Maternal and Child Health Bureau

Child Health USA 2001

U.S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

Maternal and Child Health Bureau

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This issue of Child Health USA is dedicated to the memory of Karen Etchison, grants management specialist and beloved colleague in the Maternal and Child Health Bureau.

PREFACE

The Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is pleased to present *Child Health USA 2001*, the twelfth annual report on the health status and service needs of America's children. To assess the Bureau's progress toward achieving its vision for a Nation where all individuals enjoy equal access to quality health care in a supportive, culturally competent, family and community setting, MCHB has compiled this book of secondary data for 59 health status indicators. It provides both graphical and textual summaries of data and addresses long-term trends where applicable.

Data are presented for the target populations of Title V funding: infants, children, adolescents, children with special health care needs, and women of childbearing age. In addition to population characteristics, this book also addresses health status and health services utilization. *Child Health USA 2001* also provides insight into the Nation's progress toward the goals set out in the MCHB's strategic plan—to eliminate barriers and health disparities, to assure quality of care, and to improve the health infrastructure and system.

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

The first section, Population Characteristics, presents statistics on factors that influence the well-being of children. The second section, entitled Health Status, contains vital statistics and health behavior information for infants, children, adolescents, and women of childbearing age. The third section, Health Services Utilization, contains data regarding health care financing and newly implemented health policies. The fourth and fifth sections contain information on selected indicators at the state and city levels. This edition also includes a special section that lists the national measures of maternal and child health and describes the progress toward creating a ten year action plan for children with special health care needs.

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INTRODUCTION

The theme of *Child Health USA 2001* is children with special health care needs. The past 20 years have seen a new recognition of the common needs and issues that affect children with special health care needs (CSHCN) and their families. This group of children has been broadly defined as 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. It is now generally recognized that children and youth with special health care needs do best if they have access to comprehensive, family-centered, culturally competent, coordinated, and fully inclusive systems of services at the community level. Much effort is now being devoted to the development of strategies and measures for assuring and monitoring CSHCN's access to these systems.

A basic factor that can help assure access to comprehensive health care for all children, including children with special health care needs, is the availability of affordable health insurance. Due to both the strength of the economy in the late 1990s and the availability of coverage under the State Children's Health Insurance Program, the proportion of children who were uninsured declined between 1998 and 1999 from 15.4 percent to 13.9 percent, and among children in poverty, the proportion with no insurance decreased from 26.4 percent to 24.2 percent. The percentage of children with private insurance and the percentage covered under public programs increased, both for children in poverty and for all children.

Children with special health care needs use a wide range of services, from primary and preventive care to inpatient hospital services. Children with disabilities (that is, children who are limited in their activities because of a chronic illness) use many more physician services each year than do children without limitations. In 1998, for example, 51 percent of children under age 5 with activity limitations went to the doctor four or five times, compared to 10 percent of children of the same age without limitations. While the number of services used declines with age, the gap between children with disabilities and those without remains: among children aged 5 to 14, 20 percent of those with limitations had four or five doctor visits, compared to less than five percent of those without. These statistics underscore the importance of access to physician services for children with special health care needs.

Hospital services can also be critical for CSHCN. In 1997, children with disabilities spent three to four times as many nights in the hospital as children without disabilities: children under age 5 with activity limitations spent an average of nearly 11 nights in the hospital, while children of the same age without limitations had an average of 3 hospital nights. Among children aged 5 to 14, children with limitations spent nearly 17 nights in the hospital compared to 4 nights for children without limitations. Thus, the need for tertiary care for children with disabilities is evident as well.

Of course, children with special health care needs also benefit from the preventive services that all children need. Preventive care for children begins in pregnancy with adequate levels of regular prenatal care. The proportion of women beginning prenatal care in the first trimester of pregnancy increased for the tenth consecutive year, rising from 82.8 percent in 1998 to 83.2 percent in 1999. However, the racial disparity in early entry into prenatal care persists; only 74 percent of African-American mothers, compared to 85 percent of white mothers, began prenatal care early in pregnancy. African-American and Hispanic women are also more likely to begin care very late in preg-

nancy or to deliver with no prenatal care at all.

Young mothers are particularly likely to enter prenatal care late in pregnancy, and the children of teenage mothers are more likely to face economic, health, and developmental challenges. Another area in which we have seen progress, however, is in the rate of births to adolescent women. In 1999, the birth rate among adolescents was less than 50 births per 1,000 women aged 15-19, a record low. However, again, teen birth rates are much higher within minority groups: for African-Americans, the adolescent birth rate in 1999 was 84 births per 1,000 women 15-19, and for Hispanics, the rate was 93 births per 1,000 women.

Another essential preventive service is immunization. In 2000, nearly 73 percent of 19- to 35- month-old children had been fully immunized by receiving all recommended vaccines. However, approximately 1 million children still need one or more of the recommended doses of vaccine to be fully protected. Moreover, children with special health care needs are still significantly less likely than typical children to receive the full series of vaccines.

We continue to see many indicators of improvement in health and prevention of disabilities in children in the United States. One sentinel indicator of child health is infant mortality. In 1999, the infant mortality rate remained steady at 7.1 deaths per 1,000 live births, the lowest rate ever recorded in the U.S. However, this rate ranks 27th among the industrialized nations of the world. In addition, the mortality rate among African-American infants is still more than twice that of whites. The leading causes of neonatal mortality, or death in the first 28 days of life, are birth defects and disorders related to short gestation (preterm delivery) and low birth weight. Neonatal deaths make up two-thirds of all infant deaths. The leading causes of postneonatal mortality, or death between 28 days and 1 year of age, are Sudden Infant Death Syndrome, or SIDS, and birth defects. The rate of SIDS has dropped dramatically in the past five years, as parents and caregivers have learned about the importance of putting infants down to sleep on their backs.

The health and developmental prospects of infants are also reflected in the rate of low and very low birth weight. Babies born at low birth weight (less than 2500 grams, or 5.5 pounds) are most susceptible to physical disabilities, developmental delays, and infant death. Despite improvements in the use of prenatal care, the rate of low birth weight has actually risen in recent years; the rate reported in 1999 was 7.6 percent of all live births, which is unchanged from the rate in 1999 and is similar to rates reported thirty years ago. However, the causes of these low birth weight rates appear to be changing. The recent increases in the low birth weight rates, at least among white women, can be attributed to increases in the rate of multiple births, as twins and triplets are at particular risk for being small at birth. Another important risk factor for low birth weight is smoking during pregnancy.

Infant health and development can be greatly benefitted by breastfeeding, and the rate of breastfeeding continues to rise. Breast milk has a number of preventive health benefits for both mother and child. The benefits of breastfeeding include prevention of diarrhea and infections in infants, as well as long-term preventive effects for the mother, including earlier return to pre- pregnancy weight and reduced risk of premenopausal breast cancer and osteoporosis. In 1999, more than 67 percent of mothers reported breastfeeding their babies right after delivery, the highest rate yet reported. However, rates of breastfeeding decline dramatically after the initial months of life, and only 31 percent report that they are still breast-

feeding their infants at 6 months of age. These rates are even lower among African-American women and young mothers; 50 percent of African-American women report breastfeeding in the hospital, and only 20 percent breastfed at 6 months.

As children and adolescents grow older, injury becomes one of the most important causes of both death and disability. In 1999, injuries caused the deaths of 6,154 children under age 15. By far the leading cause of these injury deaths was motor vehicle crashes, followed by firearms (including homicides) and drowning. The rate of motor vehicle deaths among children did not change significantly between 1998 and 1999. In addition to these deaths are the long-term effects on children who survive these events, many of which result in lifelong disabilities and special health care needs.

The statistics presented here paint a picture of continuing progress toward the goal of healthy children and families, but we still have a long way to go in many areas. On the National level, the U.S. Department of Health and Human Services has launched Healthy People 2010, a set of health objectives for the Nation that focuses on two major goals: increasing the quality and years of healthy life and eliminating health disparities. As part of that effort, the Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs has outlined six goals for the development of service systems for CSHCN. These "performance outcomes" are presented at the end of this document. In addition, this edition of Child Health USA displays the measures used by the Maternal and Child Health Bureau to monitor the performance and the outcomes of state Title V Maternal and Child Health Block Grant programs in their efforts to develop systems of care to assure the health of all children, including children with special health care needs.

At present, we have little national-level information that describes the health status of children with special health care needs and their access to appropriate, comprehensive health care services. Beginning in 2002, however, information from the National Survey of CSHCN will provide information from each state and for the Nation as a whole on the prevalence of CSHCN in the population, as well as the services they use and the barriers they and their families face in using care. In the meantime, it is hoped that the information presented here will provide readers with timely and accurate data that allows for an overview of the current status of child health.

POPULATION CHARACTERISTICS

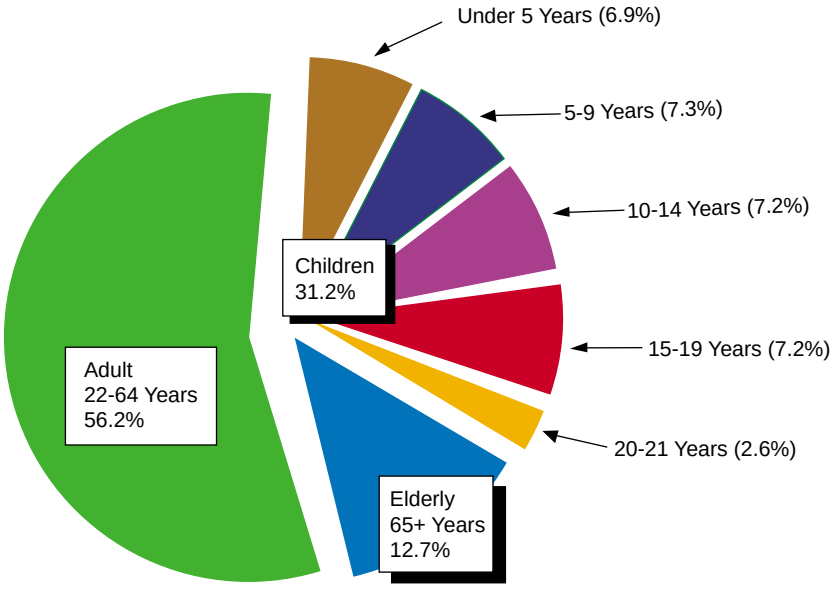
Socio-demographic characteristics provide a comprehensive picture of the country's diverse maternal and child population. The proportion of children ages 21 and below comprises roughly one-third of the U.S. population.

At the national, state, and local levels, policy-makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy-makers can then tailor programs to meet the needs of those populations.

The following section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. These include age, poverty status, living arrangements by head of household, school dropout rates, and child care trends.

U.S. RESIDENT POPULATION BY AGE GROUP: NOVEMBER 1, 2000

Source (I.1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 2000, the 86 million children through the age of 21 in the United States represented 31.2 percent of the total population, adults aged 22-64 accounted for 56.2 percent, and persons aged 65 and over represented 12.7 percent of the total population. The median age in the United States for all races was 35.9.

The number of children under 5 years of age has increased by 0.5 percent since 1990, while the number of children ages 5-19 years has increased by 12.4 percent. In the same period, the number of persons aged 65 and over has increased 11.8 percent.

CHILDREN IN POVERTY

In 1999, there were 11.5 million related* children under 18 years of age living in families with income below the Federal poverty level of $17,029** for a family of four. This figure represents a 10 percent decrease from 1998. Children living below the poverty level comprised 16.3 percent of all related children living in families.

While 1999 brought the lowest childhood poverty rate since 1979, childhood poverty continues to exceed that of adults and the elderly by approximately 70 percent. Very young children and black and Hispanic children were particularly vulnerable. Related children under age 6 had a poverty rate of 18.0 percent, while one in three black and Hispanic children were poor compared to nearly one in eight white children.

