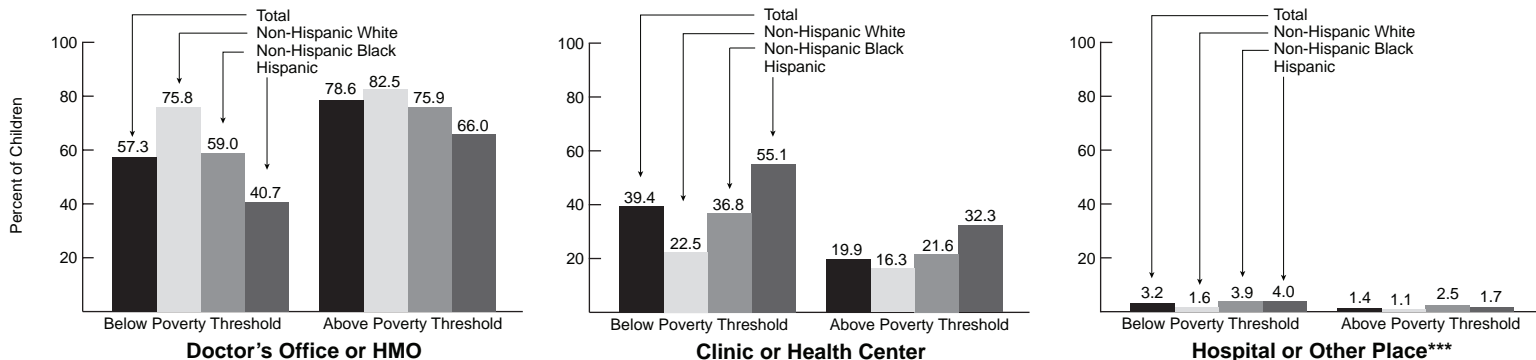
Among children living in poverty, 75.8 percent of non-Hispanic White children received sick care at a doctor's office or HMO, compared to 59.0 percent of non-Hispanic Black children and 40.7 percent of Hispanic children. Regardless of income, Hispanic children were more likely than non-Hispanic children to receive sick care at a clinic or health center. Among Hispanic children living in poverty, 55.1 percent received care at a clinic or health center, compared to 36.8 percent of their non-Hispanic Black counterparts and 22.5 percent of their non-Hispanic White counterparts. Among chil-

dren living in families with incomes above the poverty threshold, 32.3 percent of Hispanics, 21.6 percent of non-Hispanic Blacks, and 16.3 percent of non-Hispanic Whites received sick care at a clinic or health center.

Although only a small proportion of children used a hospital emergency room, hospital outpatient department, or other place as their primary source of sick care, it was more common among children living in families with incomes below the poverty threshold than among children with family incomes above the poverty threshold (3.2 percent versus 1.4 percent). Regardless of income, this was generally more common among non-Hispanic Black and Hispanic children than among non-Hispanic Whites.

Place of Physician Contact,* by Poverty** and Race/Ethnicity, 2009

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The place where the child usually goes when sick; does not include routine or preventive care visits. **The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009. ***Includes Hospital Emergency Room, Outpatient Department or some other place.

MEDICAL HOME

According to the American Academy of Pediatrics, children's medical care should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.¹ Together, these characteristics of care form the medical home model. The 2007 National Survey of Children's Health measured if a child's health care met the standards of a medical home during the previous 12 months. For this purpose, the survey included questions on the following: 1) whether the child has a personal doctor or nurse and a usual source of sick care; 2) whether the child has no problems gaining referrals to specialty care and access to therapies or other services or equipment; 3) whether the family is very satisfied with the level of commu-

nication among their child's doctors and other programs; 4) whether the family usually or always gets sufficient help coordinating care when needed, and receives effective care coordination; 5) whether the child's providers usually or always spend enough time with the family, listen carefully to concerns, are sensitive to values and customs, provide needed information, and make the family feel like a partner in the child's care; and 6) whether an interpreter is usually or always available when needed. If a child's care met all of these criteria, according to the parent, then the child was defined as having a medical home.

In 2007, the care received by 57.5 percent of children met this medical home standard. This varied substantially by household income: 39.4 percent of children in households with incomes

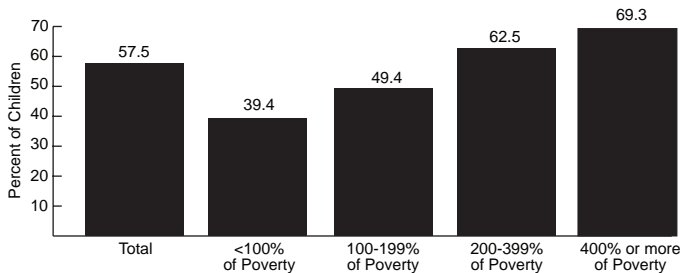
at less than 100% of the Federal poverty level (\$20,650 for a family of four in 2007) had a medical home, compared to 69.3 percent of children in households at or above 400% of the of the Federal poverty level.

Receipt of care from a medical home also varied by parent-reported health status. Children in excellent or very good health were the most likely to receive care in a medical home (61.8 percent), followed by children in good health (36.5 percent). Children in fair or poor health were the least likely to have a medical home (25.3 percent).

1 American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. Pediatrics. 2002;110(1 pt 1):184-186

Children with a Medical Home, by Poverty*, 2007

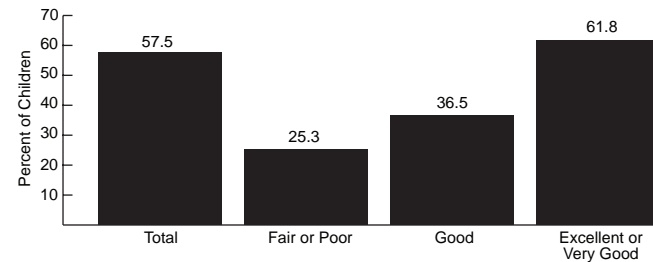
Source (III.9): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$20,650 in 2007.

Children with a Medical Home, by Parent-Reported Health Status, 2007

Source (III.10): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



EMERGENCY DEPARTMENT UTILIZATION

In 2009, more than 20.8 percent of children had at least one visit to a hospital emergency department (ED). Children living in households with incomes below the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009) were more likely than children living in households with incomes above the poverty threshold to have visited the ED in the past year. One-quarter of children living in poverty made 1–3 ED visits during the year, compared to 18.5 percent of children living in households with incomes above poverty. Similarly, 2.2 percent of children from low-income households made four or more visits to the ED, compared to 1.0 per-

cent of children from higher-income households.

Emergency department utilization also varied by age: 24.5 percent of children under 5 years of age made 1–3 visits to the ED in 2009, compared to 17.6 percent of children aged 15–17 years. Children under 5 years of age were also the most likely to make four or more ED visits (2.3 percent). There were also racial/ethnic differences in ED utilization: 24.6 percent of non-Hispanic Black children made 1–3 visits to the ED in 2009 compared to 19.0 percent of Hispanic children and 18.8 percent of non-Hispanic White children (data not shown).

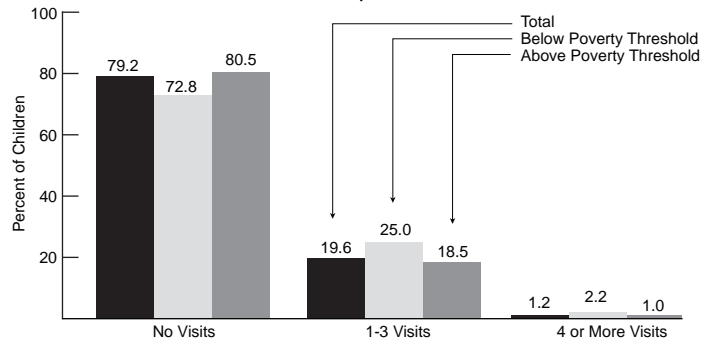
According to the 2007 National Hospital Ambulatory Medical Care Survey, the most

common reason for a visit to the emergency department among children under 15 years of age was fever (15.8 percent), followed by cough (6.1 percent), and vomiting (6.7 percent). The two most common primary diagnoses treated in ED visits among both males and females were acute upper respiratory infections (9.8 percent, combined), otitis media (middle ear infection) and Eustachian tube disorders (7.0 percent, combined), followed by unspecified viral and chlamydial infection among females (2.3 percent) and open wound of head (2.9 percent) among males.¹

1 Niska RW, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 emergency department summary. National Health Statistics Reports, No. 26; 2010 Aug.

Visits to the Emergency Room Among Children Under Age 18, by Poverty,* 2009

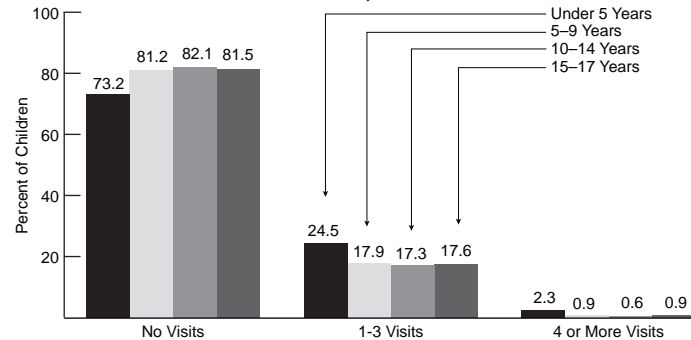
Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$21,954 in 2009.

Visits to the Emergency Department Among Children Under Age 18, by Age, 2008

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



PRENATAL CARE

Prenatal care—especially care beginning in the first trimester—allows health care providers to identify and manage a woman's risk factors and health conditions and to provide expectant parents with relevant health care advice. The reported rate of first trimester prenatal care utilization has been increasing fairly steadily since the early 1990s; however, changes made to the standard birth certificate in 2003, which are gradually being adopted by the states, make comparisons over time impossible. As of January 1, 2008, 27 states had implemented the revised birth certificate representing 65 percent of all U.S. births.¹

In 2008, in the 27 reporting areas that used the revised birth certificate, 71.0 percent of women giving birth were determined to have received prenatal care in the first trimester, while 7.0 percent of women began prenatal care in the third trimester or did not receive any prenatal care. Early prenatal care utilization differs by race/ethnicity. Non-Hispanic Asian and non-Hispanic White women were most likely to receive prenatal care beginning in the first trimester (77.9 and 76.7 percent, respectively). Non-Hispanic American Indian/Alaska Native women and non-Hispanic Native Hawaiian and Other Pacific Islander women were least

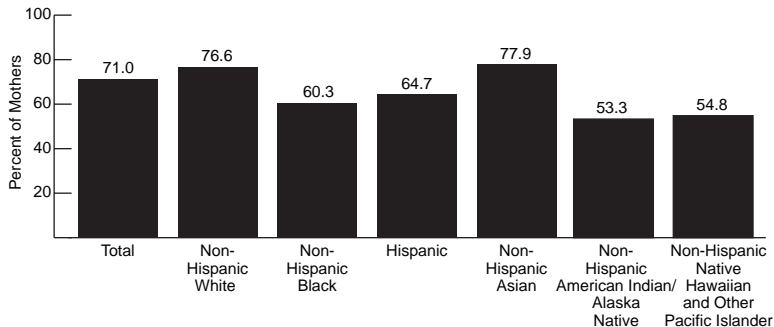
likely to receive first trimester care (53.3 and 54.8 percent, respectively).