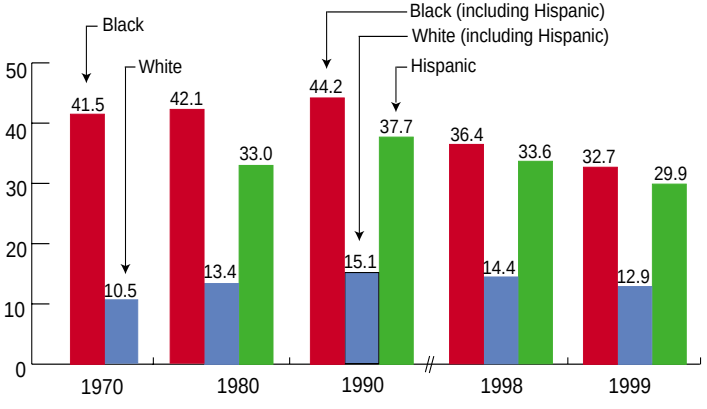
Of the 11.5 million children living in poverty, 57.4 percent lived in homes headed by a single mother, 37.3 percent lived in homes headed by married parents, and 5.3 percent lived in families with other compositions.

*Related children in a family include a householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.

**Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous year.

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL BY RACE/ETHNICITY: 1999

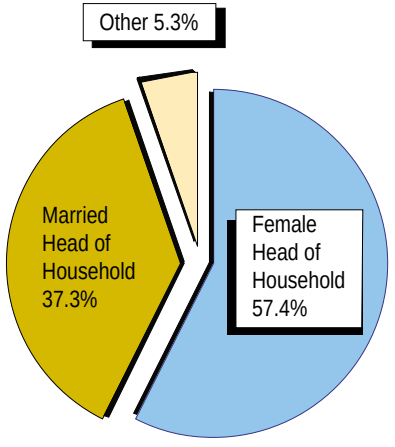
Source (I.2): U.S. Bureau of the Census



Hispanic ethnicity not reported prior to 1979.

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL, BY HOUSEHOLD STATUS: 1999

Source (I.2): U.S. Bureau of the Census



SCHOOL DROPOUTS

As of October 1999, approximately 519,000 youth aged 15 - 24 had dropped out of high school in the previous 12 months. Those who dropped out of high school during this period represented 5.0 percent of students enrolled in high school between October 1998 and 1999.

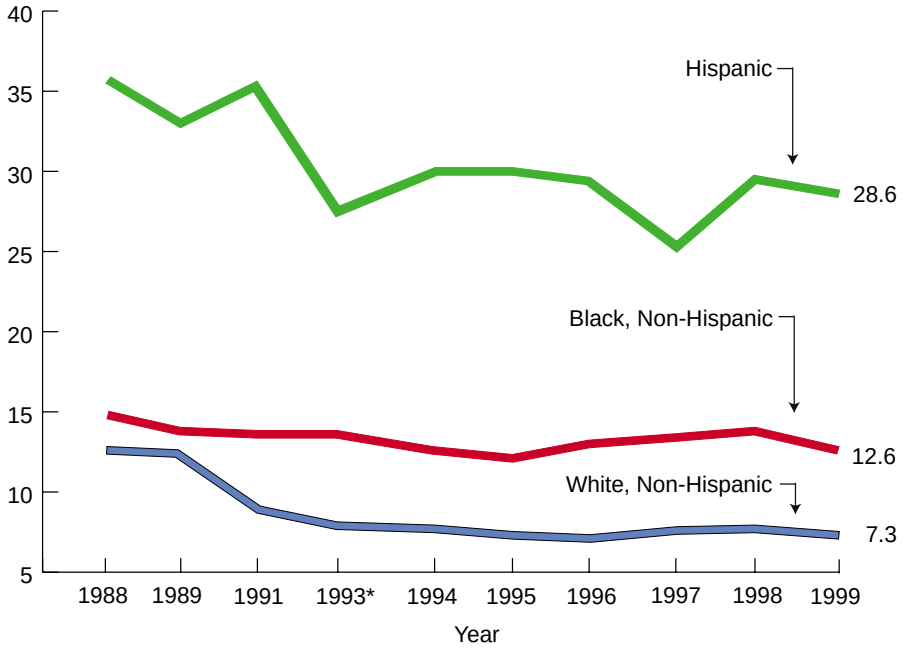
In 1999, Hispanic students were the most likely to drop out, with dropouts representing well over a quarter of Hispanic young adults. However, this figure represents a 3.0 percent decrease among Hispanic dropouts after a 16.6 percent increase between 1997 and 1998. Dropout rates decreased 5 percent among white youth and 8.7 percent among black youth between 1998 and 1999.

Those students most likely to drop out of school in 1999 were those living in western states, boys, and students aged 19 and older. Students living in low-income families were twice as likely as those in middle income families and four times as likely as those in high income families to drop out.

Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

STATUS SCHOOL DROPOUT RATES FOR AGES 16-24 BY RACE/ETHNICITY: 1999

Source (I.3): U.S. Department of Education



*Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.

WORKING MOTHERS

In 2000, 65 percent of mothers with preschool aged children (younger than 6 years) were in the labor force (either employed or looking for work), and 61 percent were actually employed. Of those mothers, 71 percent worked full-time and 29 percent worked part-time.

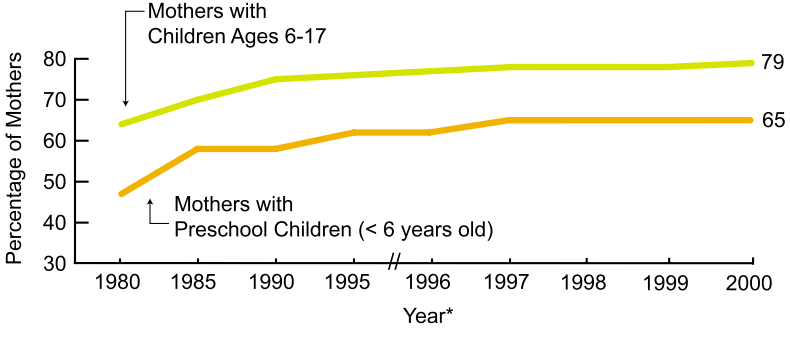
Of women with children ages 6-17, 79 percent were in the labor force in 2000 and 76 percent were actually employed. Of employed mothers, 78 percent worked full-time and 22 percent worked part-time.

CHILD CARE

In 1997, 41 percent of children under 5 years of age whose mothers worked were cared for by persons other than their parents for 35 or more hours per week. While 42 percent of children in families with higher incomes spent more than 35 hours a week in some form of child care, slightly less, or 40 percent of children in lower-income families, were in care for the same number of hours. However, a smaller proportion of children from low-income families (21 percent) were in part-time care compared to higher-income children (27 percent). Children three and four years old were more often in multiple child care arrangements (44 percent), compared to younger children (34 percent).

MOTHERS IN THE WORK FORCE: 1980-2000

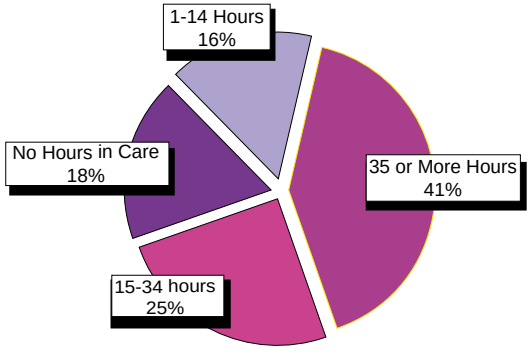
Source (I.4): U.S. Bureau of Labor Statistics



*Data for 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.

HOURS PER WEEK SPENT IN CHILD CARE BY CHILDREN UNDER FIVE WITH WORKING MOTHERS: 1997

Source (I.5): National Survey of America's Families, The Urban Institute




Whales

MATERNAL AGE

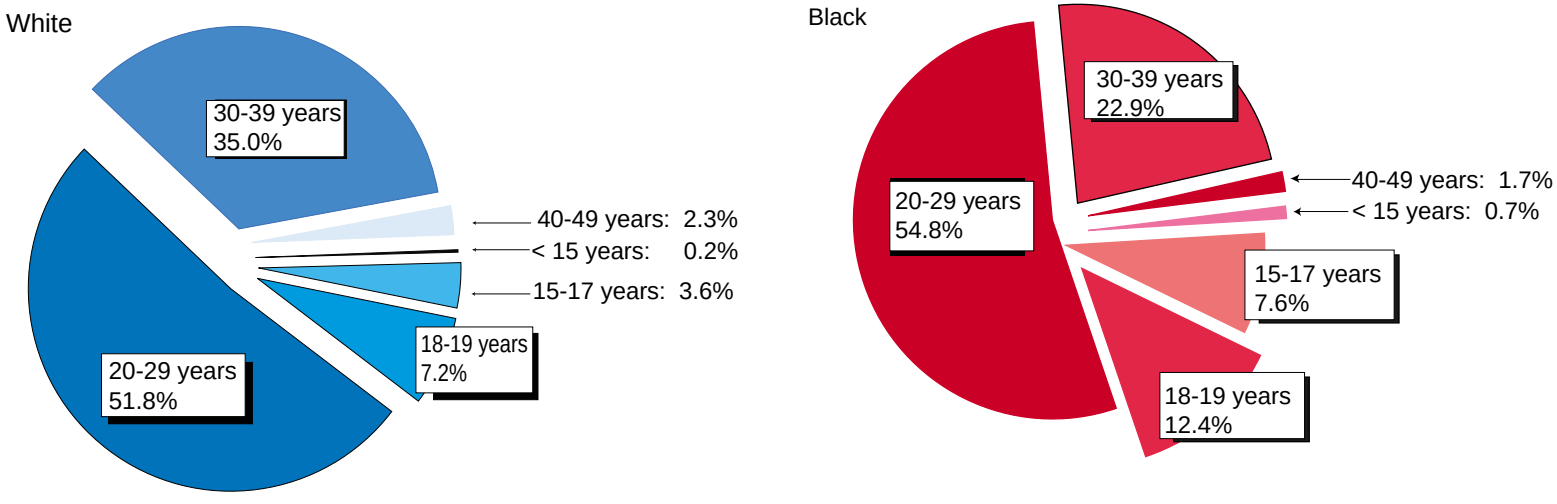
The overall birth rate fell slightly in 1999, matching the record low of 1997. This fall follows a small increase in the birth rate during 1998. Birth rates for teenagers also fell to a record low in 1999, declining 3 percent from 1998. Birth rates to women in their early twenties declined slightly, while rates grew among women in their late twenties, women in their thirties, and women in their early forties. The birth rate remained unchanged from the previous year for women in their late forties.

Among 1999 births, over half were to women in their twenties, one-third were to women in their thirties and 12 percent were to women under 19 years of age. The remaining two percent were to women in their forties.

Among both black and white women, more than half of births in 1999 were to women in their twenties. However, a substantially higher proportion of white births were to women in their thirties and forties while the percentage of births to teens was almost twice as high among blacks as among whites.

PERCENT DISTRIBUTION OF BIRTHS BY MATERNAL AGE, BY RACE, 1999

Source (I.6): National Center for Health Statistics



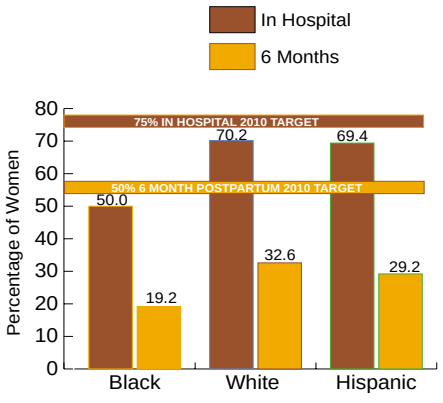
HEALTH STATUS

The systematic assessment of the health status of children enables health professionals to determine the impact of past and current health intervention and prevention programs. Program planners and policy-makers identify trends by examining and comparing information from one data collection year to the next. Although indicators are often assessed on an annual basis, some surveillance systems may only collect data every two, three, or five years.

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. Population-based samples are designed to yield data that are representative of the maternal and child population that are affected by, or in need of, specific health services.

BREASTFEEDING BY RACE: 1999*

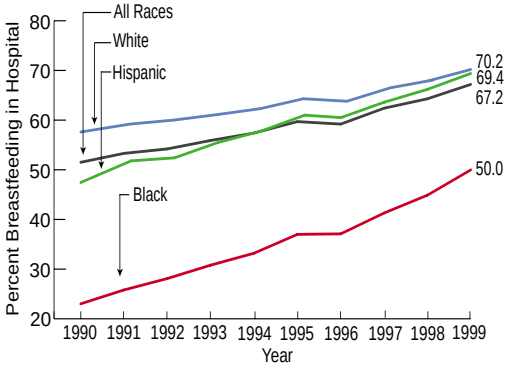
Source (II.1): Abbott Laboratories



*Includes exclusive and supplemented breastfeeding.

BREASTFEEDING BY RACE: 1990-1999

Source (II.1): Abbott Laboratories



INFANT FEEDING

Throughout the 1970's and early 1980's, the percentage of mothers who began breastfeeding in the hospital increased steadily to 61.9 percent, but then gradually declined to 51.5 percent by 1990. Since 1991, the breastfeeding initiation rates steadily increased among black, Hispanic, and white women. In 1999, breastfeeding rates in the hospital reached 67.2 percent, the highest rate recorded since national breastfeeding data have been collected.

Since 1990, rates of breastfeeding immediately after delivery grew the most among groups of mothers that have traditionally been the least likely to breastfeed, such as black and Hispanic women. Over the past nine years, the rate of breastfeeding initiation has more than doubled among black women and has increased 45 percent among Hispanic mothers. These increases have contributed to a substantial reduction in the gap in breastfeeding rates between white and non-white women.

Breastfeeding rates for women of all races decrease substantially between delivery and 6 months postpartum, the breastfeeding period recommended as most critical for the infant's health by the Surgeon General of the United States. The percentage of women who report that they are still breastfeeding at 6 months postpartum reached a high of 30.7 percent in 1999. At six months postpartum, 32.6 percent, 29.2 percent, and 19.9 percent of white, Hispanic, and black women, respectively were still breastfeeding. These rates represent a sharp decline from rates immediately after delivery of 70.2 percent among whites, 69.4 percent among Hispanics, and 50.0 percent among blacks.

Breastfeeding rates were highest among women over 35 years of age, college educated, not participating in the Women, Infants, and Children (WIC) dietary supplement program, and/or living in the western states. Women were also more likely to breastfeed their first child. Women least likely to breastfeed were younger than 20 years of age, not employed, low-income, black and/or living in the southeastern United States.

LOW BIRTH WEIGHT

In 1999, 301,183 babies (7.6 percent of all live births) were of low birth weight, weighing less than 2,500 grams, or about 5.5 pounds, at birth. This rate was unchanged from 1998.

The percentage of newborns born at low birth weight rose from a low of 6.8 percent in 1985 to 7.6 percent in 1998 and currently rivals the rates reported nearly thirty years ago. Some of the increase of low birth weight is due to an increase in the proportion of multiple births, as these infants are at a much greater risk of weighing less than 2,500 grams at birth. In 1999, only 6 percent of singleton newborns weighed less than 2,500 grams, compared to 57 percent of twins, triplets and higher-order multiples.

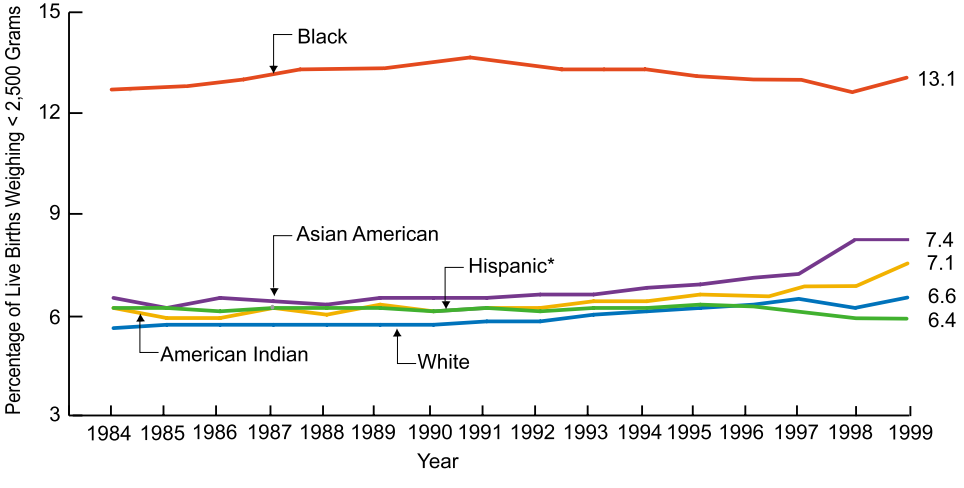
The black low birth weight rate remains nearly twice the white rate. The low birth weight rate among infants born to black mothers has declined more than 3 percent from a high of 13.6 percent in 1991, while the rate among infants of white mothers has increased nearly 14 percent over the same period. This is largely due to the higher prevalence of multiple births among white women.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disability or to die during the first year of life than are infants of normal weight.

In 1999, 12.1 percent of infants born to smokers were of low birth weight, compared with 7.2 percent of births to nonsmokers. This nearly twofold differential has been observed since 1989 among both black and white infants. Other factors associated with increased risk of low birth weight include poverty, maternal smoking, and low levels of educational attainment.

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT BY RACE: 1984-1999

Source (II.2) National Center for Health Statistics



**Hispanic can be of any race.*

Note: 1984-1988 data based on race of child; 1989-1999 data based on race of mother.

VERY LOW BIRTH WEIGHT

In 1999, the rate of very low birth weight remained unchanged at nearly 1.5 percent of live births to U.S. women.

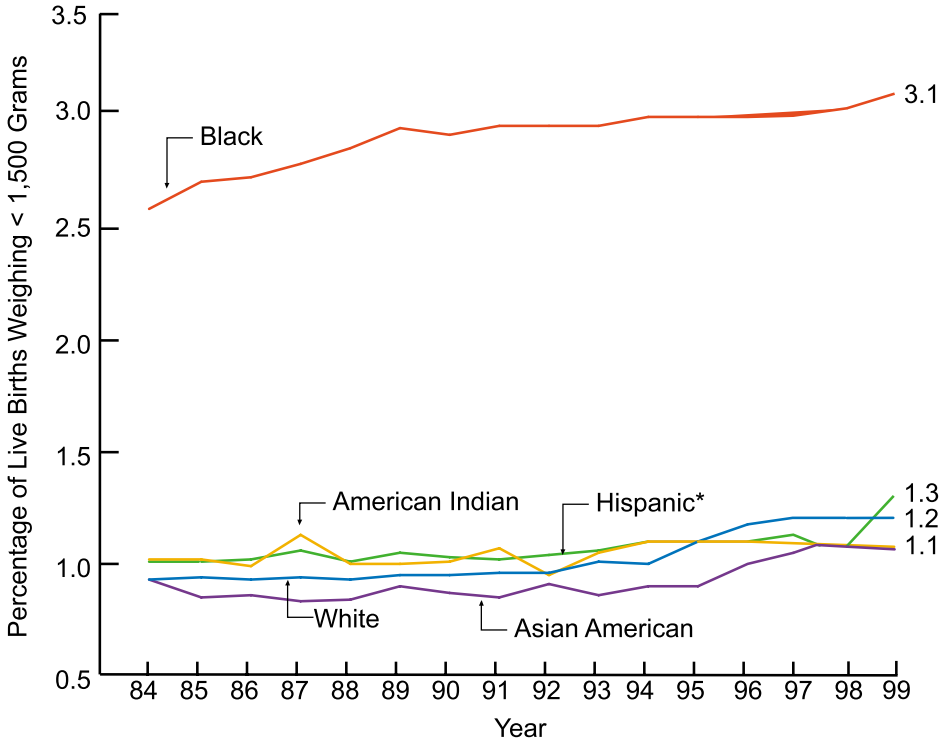
Although infants weighing less than 1500 grams (about 3.3 pounds) account for a small percentage of births, they account for up to half of the deaths of newborns. Approximately 9 of 10 of the very smallest infants—those with birth weights of less than 500 grams—die within the first year of life.

Very low birth weight infants who survive are at significantly increased risk of severe problems, including physical and visual difficulties, developmental delays and cognitive impairment requiring increased levels of medical, educational and parental care.

The rate of very low birth weight among black babies is 2.5 times higher than that among whites, and is more than twice the rate for the total birth population. This disparity is a major contributor to the disparity in infant mortality rates between black and white infants.

PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT BY RACE: 1984-1999

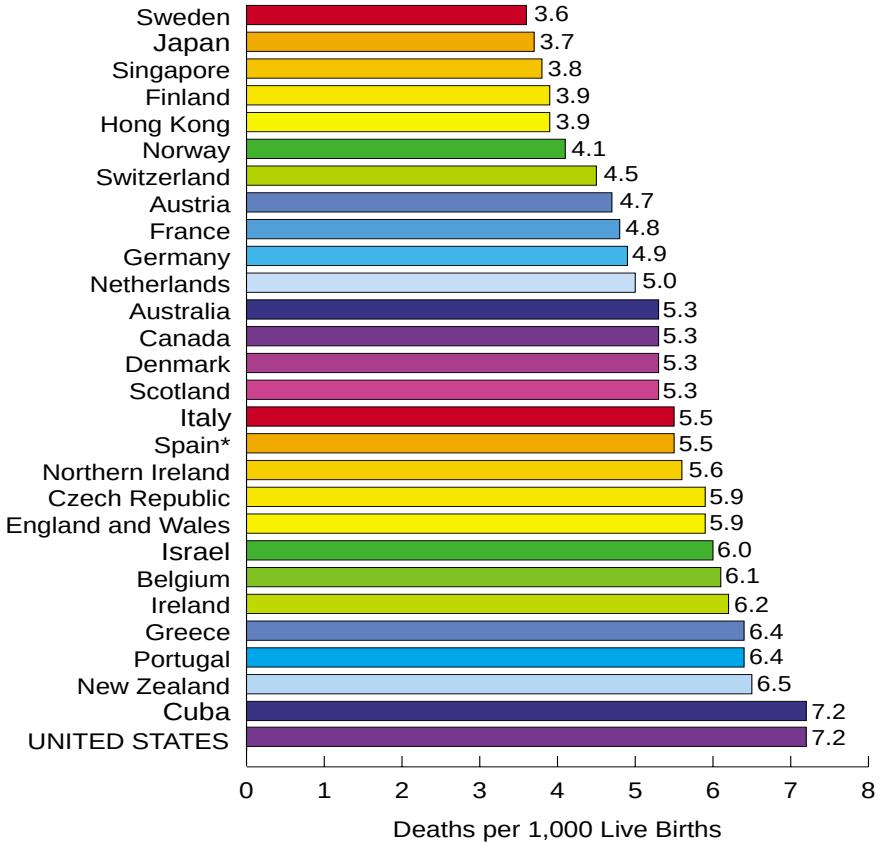
Source (II.2): National Center for Health Statistics



* *Hispanic can be of any race.*

COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1997

Source (II.3): National Center for Health Statistics



*Rate is for 1996

COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy as well as the quality and accessibility of primary care for pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the Nation dropped one rank to 27th among industrialized nations in 1997.

In 1997, Sweden reported the lowest recorded rate of infant mortality in history, with a rate of 3.6 deaths per thousand live births. The risk of a Swedish child dying in infancy was half that of a child born in the United States.