Timing of prenatal care initiation also varied by maternal age. Teen-aged mothers were least likely to receive timely prenatal care, with less than one-third of those under the age of 15 and about half of those aged 15-19 years initiating prenatal care in the first trimester (32.9 percent and 54.3 percent, respectively). In comparison, over 70 percent of mothers-to-be aged 25 years and older received early prenatal care.

1 Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2008. National vital statistics reports; vol 59 no 1. Hyattsville, MD: National Center for Health Statistics. 2010.

Receipt of First Trimester Prenatal Care,* by Maternal Race/Ethnicity, 2008

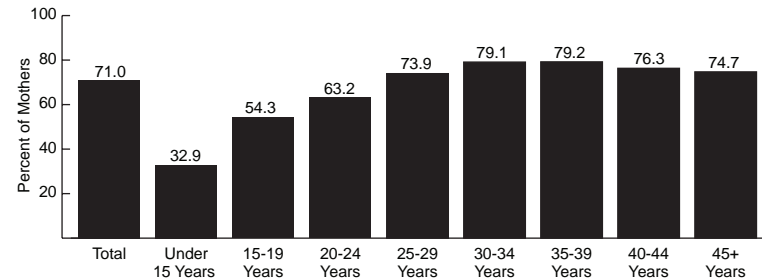
Source (III.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*In the 27 reporting areas (States and territories) that used the revised birth certificate.

Receipt of First Trimester Prenatal Care,* by Maternal Age, 2008

Source (III.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*In the 27 reporting areas (States and territories) that used the revised birth certificate.



STATE DATA

While the indicators presented in the previous sections are representative of the U.S. population as a whole, the following section presents data at the State level. Geographic differences in health status and health care utilization play an important role in tailoring health programs and interventions to specific populations. Included are data on infant, neonatal, and perinatal mortality, low birth weight, preterm birth, health care financing, Medicaid enrollment and expenditures, and CHIP enrollment.

The following pages reveal important disparities in these measures across States. For instance, the proportion of infants born low birth weight (less than 2,500 grams, or 5 pounds 8 ounces) was highest in Mississippi, followed by Louisiana and several other southern States. Births to unmarried women tended to be highest in these States, as well.

All of the issues presented here have geographic program and policy implications. State and local leaders can use this information to better serve their maternal and child populations in need.

Children's Health Insurance Program (CHIP) Program Design and Aggregate Enrollment, 2009*

Source (IV.1, IV.2): Centers for Medicare and Medicaid Services, SCHIP Statistical Enrollment Data System; Kaiser Commission on Medicaid and the Uninsured

State	Type of CHIP Program**	Upper Eligibility	Total CHIP Enrollment	Presumptive Eligibility†
Alabama	Separate	300%	110,158	N
Alaska	Medicaid	175%	11,655	N
Arizona	Separate	200%	66,275	N
Arkansas	Combo	200%	101,312	N/N
California	Combo	250%	1,748,135	Y/Y
Colorado	Separate	205%	102,395	Y
Connecticut	Separate	300%	21,874	N
Delaware	Combo	200%	12,599	N/N
District of Columbia	Medicaid	300%	9,260	N
Florida	Combo	200%	417,414	N/N
Georgia	Separate	235%	254,365	N
Hawaii	Medicaid	300%	24,691	N
Idaho	Combo	185%	44,319	N/N
Illinois	Combo	200%	376,618	Y/Y
Indiana	Combo	250%	142,665	N/N
Iowa	Combo	300%	52,608	Y/Y
Kansas	Separate	241%	48,090	Y
Kentucky	Combo	200%	73,143	N/N
Louisiana	Combo	250%	170,082	N/N
Maine	Combo	200%	31,349	N/N
Maryland	Medicaid	300%	124,622	N
Massachusetts	Combo	300%	143,044	Y/Y
Michigan	Combo	200%	72,035	Y/Y
Minnesota	Combo	280%	5,470	N/N
Mississippi	Separate	200%	86,839	N
Missouri	Combo	300%	103,709	Y/N

State	Type of CHIP Program**	Upper Eligibility	Total CHIP Enrollment	Presumptive Eligibility†
Montana	Separate	250%	25,749	N
Nebraska	Medicaid	200%	48,139	N
Nevada	Separate	200%	33,981	N/N
New Hampshire	Combo	300%	13,197	Y/N
New Jersey	Combo	350%	167,009	Y/Y
New Mexico	Medicaid	235%	11,169	Y
New York	Separate	400%	532,635	Y
North Carolina	Combo	200%	259,652	N/N
North Dakota	Combo	160%	6,983	N/N
Ohio	Medicaid	200%	265,680	N
Oklahoma	Combo	185%	123,681	N/N
Oregon	Separate	300%	51,835	N
Pennsylvania	Separate	300%	264,847	N
Rhode Island	Combo	250%	19,596	N/N
South Carolina	Combo	200%	85,046	N/N
South Dakota	Combo	200%	15,249	N/N
Tennessee	Combo	250%	83,333	N/N
Texas	Separate	200%	869,867	N
Utah	Separate	200%	59,806	N
Vermont	Separate	300%	7,092	N
Virginia	Combo	200%	167,589	N/N
Washington	Separate	300%	27,415	N
West Virginia	Separate	250%	38,200	N
Wisconsin	Combo	300%	153,917	Y/N
Wyoming	Separate	200%	8,871	N

* Data on Program Type and Total Enrollment are from Federal Fiscal Year 2009 (October 2008-September 2009); data on eligibility are from calendar year 2009 (January 2009-December 2009).

**Programs may be an expansion of Medicaid, a separate CHIP program, or a combination of the two.

†Presumptive eligibility provides immediate but temporary benefits for applicants who appear to meet eligibility requirements but have not yet been officially approved; in some States, this is only available for certain populations (e.g., infants). For States with a combination plan, information for the Medicaid plan is listed first, followed by information for the separate SCHIP plan.

Medicaid Enrollment and EPSDT^o Utilization for Children Under 21, FY 2009

Source (IV.3): Centers for Medicare and Medicaid Services. Annual EPSDT Report and Medicaid Statistical Information System and Medicaid Statistical Information System

State	Medicaid Enrollees*	EPSDT Participation Ratio**	Medicaid Expenditures (per enrollee)***
Alabama	520,955	53%	\$2,473
Alaska	85,889	56%	\$5,136
Arizona	760,837	66%	\$3,532
Arkansas	421,494	38%	\$3,068
California	4,527,629	87%	\$1,834
Colorado	382,800	56%	\$2,374
Connecticut	300,731	65%	\$2,705
Delaware	95,766	61%	\$3,902
District of Columbia	96,552	68%	\$3,694
Florida	1,868,563	71%	\$2,265
Georgia	1,146,385	51%	\$2,311
Hawaii†	145,702	72%	\$2,183
Idaho	173,214	95%	\$2,956
Illinois	1,561,906	74%	\$1,697
Indiana	728,832	65%	\$2,026
Iowa	277,541	75%	\$2,813
Kansas	230,551	50%	\$2,926
Kentucky	519,259	58%	\$3,438
Louisiana	776,127	72%	\$2,200
Maine	140,884	61%	\$2,792
Maryland	556,206	61%	\$3,298
Massachusetts†	593,187	67%	\$3,647
Michigan†	1,126,951	54%	\$1,863
Minnesota	439,513	70%	\$4,225
Mississippi	409,443	41%	\$2,432

State	Medicaid Enrollees*	EPSDT Participation Ratio**	Medicaid Expenditures (per enrollee)***
Missouri†	665,577	71%	\$2,455
Montana	67,648	65%	\$3,267
Nebraska	170,714	54%	\$2,955
Nevada	192,778	70%	\$2,481
New Hampshire	98,747	71%	\$2,984
New Jersey	642,519	64%	\$2,833
New Mexico	359,515	70%	\$2,990
New York	2,068,245	65%	\$3,626
North Carolina	1,070,396	53%	\$3,067
North Dakota	46,075	49%	\$2,873
Ohio	1,323,868	52%	\$2,526
Oklahoma	538,449	58%	\$2,451
Oregon†	272,379	64%	\$2,459
Pennsylvania†	1,181,406	59%	\$3,422
Rhode Island	107,991	58%	\$3,956
South Carolina	555,486	60%	\$2,564
South Dakota	97,657	47%	\$2,831
Tennessee	854,062	62%	\$2,766
Texas	3,111,775	64%	\$2,764
Utah†	194,038	64%	\$2,486
Vermont	63,141	52%	\$4,232
Virginia	607,911	70%	\$3,061
Washington	714,210	65%	\$1,976
West Virginia	213,390	47%	\$2,718
Wisconsin†	575,755	71%	\$1,592
Wyoming	56,593	48%	\$3,329

^oEarly and Periodic Screening, Diagnosis, and Treatment Program is the child health component of Medicaid. It is designed to improve the health of low-income children by financing appropriate and necessary pediatric services.

*Unduplicated number of individuals under age 21 determined to be eligible for EPSDT services.

**The ratio of Medicaid eligibles receiving any EPSDT services to the number of eligibles who should have received such services.

***Represents total Medicaid vendor payments divided by Medicaid eligibles under 21.

†Enrollee and Participation data for Michigan and Oregon are from FY 2008. Expenditure data for Hawaii, Massachusetts, Missouri, Pennsylvania, Utah, and Wisconsin, are from FY 2008.

Health Insurance Status of Children Under 18,* 2009

Source (III.1): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement

State	Percent with Private Insurance	Percent with Public Insurance**	Percent Uninsured
Alabama	54.8%	46.7%	7.9%
Alaska	55.9%	46.1%	9.9%
Arizona	51.5%	41.7%	13.4%
Arkansas	50.1%	46.4%	11.5%
California	54.2%	40.8%	10.7%
Colorado	66.0%	30.4%	9.6%
Connecticut	76.4%	21.3%	7.7%
Delaware	65.9%	31.1%	8.8%
District of Columbia	45.1%	54.6%	8.0%
Florida	55.1%	34.2%	17.9%
Georgia	59.9%	36.0%	11.3%
Hawaii	66.3%	44.3%	3.5%
Idaho	66.6%	31.1%	10.2%
Illinois	59.4%	37.0%	9.1%
Indiana	59.3%	38.3%	8.6%
Iowa	72.0%	33.5%	5.9%
Kansas	64.9%	35.0%	8.1%
Kentucky	58.0%	40.3%	8.2%
Louisiana	58.2%	39.9%	8.4%
Maine	62.3%	43.4%	4.0%
Maryland	72.0%	27.4%	7.0%
Massachusetts	72.5%	33.1%	2.9%
Michigan	70.3%	32.5%	5.6%
Minnesota	71.6%	29.6%	5.5%
Mississippi	45.4%	51.6%	10.9%
Missouri	64.8%	35.0%	9.7%