INFANT MORTALITY

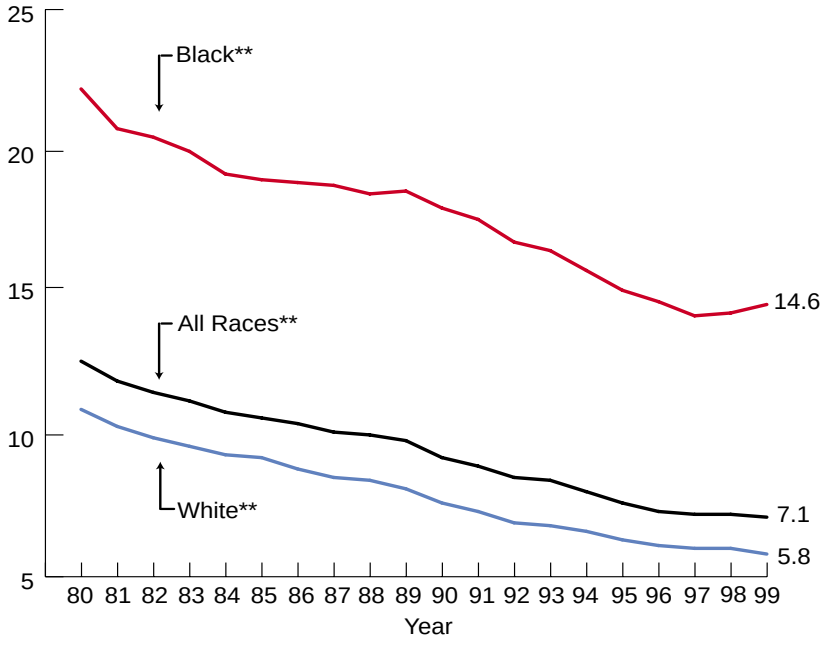
In 1999, 27,953 infants died before their first birthday. The preliminary infant mortality rate was 7.1 deaths per 1,000 live births. This rate was not statistically different from that reported in 1998.

The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s. Major advances including the approval of synthetic surfactants and the recommendation that infants be placed on their backs when sleeping may have caused a renewed decline during the 1990s. Based on preliminary data, between 1998 and 1999, mortality among white infants decreased 3 percent to 5.8, while the preliminary rate for blacks of 14.6 was not statistically different from the reported 1998 rate.

The preliminary 1999 infant mortality rate for black infants was 2.5 times that for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between the black and white rates has remained largely unchanged.

U.S. INFANT MORTALITY RATES BY RACE OF MOTHER: 1980-1999*

Source (II.4): National Center for Health Statistics



*preliminary data

**Includes the ethnic classification of Hispanic.

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1999, 18,740 infants younger than 28 days died, resulting in a preliminary neonatal mortality rate of 473.3 deaths per 100,000 live births. This neonatal mortality rate was not statistically different from that reported in 1998.

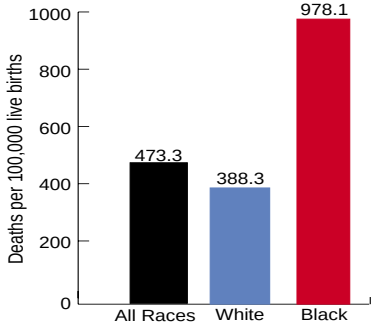
Postneonatal

In 1999, 9,213 infants 28 days through 11 months old died; the preliminary postneonatal mortality rate was 232.7 deaths per 100,000 live births, which represents a 3 percent decline from 1999.

Information about the causes of neonatal and postneonatal mortality was not available at the time of publication.

PRELIMINARY NEONATAL MORTALITY RATES BY RACE OF MOTHER: 1999*

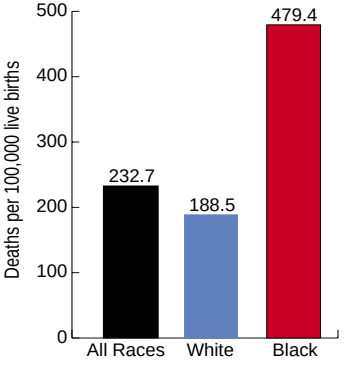
Source (II.4): National Center for Health Statistics



*preliminary data

PRELIMINARY POSTNEONATAL MORTALITY RATES BY RACE OF MOTHER: 1999*

Source (II.4): National Center for Health Statistics



*preliminary data

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed, and the maternal mortality rate was not statistically different in 1998 than in 1997.

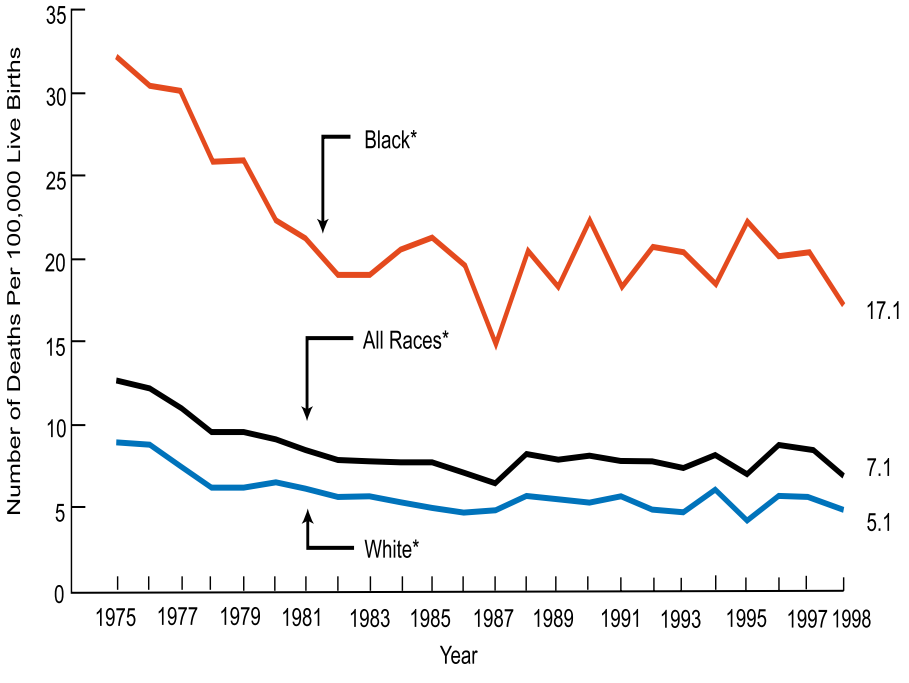
In 1998, there were 281 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

The maternal mortality rate for black women (17.1 per 100,000 live births) is more than three times the rate for white women (5.1 per 100,00 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35-39 years old have approximately twice the risk of maternal death than those aged 20-24 years.

MATERNAL MORTALITY RATES BY RACE OF MOTHER: 1975-1998

Source (II.5): National Center for Health Statistics



*Includes the ethnic classification of Hispanic

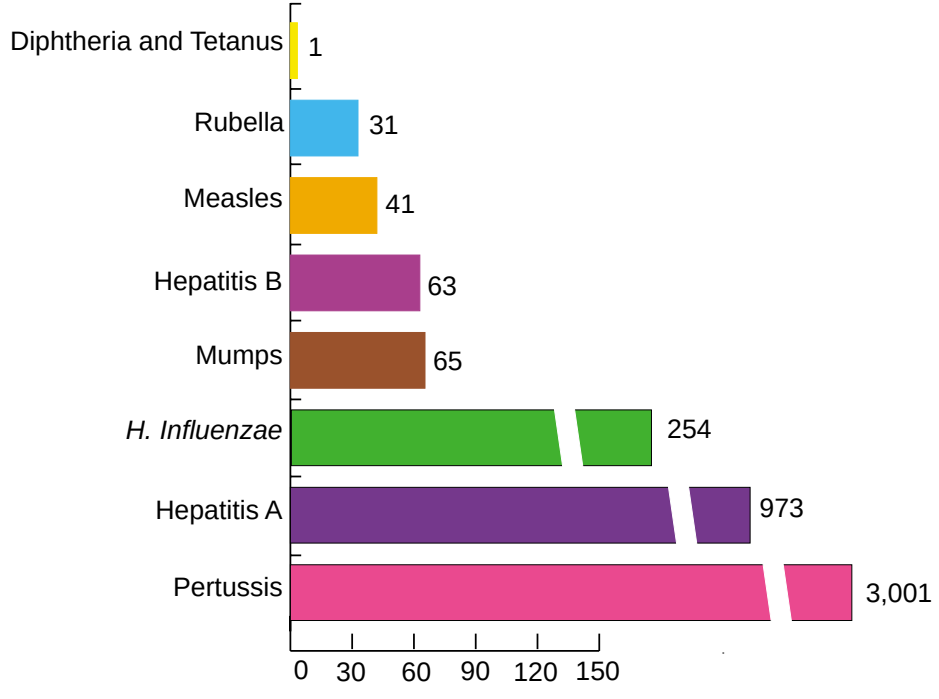
VACCINE-PREVENTABLE DISEASES

The number of reported cases of vaccine-preventable diseases has decreased steadily since the introduction of the Childhood Immunization Initiative. While the number of cases of *H. Influenzae*, measles, and rubella increased slightly among children under 5 from 1998 to 1999, the number of mumps, Hepatitis A, and Hepatitis B cases decreased dramatically. Diphtheria and tetanus remained the same. Our progress in the control of vaccine-preventable diseases is exemplified in the decline in the number of cases of measles in children since the measles epidemic of the late 1980s. Also significant is the near-eradication of polio, with no cases reported in 1999 among children under 5 years of age.

Although much progress has been made in reducing the number of reported cases of vaccine-preventable diseases, several of these diseases are still common. The number of cases of pertussis, Hepatitis A, and *H. Influenzae* remains substantial and indicates a need to continue to promote immunization efforts.

NUMBER OF CASES OF REPORTABLE VACCINE-PREVENTABLE DISEASES AMONG CHILDREN UNDER 5: 1999

Source (II.6): Centers for Disease Control and Prevention



CHILD ABUSE AND NEGLECT

In 1999, investigations by state child protective services agencies determined that an estimated 826,000 children were victims of abuse or neglect, equivalent to a rate of 11.8 per 1,000 children under 18 years of age. Eighty-seven percent of the perpetrators of child maltreatment were the parents of the victim.

Approximately 58 percent of all victims suffered neglect, 21 percent physical abuse, 11 percent sexual abuse, 8 percent psychological maltreatment, and 28 percent other forms of maltreatment. Some children suffered multiple types of maltreatment. Data from 15 states show that children with a history of maltreatment prior to 1999 were nearly three times as likely to experience a recurrence during the 6 months following their first 1999 victimization than children without a prior history.

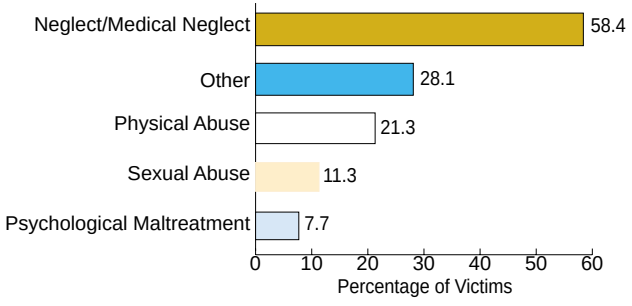
Victimization is highest among the youngest children. In 1999, the victimization rate for children ages 0 to 3 was 13.9 per 1,000, compared to 5.9 per 1,000 among children age 16 to 17. Among the estimated 1,100 children who died of abuse and neglect in 1999, children younger than one year accounted for 42.6 percent of fatalities and children younger than 6 years accounted for 86.1 percent. Fatalities were most often associated with neglect (38.2 percent) than with any other type of maltreatment.