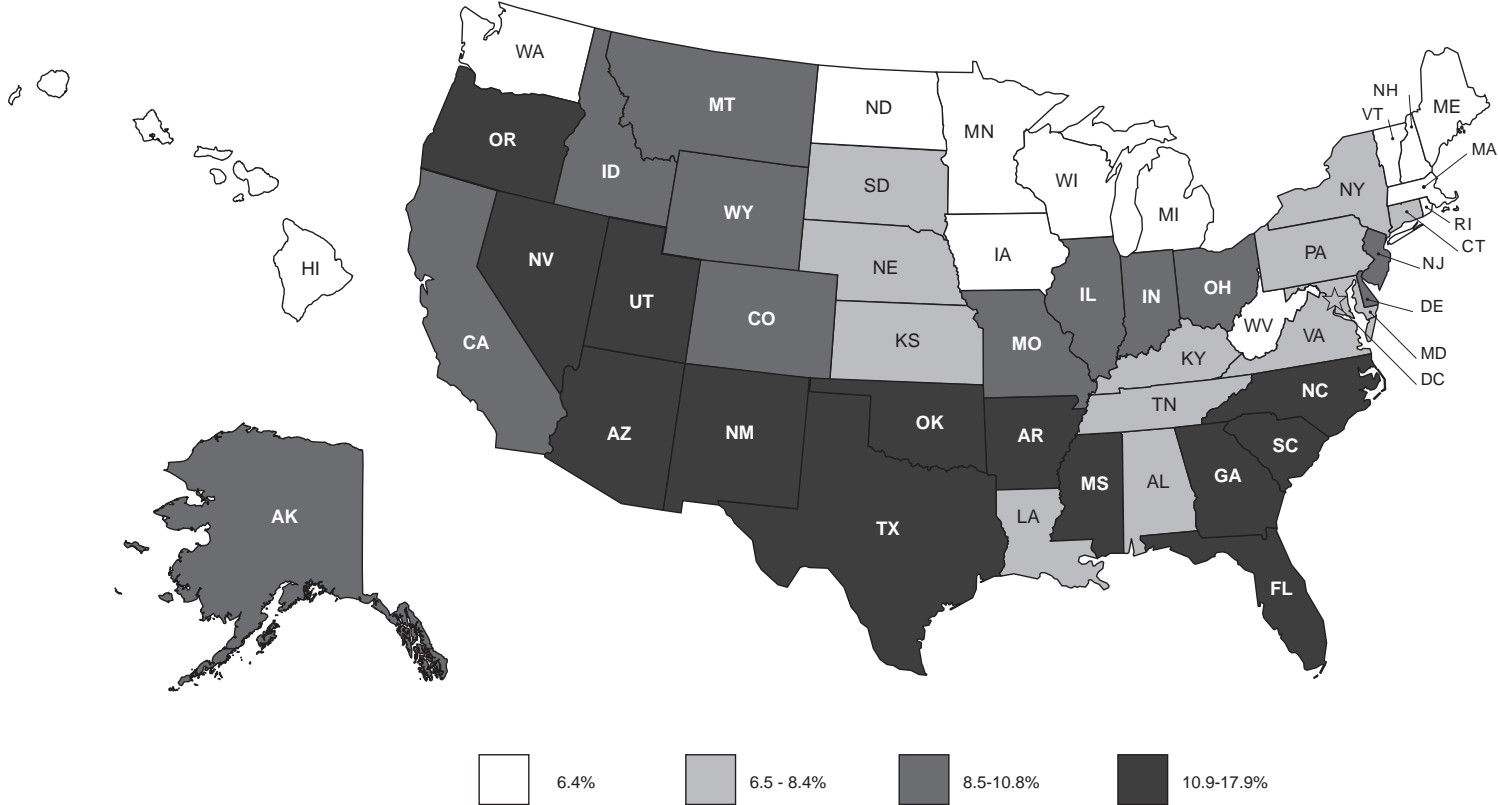
State	Percent with Private Insurance	Percent with Public Insurance**	Percent Uninsured
Montana	59.4%	35.8%	10.4%
Nebraska	70.1%	33.2%	6.7%
Nevada	65.2%	26.9%	13.4%
New Hampshire	78.7%	22.0%	3.8%
New Jersey	72.6%	23.7%	9.2%
New Mexico	42.2%	50.0%	14.0%
New York	58.5%	41.4%	7.5%
North Carolina	57.2%	38.7%	11.8%
North Dakota	74.8%	27.3%	5.9%
Ohio	66.3%	31.3%	8.7%
Oklahoma	52.2%	45.1%	12.6%
Oregon	63.7%	32.4%	11.9%
Pennsylvania	67.3%	32.4%	6.8%
Rhode Island	62.4%	39.9%	6.0%
South Carolina	63.1%	31.4%	12.3%
South Dakota	67.8%	36.4%	8.4%
Tennessee	58.5%	44.9%	6.6%
Texas	48.5%	40.2%	16.5%
Utah	73.9%	20.2%	11.3%
Vermont	59.1%	47.4%	5.6%
Virginia	70.1%	31.2%	7.5%
Washington	62.9%	46.1%	4.8%
West Virginia	59.3%	46.6%	6.2%
Wisconsin	73.7%	32.1%	4.7%
Wyoming	68.5%	32.1%	9.6%

*Children may have more than one type of coverage.

**Includes children covered by Medicare, Medicaid, SCHIP, state-specific plans, military health insurance, and the Indian Health Service.

Health Insurance Status: Percent of Children Under 18 Who Are Uninsured, by State, 2009

Source (III.1): U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



Low Birth Weight, Preterm Birth, and Births to Unmarried Women (Percent), by State and Maternal Race/Ethnicity, 2008

Source (III.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

State	Low Birth Weight*				Preterm Birth**				Births to Unmarried Women			
	Total	Non-Hispanic White	Black	Hispanic	Total	Non-Hispanic White	Black	Hispanic	Total	Non-Hispanic White	Black	Hispanic
United States	8.2	7.2	13.7	7.0	12.3	11.1	17.5	12.1	40.6	28.7	72.3	52.6
Alabama	10.6	8.4	15.8	6.9	15.7	13.6	20.5	14.2	39.9	25.6	72.9	24.1
Alaska	6.0	5.0	11.9	8.6	10.3	8.5	13.8	12.3	37.6	24.3	47.1	34.9
Arizona	7.1	6.8	11.8	6.7	12.9	11.8	18.3	13.3	45.3	29.7	62.8	56.5
Arkansas	9.2	8.0	15.1	6.4	13.5	12.2	18.9	12.1	44.6	33.8	80.3	50.1
California	6.8	6.4	12.1	6.1	10.5	9.6	14.8	10.6	40.2	24.1	68.0	51.6
Colorado	8.9	8.5	14.8	8.5	11.4	10.7	15.6	12.0	24.9	17.5	49.3	36.3
Connecticut	8.0	6.6	13.6	8.1	10.4	9.4	14.6	10.6	36.4	22.1	69.8	64.2
Delaware	8.5	7.0	12.6	7.0	12.9	11.1	16.4	13.8	48.0	34.3	72.7	64.7
District of Columbia	10.5	6.8	13.7	5.8	15.5	9.7	19.3	12.6	57.8	7.0	79.1	72.6
Florida	8.8	7.5	13.5	7.3	13.8	11.8	18.9	13.4	46.9	35.3	69.9	50.5
Georgia	9.6	7.6	13.8	6.8	13.4	12.0	16.8	10.9	45.4	26.9	70.2	50.9
Hawaii	8.1	6.4	1.07	7.6	12.8	10.1	14.5	12.5	37.9	25.9	29.7	49.5
Idaho	6.5	6.2	N/A	7.4	9.8	9.1	13.6	12.3	25.3	21.0	37.7	43.3
Illinois	8.4	7.3	13.8	6.6	12.7	11.6	17.7	11.9	40.7	25.9	79.8	52.1
Indiana	8.3	7.7	14.1	6.8	12.4	11.6	18.0	12.5	43.3	36.8	79.5	57.5
Iowa	6.6	6.3	11.9	7.0	11.5	11.0	17.5	12.8	35.2	31.6	77.1	50.8
Kansas	7.2	6.8	12.4	6.1	11.2	10.6	15.7	11.4	37.8	31.1	74.6	53.2
Kentucky	9.2	8.7	15.0	6.1	14.0	13.6	19.2	12.0	40.7	36.5	76.7	53.0
Louisiana	10.8	8.0	15.1	7.0	15.4	12.4	20.0	12.6	53.0	34.2	79.4	57.1
Maine	6.7	6.6	9.7	N/A	10.3	10.2	12.2	11.8	39.7	39.9	31.7	45.7
Maryland	9.2	7.2	13.1	7.0	13.0	10.8	16.7	12.5	42.4	26.7	64.2	57.1
Massachusetts	7.8	7.1	11.1	8.3	10.8	10.2	13.6	12.1	34.0	26.0	58.4	66.1
Michigan	8.6	7.2	14.5	6.8	12.7	11.4	18.1	12.2	40.2	30.2	78.9	49.8
Minnesota	6.4	5.7	10.8	6.0	10.0	9.6	12.4	9.6	33.3	26.0	60.9	57.9
Mississippi	11.8	8.6	16.1	6.5	18.0	14.8	22.3	12.8	54.5	31.8	80.5	59.0
Missouri	8.1	7.2	13.3	6.1	12.3	11.2	18.0	11.6	40.9	33.1	79.1	51.5
Montana	7.4	7.3	N/A	7.4	11.5	11.2	N/A	9.7	36.7	30.3	52.8	52.1
Nebraska	7.0	6.5	12.5	6.9	11.8	11.0	16.2	13.6	33.9	27.0	68.3	50.4
Nevada	8.0	8.0	13.1	6.9	13.5	12.6	19.1	12.9	42.5	30.4	71.0	50.9
New Hampshire	6.5	6.4	N/A	7.5	9.6	9.5	16.3	11.2	32.9	33.1	39.5	48.7
New Jersey	8.4	7.4	13.1	7.6	12.5	11.2	17.2	13.1	35.0	17.7	68.2	59.4
New Mexico	8.5	8.2	12.3	8.7	12.3	11.8	10.9	12.4	52.9	31.9	60.5	58.8
New York	8.2	6.8	12.8	7.9	12.0	10.2	16.7	13.0	41.4	24.6	69.5	65.7
North Carolina	9.1	7.7	14.4	6.2	12.9	11.1	17.9	12.1	42.0	26.7	72.4	53.2
North Dakota	6.8	6.7	N/A	7.5	11.1	10.7	N/A	10.4	33.6	26.9	37.2	45.9
Ohio	8.6	7.4	14.5	7.6	12.6	11.5	17.5	12.7	43.4	35.5	79.1	59.5
Oklahoma	8.3	7.8	15.1	6.7	13.4	12.9	18.0	12.5	42.3	34.4	75.7	49.0
Oregon	6.1	5.9	10.8	5.8	10.1	9.3	14.8	11.7	36.1	32.0	63.2	49.0
Pennsylvania	8.3	7.1	13.5	8.7	11.6	10.4	16.5	12.8	40.8	30.9	78.0	66.4
Rhode Island	7.9	6.8	11.0	8.3	11.2	9.6	14.0	13.5	43.9	33.8	68.0	65.8
South Carolina	9.9	7.7	14.5	6.4	14.3	11.9	18.7	13.0	47.8	30.1	78.0	49.8
South Dakota	6.5	6.2	9.8	8.9	11.9	10.7	14.0	15.2	38.4	27.9	52.1	51.5
Tennessee	9.2	8.1	13.9	6.2	13.5	12.1	18.7	11.9	44.1	32.8	78.2	53.7
Texas	8.4	7.7	14.0	7.6	13.3	12.2	17.4	13.3	41.7	26.7	66.5	49.0
Utah	6.8	6.5	13.0	7.4	11.0	10.5	16.6	12.7	20.4	13.6	47.7	45.8
Vermont	7.0	7.0	N/A	N/A	9.5	9.6	N/A	N/A	38.8	39.1	40.2	56.0
Virginia	8.3	7.0	13.0	6.6	11.3	10.1	15.0	11.6	35.8	23.9	66.8	51.4
Washington	6.3	6.0	9.0	6.0	10.7	10.0	12.8	11.5	34.0	28.6	54.2	50.9
West Virginia	9.5	9.4	14.5	N/A	13.7	13.6	18.4	10.4	42.0	40.8	75.0	45.0
Wisconsin	7.0	6.3	13.0	6.2	11.1	10.3	16.9	11.3	36.3	27.9	83.9	53.8
Wyoming	8.3	8.1	N/A	9.0	11.2	10.7	N/A	12.2	34.6	30.0	56.9	51.2

* Low birth weight is less than 2,500 grams or 5 pounds 8 ounces.