State child protective services received reports alleging the maltreatment of approximately 2.9 million children in 1999. Slightly more than half of these reports were received from community professionals, while the remainder were received from family, friends, relatives, or neighbors of these children.

The data were obtained from the National Child Abuse and Neglect Data System, the primary source of national information on abused and neglected children known to state child protective services agencies.

PERCENTAGE OF CHILD ABUSE AND NEGLECT VICTIMS BY TYPE OF MALTREATMENT: 1999

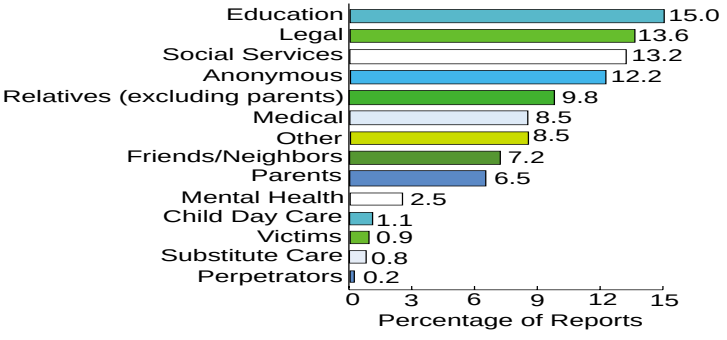
Source (II.7): U.S. Department of Health and Human Services



Note: Percentage totals more than 100% because some states report more than one type of maltreatment per victim. Includes victims in 49 states.

SOURCES OF MALTREATMENT REPORTS: 1999

Source (II.7): U.S. Department of Health and Human Services



Note: 1,805,756 reports from 46 states.

PEDIATRIC AIDS

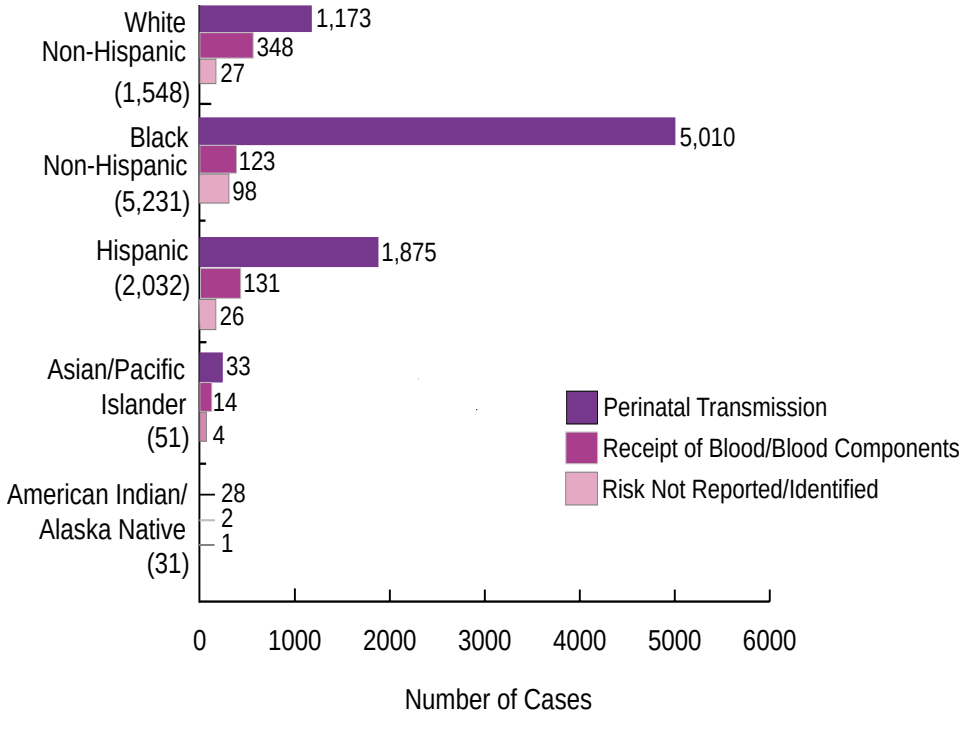
As of December 31, 2000, 8,908 cases of AIDS in children younger than 13 had been reported in the U.S.; this total includes 196 newly reported cases in 2000. Pediatric AIDS cases represented less than 1.2 percent of all cases reported to date.

The majority of pediatric AIDS cases result from transmission before or during birth (perinatal transmission). However, the number of new cases of pediatric AIDS due to perinatal transmission has declined by 76 percent since 1993. A major factor in this decline is the increasing use of zidovudine (ZDV) treatment during pregnancy to reduce perinatal HIV transmission. In 1994, the U.S. Public Health Service recommended this treatment for all HIV-positive pregnant women, and in 1995, routine HIV counseling and voluntary testing for all pregnant women were recommended. It is expected that the perinatal transmission rate will continue to decline with increased use of aggressive treatments and obstetric procedures, such as elective cesarean section.

The number of pediatric AIDS cases ever reported in black, non-Hispanic children is more than three times that of white, non-Hispanic children and over two and one-half times that of Hispanic children.

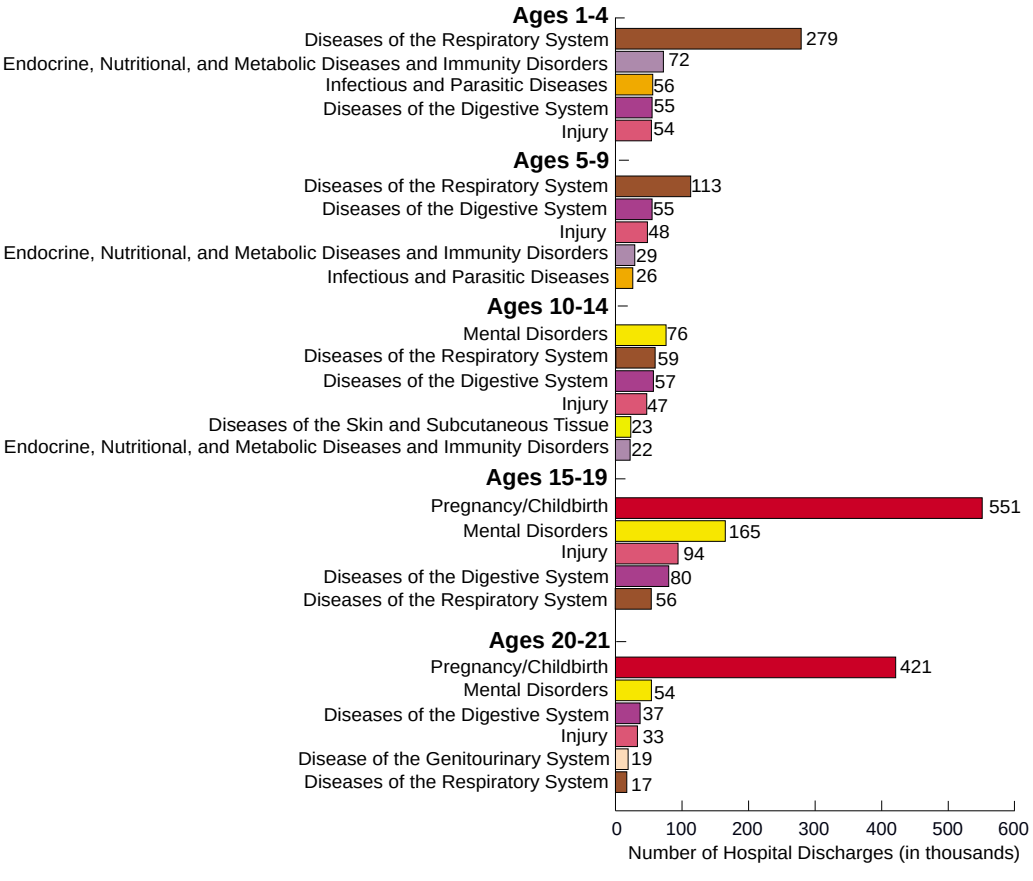
PEDIATRIC AIDS BY RACE/ETHNICITY AND EXPOSURE CATEGORY: 1981-2000

Source (II.8): Centers for Disease Control and Prevention



MAJOR CAUSES OF HOSPITALIZATION BY AGE: 1999

Source (II.9): National Center for Health Statistics



HOSPITALIZATION

In 1999, there were 3.5 million hospital discharges of children 1 through 21 years old, or 4.2 discharges per 100 children.

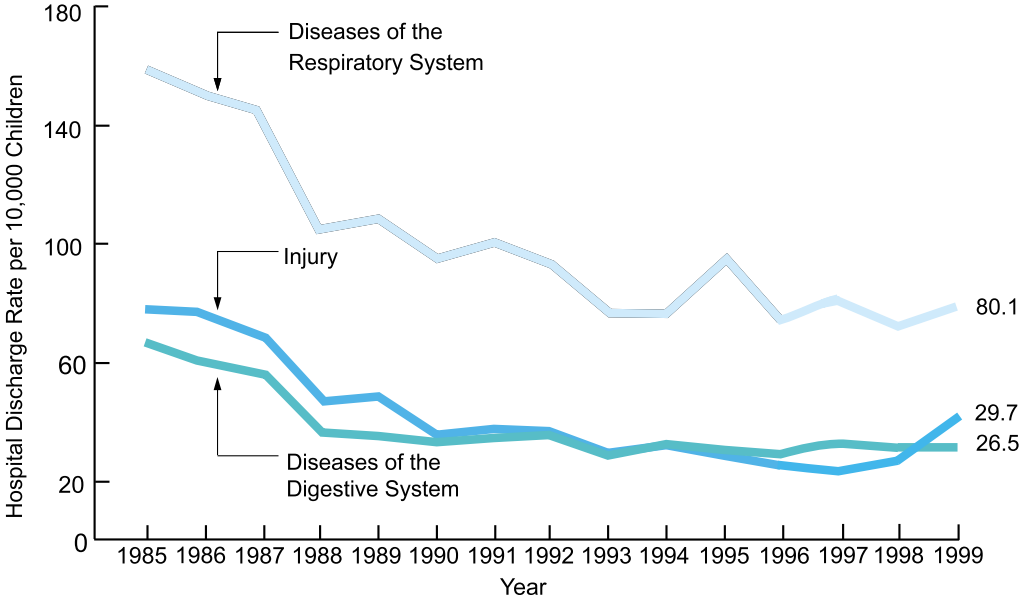
Diseases of the respiratory system were the major causes of hospitalization for children 1-9 years of age and accounted for 33 percent of their discharges.

Hospital discharge rates generally decrease until about age 10 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 9 percent of the hospital discharges of children 1-14 years old in 1999. Pregnancy and childbirth accounted for 69 percent of discharges of young women ages 15-21.

DISCHARGE RATE OF PATIENTS 1-14 YEARS OLD FOR SELECTED DIAGNOSES: 1985-1999

Source (II.9): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1985, there has been a 37 percent decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1985 and 1999, there was a 40 percent decline in the hospital discharge rate for diseases of the respiratory system in children in this age group.

Three diagnostic categories (respiratory diseases, injury, and digestive diseases) accounted for 47 percent of the discharges of children aged 1-14 years in 1999.