** Preterm birth is less than 37 completed weeks of gestation.

N/A: Figure does not meet standards of reliability or precision; based on fewer than 20 births in the numerator.

Infant and Neonatal Mortality,* by State and Maternal Race, 2007

Source (II.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

State	Infant Deaths			Neonatal Deaths		
	Total**	White***	Black***	Total**	White***	Black***
Alabama	9.89	7.98	14.35	6.27	4.90	9.50
Alaska	6.51	5.20	N/A	3.17	3.03	N/A
Arizona	6.83	6.49	14.95	4.69	4.53	10.12
Arkansas	7.66	6.47	13.17	4.33	3.38	8.61
California	5.20	4.89	12.35	3.55	3.34	7.98
Colorado	6.12	5.85	13.16	4.17	4.01	8.19
Connecticut	6.63	5.90	12.07	5.06	4.46	9.41
Delaware	7.48	6.12	11.84	5.34	4.32	8.80
District of Columbia	13.09	8.52	16.61	9.70	5.87	12.60
Florida	7.05	5.52	12.21	4.42	3.53	7.47
Georgia	7.98	5.56	12.77	5.07	3.58	7.90
Hawaii	6.48	6.11	N/A	4.23	3.59	N/A
Idaho	6.75	6.59	N/A	4.52	4.46	N/A
Illinois	6.73	5.22	14.16	4.78	3.84	9.46
Indiana	7.58	6.61	15.99	4.79	4.13	10.40
Iowa	5.50	5.34	11.58	3.30	3.27	N/A
Kansas	7.93	7.03	18.98	5.00	4.49	11.63
Kentucky	6.69	6.01	12.69	4.06	3.73	7.58
Louisiana	9.17	6.14	14.08	5.35	3.49	8.37
Maine	6.30	6.33	N/A	4.46	4.54	N/A
Maryland	8.00	4.79	13.63	5.80	3.54	9.67
Massachusetts	4.93	4.54	8.76	3.42	3.11	6.12
Michigan	7.94	6.11	16.39	5.56	4.37	11.12
Minnesota	5.55	4.69	11.70	3.80	3.28	7.13
Mississippi	10.04	6.65	13.87	5.89	3.83	8.37
Missouri	7.48	5.89	16.48	4.99	3.77	11.69

State	Infant Deaths			Neonatal Deaths		
	Total**	White***	Black***	Total**	White***	Black***
Montana	6.35	5.94	N/A	3.62	3.49	N/A
Nebraska	6.76	6.12	14.04	4.86	4.38	10.53
Nevada	6.36	6.03	12.35	4.03	3.81	8.15
New Hampshire	5.36	5.34	N/A	3.25	3.31	N/A
New Jersey	5.18	4.13	11.02	3.44	2.86	6.87
New Mexico	6.27	5.99	N/A	3.89	3.88	N/A
New York	5.57	4.95	8.82	3.70	3.27	5.95
North Carolina	8.49	6.35	15.14	5.70	4.24	10.28
North Dakota	7.47	6.80	N/A	4.86	5.07	N/A
Ohio	7.69	6.34	14.81	5.18	4.21	10.20
Oklahoma	8.52	7.25	18.03	4.78	4.16	10.82
Oregon	5.75	5.70	N/A	3.95	3.93	N/A
Pennsylvania	7.56	6.12	15.07	4.98	4.12	9.45
Rhode Island	7.35	6.52	16.00	5.41	4.79	N/A
South Carolina	8.57	6.03	13.69	5.66	3.93	9.13
South Dakota	6.44	5.55	N/A	4.16	4.01	N/A
Tennessee	8.31	6.44	15.74	5.19	3.91	10.19
Texas	6.29	5.68	11.51	3.86	3.43	7.37
Utah	5.08	4.98	N/A	3.39	3.35	N/A
Vermont	5.07	4.76	N/A	3.07	N/A	N/A
Virginia	7.79	5.80	15.41	5.35	3.76	11.26
Washington	4.82	4.33	10.28	2.85	2.63	5.55
West Virginia	7.46	6.95	N/A	4.68	4.33	N/A
Wisconsin	6.46	5.37	15.18	4.03	3.56	8.34
Wyoming	7.35	6.65	N/A	3.67	3.66	N/A

*Mortality figures are presented as number of deaths per 1,000 live births. Infant mortality is defined as death during the first year of life; neonatal mortality is death during the first 28 days of life.

Includes all races. *Includes Hispanics. N/A: Figure does not meet the standards of reliability or precision.



CITY DATA

The following section compares urban health to the national average for several indicators. Included are data on low and very low birth weight for infants born in U.S. cities with over 100,000 residents, and infant mortality among infants born in cities with more than 250,000 residents.

These comparisons indicate that the health status of infants living in large U.S. cities is generally poorer than that of infants in the Nation as a whole. In 2008, 8.7 percent of infants living in cities were born at low birth weight, compared to a national average of 8.2 percent. The infant mortality rate in 2006, the most recent year for which city-level data are available, showed a similar disparity, with a rate of 7.2 per 1,000 live births among infants in cities compared to 6.7 deaths per 1,000 live births for the Nation as a whole.

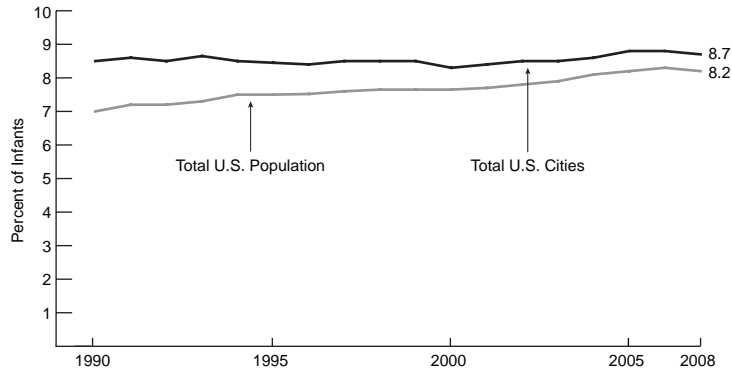
BIRTH WEIGHT

Low Birth Weight. Disorders related to short gestation and low birth weight are the second leading cause of neonatal mortality in the United States. In 2008, 118,712 babies born to residents of U.S. cities with populations over 100,000 were low birth weight (weighing less than 2,500 grams, or 5 pounds 8 ounces); this represents 8.7 percent of infants in U.S. cities. The rate of low birth weight among urban infants was 6 percent higher than the rate nationwide (8.2 percent). Although this has been a persistent disparity, the gap has decreased somewhat since 1990.

Very Low Birth Weight. Infants born very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces) are at highest risk for poor health outcomes. In 2008, 1.6 percent of live births in cities with populations over 100,000 were very low birth weight. This exceeded the rate of very low birth weight nationwide (1.5 percent) by 7 percent.

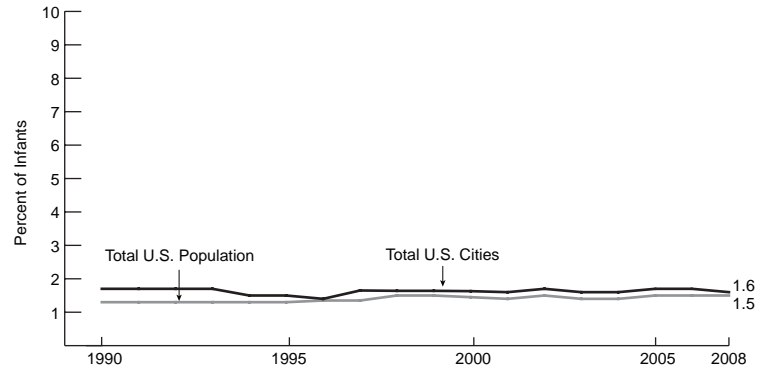
Infants Born Low Birth Weight in U.S. Cities with Populations over 100,000, 1990–2008

Source (IV.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



Infants Born Very Low Birth Weight in U.S. Cities with Populations over 100,000, 1990–2008

Source (IV.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

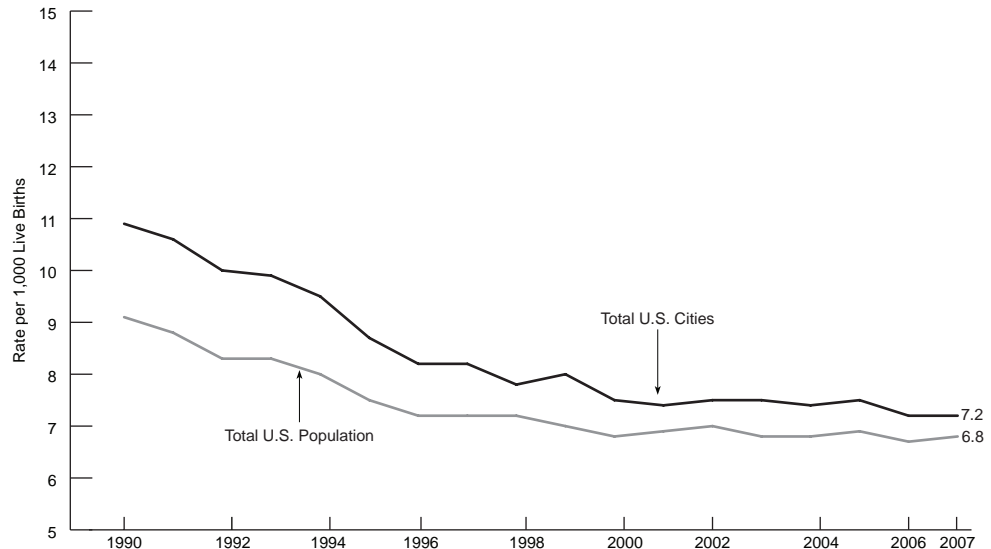


INFANT MORTALITY

In 2007, 6,583 infants born to residents of cities in the United States with populations over 250,000 died in the first year of life. The infant mortality rate in U.S. cities was 7.2 deaths per 1,000 live births, which was higher than the rate for the Nation as a whole (6.8 per 1,000). Although the infant mortality rate in cities has consistently been higher than the rate nationwide, it declined over the past decade, and the disparity in infant mortality rates between infants in cities and the Nation as a whole decreased by 50 percent. Between 1990 and 2007, the infant mortality rate in cities declined by one-third, while the nationwide decline during the same period was approximately 25 percent. Declines in infant mortality rates since 2000, however, have been relatively small for both cities and the population as a whole.

Infant Mortality Rates in U.S. Cities,* 1990–2007

Source (V.1): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data for 1990–2002 were for cities with populations over 100,000; data after 2002 reflect cities with populations over 250,000.

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