CHILD MORTALITY

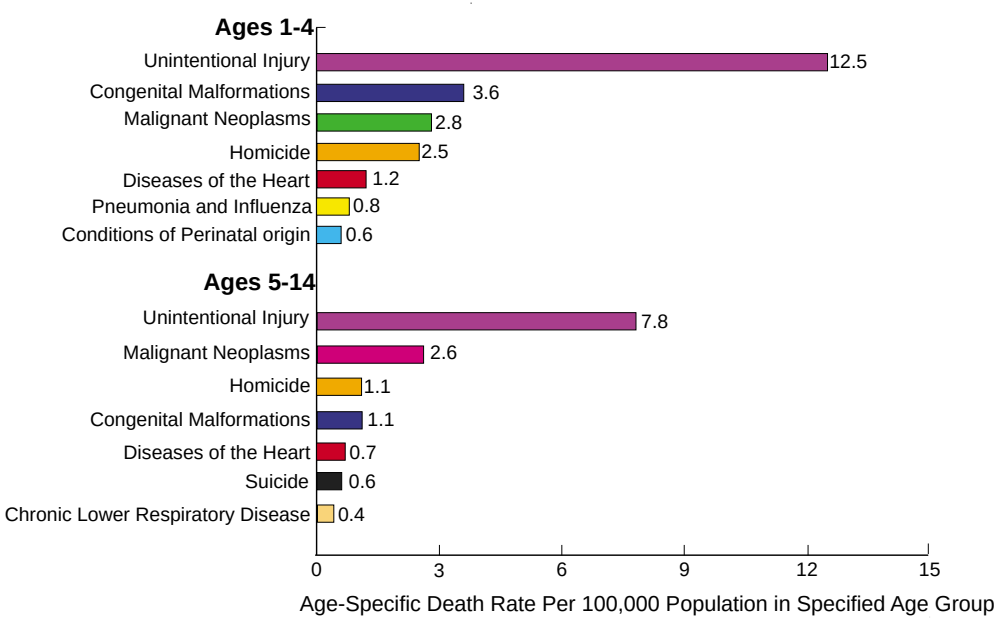
There were 12,845 deaths of children ages 1-14 in 1999, based on preliminary data. Injury, regardless of intent, was the primary cause of death in that age group. Among 1- to 4-year-old children, injuries accounted for 36 percent of all deaths, followed by deaths due to congenital malformations (birth defects), malignant neoplasms (cancer), homicide, and diseases of the heart.

Injuries comprised 40.7 percent of all deaths among 5- to 14-year-old children, followed by malignant neoplasms, homicide, congenital malformations, diseases of the heart, and suicide.

Childhood death rates have declined substantially over the past several decades. Preliminary death rates for children 1-4 years of age were not statistically different from those reported in 1998, while those for children aged 5-14 years decreased 3.5 percent.

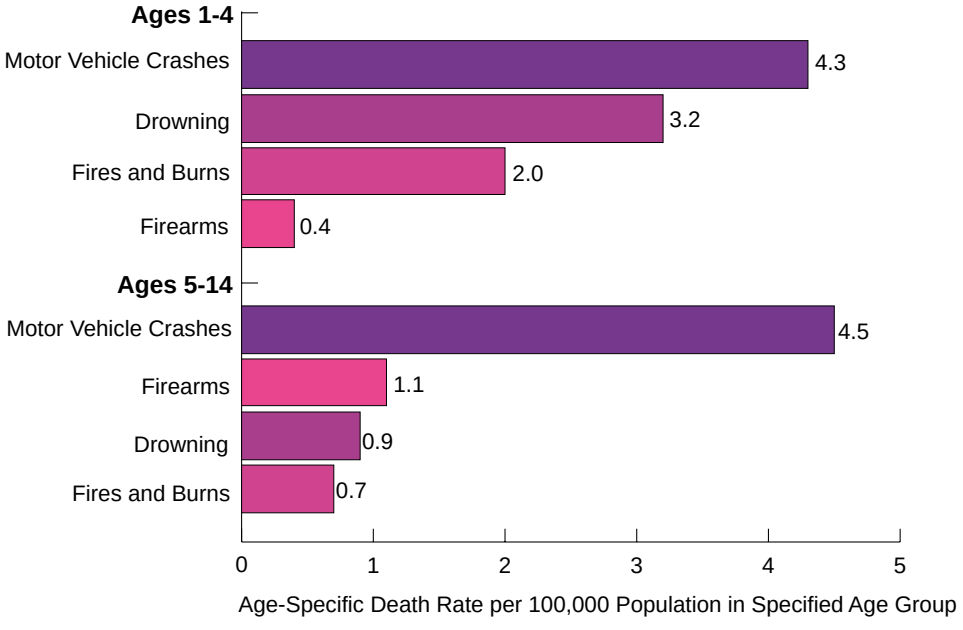
LEADING CAUSES OF DEATH IN CHILDREN AGES 1-14: 1999*

Source (II.4): National Center for Health Statistics



*preliminary data

CHILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 1999*
Source (II.4): National Center for Health Statistics



*preliminary data

CHILDHOOD DEATHS DUE TO INJURY

In 1999, injuries caused the deaths of 2,328 1- to 4-year-old children and 3,826 5- to 14-year- old children. These injuries include homicides, suicides, unintentional deaths, and those of undetermined intent.

Among 1- to 4-year-old children, motor vehicle crashes, drowning, and fire were the most common causes of injury death. Motor vehicle crashes were the most common cause of injury death among 5- to 14-year-old children, followed by firearm deaths.

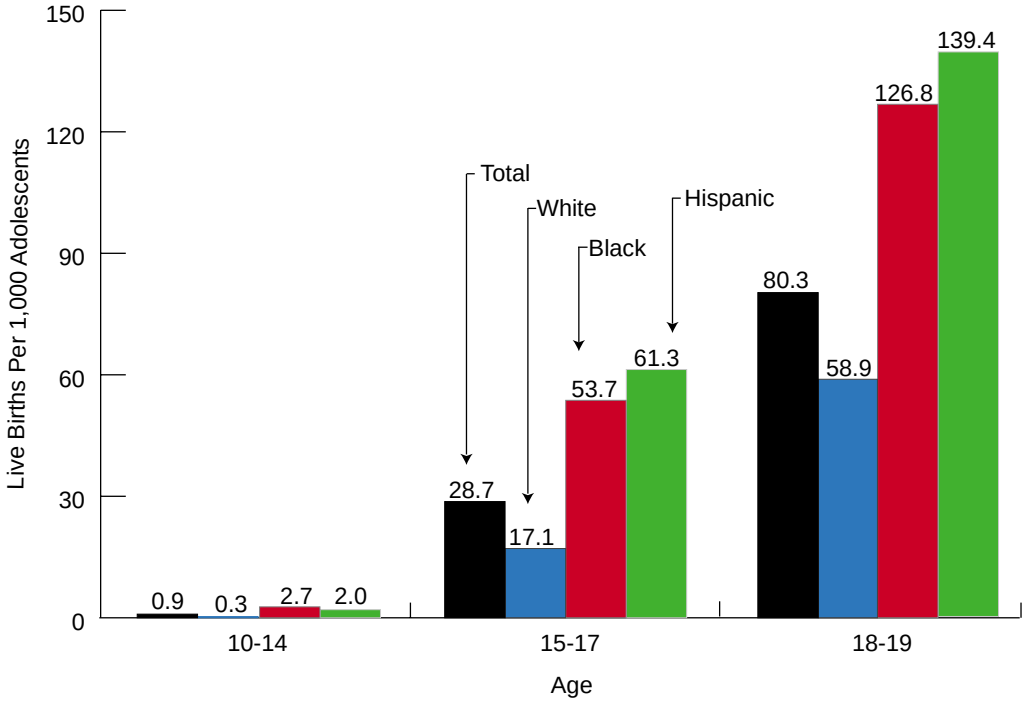
ADOLESCENTS

In 2000, individuals aged 13-19 accounted for roughly 10 percent of the U.S. population. For the most part, adolescents are a healthy population. However, adolescence is a time of physical and emotional growth and exploration. Many adolescents engage in risk-taking behaviors that may result in acute illnesses and infections, poor long-term health outcomes, and even disability and death. For example, adolescents may experiment with cigarettes and drugs, are involved in motor vehicle crashes, and engage in unprotected sex. This section features many health status indicators related to cigarette smoking, use of illicit drugs, adolescent mortality, injury, sexual intercourse, sexually transmitted diseases, and pregnancy. Many of these data are presented by age, gender, race, and ethnicity.

Adolescence is also a period during which many lifelong health habits are formed, such as diet, exercise, and the use of the health care services. National data related to physical activity and overweight are also explored in this section. Traditionally, teenagers do not use health services in great numbers, particularly preventive health services. The following section addresses health service utilization patterns among children.

ADOLESCENT BIRTH RATES, BY AGE AND RACE OF MOTHER: 1999

Source (II.2): National Center for Health Statistics



ADOLESCENT CHILDBEARING

Birth rates among adolescents of all ages and races continue to decline. In 1999, the live birth rate per 1,000 adolescent females was 0.9 for ages 10-14, 28.7 for ages 15-17, and 80.3 for ages 18-19 years old. The birth rates among 15- to 19-year-olds in 1999 represent an overall 20 percent decrease between 1991 and 1999.

In 1999, there were 212,923 live births among white females ages 15-19 and 118,285 births to black teenagers. The birth rates were 34.0, 83.7, and 93.4 for white, black, and Hispanic teenagers respectively. Although the birth rate for black teenagers remains relatively high in comparison to the rate for white teens, the largest decline in birth rates by race between 1991 and 1999 has been seen in black teens. The overall rate of adolescent childbearing among black teens 15-19 years old fell by nearly 30 percent to 83.7 per 1,000 the lowest rate ever recorded. The birth rate among Hispanic teens fell the least, 12.5 percent, leaving Hispanic teenagers with the highest adolescent birth rate among the three groups.

SEXUAL INTERCOURSE

The recent downward trend in the percentage of high school students reporting ever having sexual intercourse was reversed in 1999. In 1997, 48.4 percent of all high school students reported ever having sexual intercourse compared to 49.9 percent in 1999. Black students (71 percent) were most likely to report having had sexual intercourse, followed by Hispanic students (54 percent) and white students (45 percent).

Approximately 51 percent of students in the 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among both females (24.0 percent to 53.0 percent) and males (29.1 percent to 48.1 percent). Overall, male students were significantly more likely than female students (19.3 percent versus 13.1 percent) to have had four or more sex partners during their lifetime.

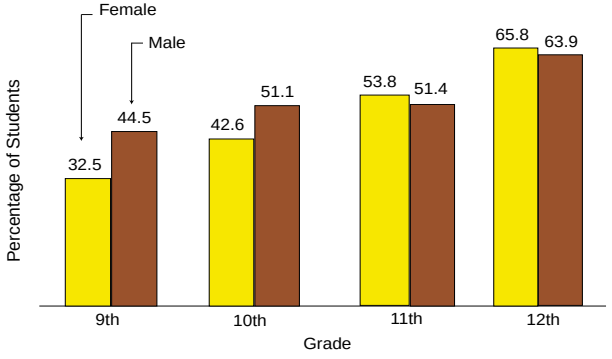
CONDOM USE

In 1999, more than half (58 percent) of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used. Black students were more likely than white and Hispanic students to report using a condom during last sexual intercourse.

Sexual activity increased by grade for all students; however, condom use decreased by grade, with 12th-graders being the least likely to use condoms.

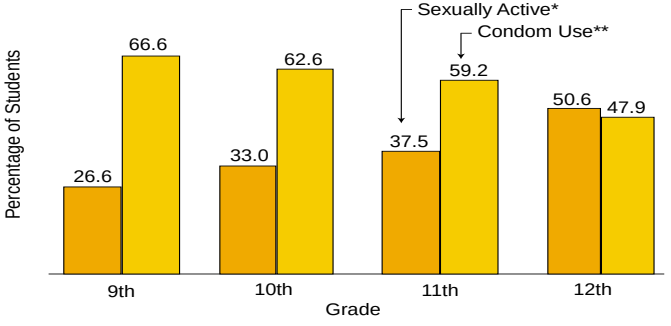
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 1999

Source (II.10): Centers for Disease Control and Prevention



SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS: 1999

Source (II.10): Centers for Disease Control and Prevention



**Sexual intercourse during the three months prior to the survey.*
*** Among sexually active students at last sexual intercourse.*

SEXUALLY TRANSMITTED DISEASES

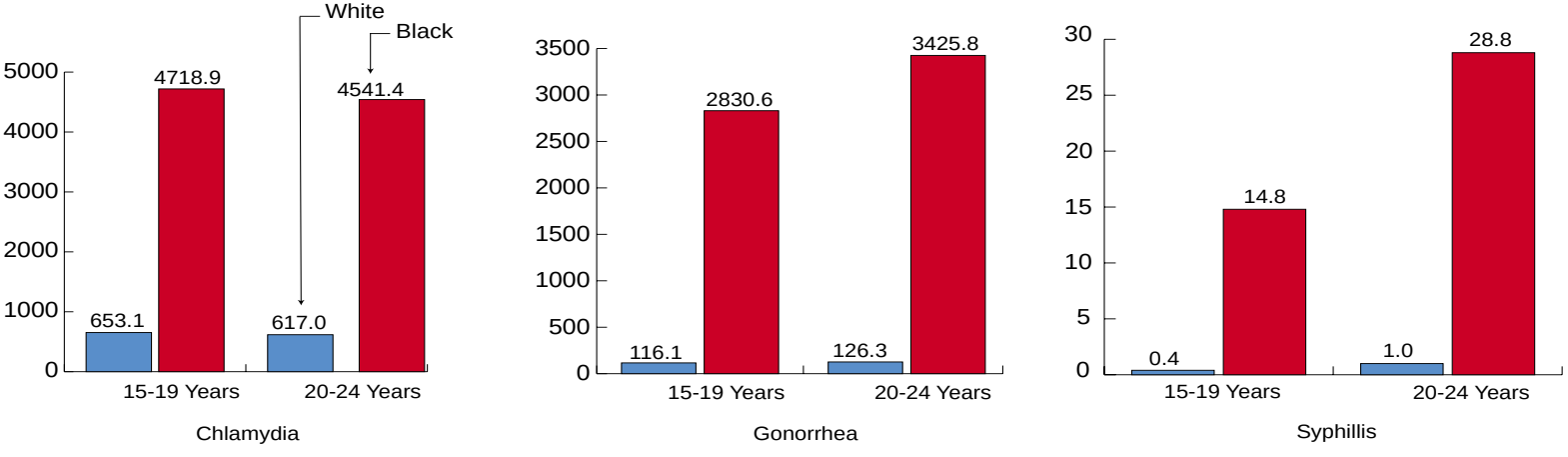
Rates of reportable sexually transmitted diseases (STDs) are particularly high among adolescents (ages 15-19) and young adults (ages 20-24). In these age groups, reported rates of chlamydia, gonorrhea, and syphilis are much higher among black non-Hispanic youth than white non- Hispanics.

The most common STD in adolescents and young adults in 1999 was chlamydia, a bacterial infection, with 1,383 cases per 100,000 adolescents and 1,329 per 100,000 young adults. Gonorrhea followed in prevalence with 534 cases per 100,000 adolescents and 615 cases per 100,000 young adults. Infection rates for chlamydia increased for both age groups in 1999. Gonorrhea among adolescents declined slightly while the rate for young adults increased. Syphilis is much rarer among young people, with only 2.7 cases per 100,000 adolescents and 5.5 cases per 100,000 young adults in 1999, a slight decline in both age groups from 1998.

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV and untreated STDs can lead to pelvic inflammatory disease and infertility in women.

RATES OF SEXUALLY TRANSMITTED DISEASES PER 100,00 ADOLESCENTS BY AGE AND RACE: 1999

Source (II.11): Centers for Disease Control and Prevention



ADOLESCENT AIDS

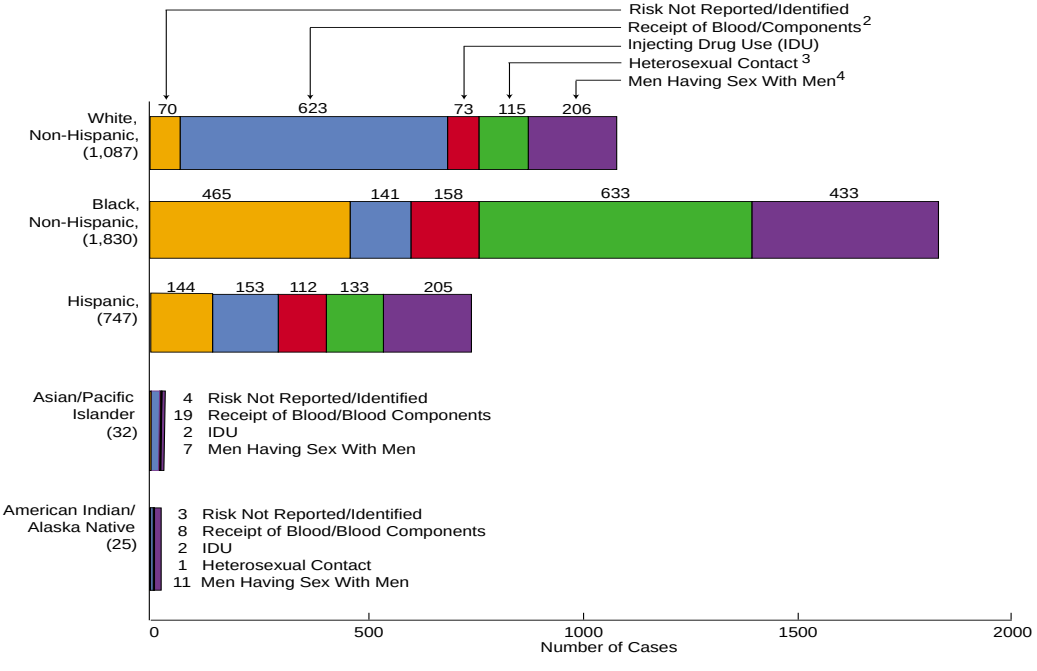
As of December 31, 1999, 3,725 cases of AIDS had been reported in adolescents aged 13-19 years. This total includes 312 newly reported cases in 1999.

Forty-nine percent of adolescent AIDS cases were among black non-Hispanics. Thirty-five percent of blacks aged 13-19 were exposed to HIV through heterosexual contact and 24 percent were exposed through male-to-male sexual contact.

Whites comprised 29 percent of the AIDS cases among adolescents. Of these, 57 percent were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions (however, only 6.4 percent of newly-reported cases in 1999 involved this source of transmission). Nineteen percent of whites aged 13-19 years were exposed to HIV through male-to-male sexual contact.

ADOLESCENT AIDS CASES, BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 13-19: 1981-1999

Source (II.12): Centers for Disease Control and Prevention



Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/uL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/Blood components:

- *Received clotting factor for hemophilia coagulation disorder*
- *Received blood transfusions, blood components, or tissue*

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

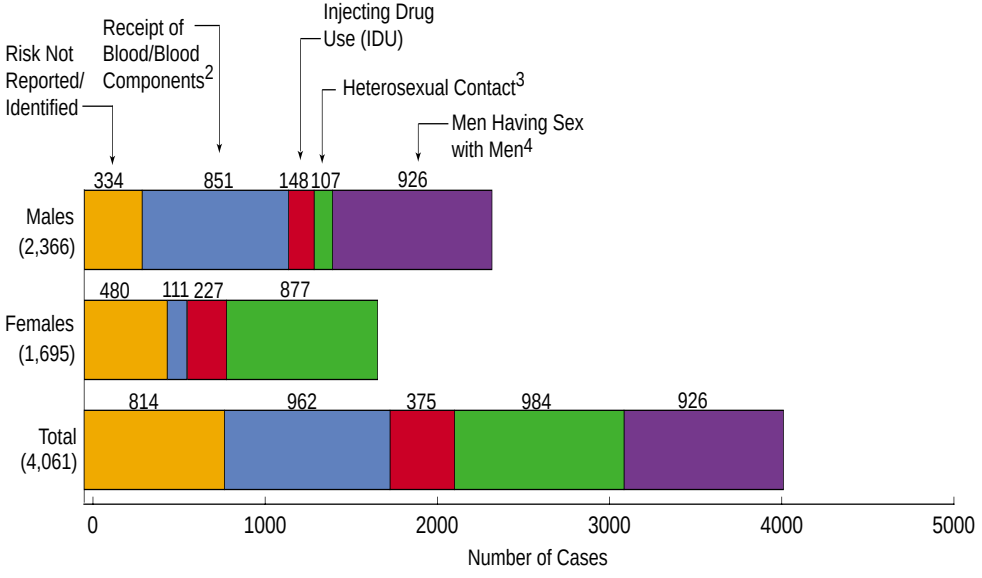
ADOLESCENT AIDS

Males comprise 58 percent of the 4,061 AIDS cases ever reported among adolescents aged 13-19 years old and represent 46 percent of the new AIDS cases reported among adolescents in 2000. About one third of these new cases were transmitted by men having sex with men. The risk category was not reported or identified for 45 percent of adolescent male AIDS cases reported in 2000.

Forty-two percent of adolescent AIDS cases ever reported were among females. The proportion of AIDS cases that are new in adolescent females has been increasing in recent years. However, 54 percent of new AIDS cases reported in 2000 were among adolescent females, down from 58 percent in 1999. Of these, 40 percent acquired HIV infection through heterosexual contact, nearly 8 percent had sex partners who were injecting drug users, and 7 percent were injecting drug users themselves. The risk category was not reported for 51 percent of new adolescent female cases in 2000.

ADOLESCENT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 13-19: 1981-2000

Source (II.8): Centers for Disease Control and Prevention



Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV- infected persons with CD4 counts of less than or equal to 200 cells/uL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

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3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS

As of December 31, 2000, 27,232 cases of AIDS were reported in young adults aged 20-24 years. This total includes 1,346 newly reported cases in 2000. The number of newly reported cases decreased by 10 percent from 1999 to 2000.

Males aged 20-24 years represent 60 percent of the AIDS cases reported in 2000. However, from 1999 to 2000, the number of newly reported AIDS cases among young adult men aged 20-24 years has decreased by 15 percent. Over half of these new cases were transmitted by men having sex with men.

Newly reported AIDS cases among females 20-24 years of age decreased by 3 percent from 1999 to 2000. Young adult women are exposed to HIV primarily through injecting drug use (26 percent) and through heterosexual sex (55 percent), including having sex with an injecting drug user.

Notes:

1 On January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV- infected persons with CD4 counts of less than or equal to 200 cells/uL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

2 Receipt of Blood/Blood components:

- Received clotting factor for hemophilia coagulation disorder

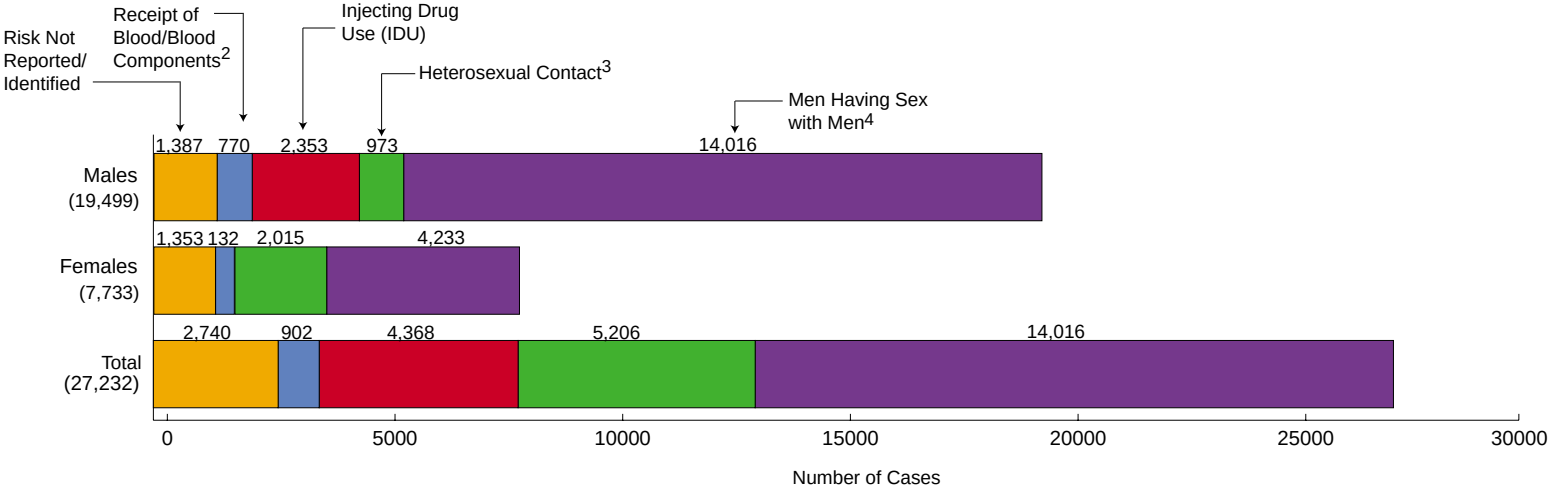
- Received blood transfusions, blood components, or tissue

3 Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV infected person, risk not specific; a bisexual male (females only).

4 The category "Men who have sex with men" includes men who have sex with men and inject drugs.

YOUNG ADULT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 20-24: 1981-2000

Source (II.8): Centers for Disease Control and Prevention



VIOLENCE

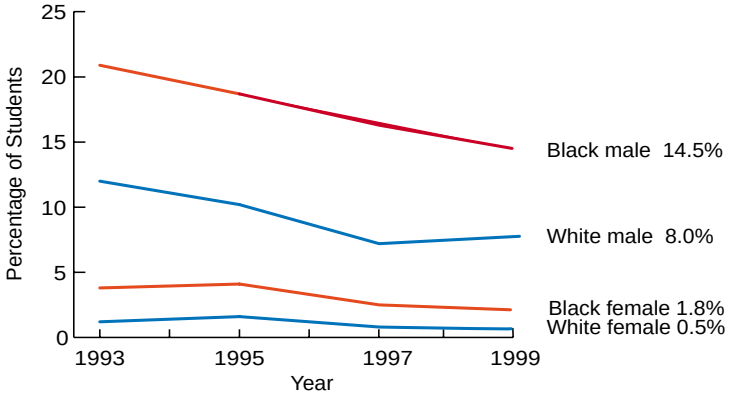
Violence among adolescents has been a longstanding problem in the United States. Firearms (including homicides, suicides, and accidents) were the second leading external cause of death in adolescents ages 15-19 in 1999.

Results of the Youth Risk Behavior Surveillance System (YRBSS) show that in 1999, 17.3 percent of high school students had carried a weapon, such as a gun, knife, or club on one or more days in the last 30 days; nearly 5 percent of students had carried a gun. Boys (28.6 percent) were more than four times as likely as girls (6.0 percent) to carry a weapon. The percentage of high school students who carry weapons has decreased 22 percent since 1993.

Some high school students also reported taking weapons to school. In 1999, 6.9 percent of students had carried a weapon on school property in the last thirty days—a decrease of 42 percent since 1993. However, despite the fact that the percentage of high school students who carry weapons on school property has declined in recent years, the percentage of students who reported being threatened or injured with a weapon on school property in 1999 (7.7 percent) has remained about the same since 1993. In addition, five percent of high school students felt too unsafe to go to school. Girls, younger students, and Black and Hispanic students expressed the most concern for their safety.

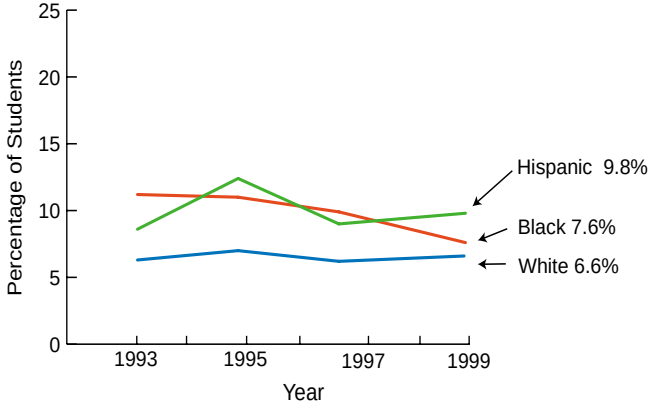
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO CARRIED A GUN IN THE PAST 30 DAYS, BY SEX AND RACE, 1993-1999

Source (II.10): Centers for Disease Control and Prevention



PERCENTAGE OF HIGH SCHOOL STUDENTS WHO WERE THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY, BY RACE, 1993-1999

Source (II.10): Centers for Disease Control and Prevention



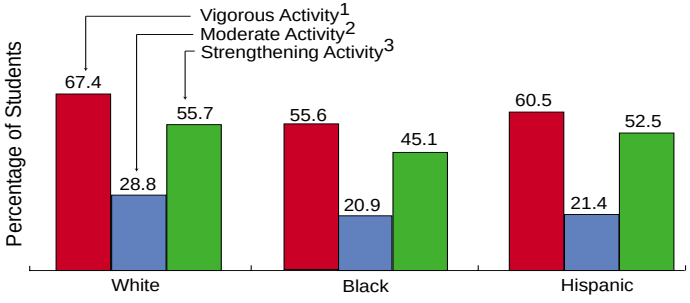
PHYSICAL ACTIVITY AND OVERWEIGHT

Results of the 1999 Youth Risk Behavior Surveillance System Survey (YRBSS) show that nearly two-thirds of students participate regularly in vigorous physical activity and over one quarter regularly participate in moderate physical activity. Furthermore, 54 percent of the students do regular strengthening exercises. Nationwide, 56 percent of students were enrolled in a physical education class, but students in 9th grade were significantly more likely to be enrolled than students in 11th and 12th grades.

The 1999 YRBSS revealed that 30 percent of high school students thought that they were overweight, representing a 10 percent increase from 1997 data. Approximately 43 percent of students were attempting weight loss. Female students were more than twice as likely as male students to be attempting weight loss (59 percent versus 26 percent). Nationwide, 40 percent of all students had dieted either to lose weight or to keep from gaining weight during the 30 days preceding the survey. Nearly 60 percent of students had exercised either to lose weight or to keep from gaining weight.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 1999

Source (II.10): Centers for Disease Control and Prevention



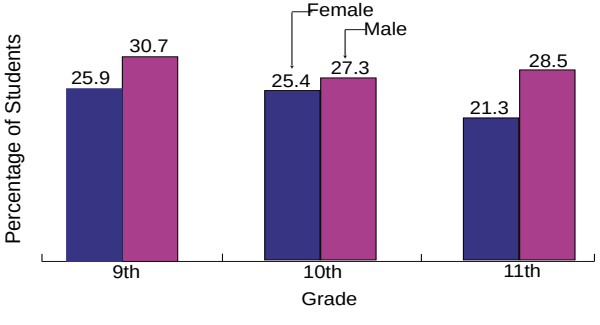
1 Activities that caused sweating and hard breathing for at least 20 minutes ≥ 3 of the preceding 7 days

2 Walked or bicycled for at least 30 minutes on ≥ 5 of the 7 days preceding the survey.

3 Such as push-ups, sit-ups, or weight lifting on ≥ 3 of the 7 days preceding the survey.

PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN MODERATE PHYSICAL ACTIVITY, BY GRADE: 1999

Source (II.10): Centers for Disease Control and Prevention



CIGARETTE SMOKING

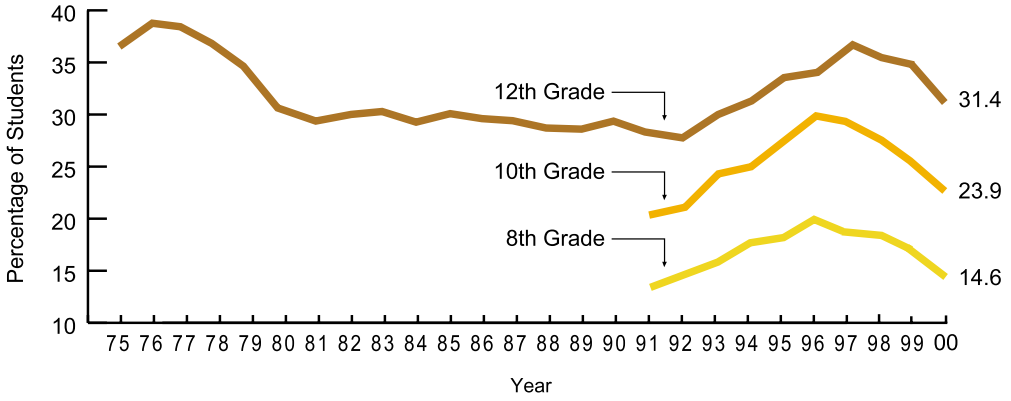
Cigarette smoking among eighth, tenth, and twelfth graders continued to decline in 2000 from a high in 1996, as reported by the University of Michigan's Monitoring the Future Study. All three grades showed a statistically significant decrease from 1999 on one or more smoking measures—current smoking, current daily smoking, or current half-pack-a-day-smoking. Just over 31 percent of high school seniors reported smoking during the 30 days prior to the survey, while nearly 24 percent and 15 percent of tenth and eighth graders respectively had smoked during the same time period. While all grades showed a decrease between 1999 and 2000, high school seniors reported the largest decrease on this measure, 9.2 percent. Researchers speculate that these declines result from an increase in the perceived risk and disapproval of smoking, increases in cigarette price, and declining accessibility to cigarettes. These improvements are likely to have significant long-term health consequences for this generation of adolescents.

The prevalence of smoking among teens increased substantially between 1991 and 1996. These increases occurred in virtually every sociodemographic group; among both sexes, among those college-bound or not, among the four regions of the country, among those living in rural or urban areas, and among whites, blacks, and Hispanics. While this increase occurred broadly, the recent decline between 1996 and 2000 also occurred within these same groups.

Though absolute rates of smoking have declined among adolescents, certain subgroups are less likely to smoke than others. Black adolescents are less likely to smoke than whites or Hispanics. Those who will attend college are less likely to smoke than those who do not plan to complete college. Urban teens are less likely to smoke than those living in non-urban areas.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF CIGARETTE SMOKING FOR 8TH, 10TH, AND 12-GRADERS: 1975-2000

Source (II.13): The Monitoring the Future Study, University of Michigan



SUBSTANCE ABUSE

Prevalence and Incidence

Results of the Substance Abuse and Mental Health Services Administration's 1999 National Household Survey on Drug Abuse (NHSDA) show that the percentage of adolescents ages 12-17 who reported using illicit drugs in the month prior to the survey continued to decline. The rate of adolescent use of any illicit drugs declined from 11.4 percent in 1997 to 9.9 percent in 1998 to 9.0 in 1999.

There was no statistically significant change in the reported use of alcohol, marijuana, cocaine, heroin, hallucinogens, or inhalants from 1998 to 1999. However, the proportion of adolescents reporting using marijuana in the past month decreased from 8.3 percent in 1998 to 7.0 in 1999. Marijuana use among adolescents has declined substantially from the highest level recorded in 1979 (14.2 percent); however, use has more than doubled from the lowest recorded rate of 3.4 percent in 1992. Nineteen percent of adolescents age 12-17 are current drinkers. Of these, 7.8 percent reported binge drinking, and 3.6 percent reported heavy alcohol use.

A new component of the 1999 NHSDA revealed that more than 1.5 million Americans under the age of 18 first used marijuana in 1998. The youth rates of marijuana initiation have increased considerably since the early 1990s. Also, one quarter of those who reported smoking, sniffing, or snorting heroin for the first time in 1998 were persons under the age of 18, representing approximately 125,000 youth.

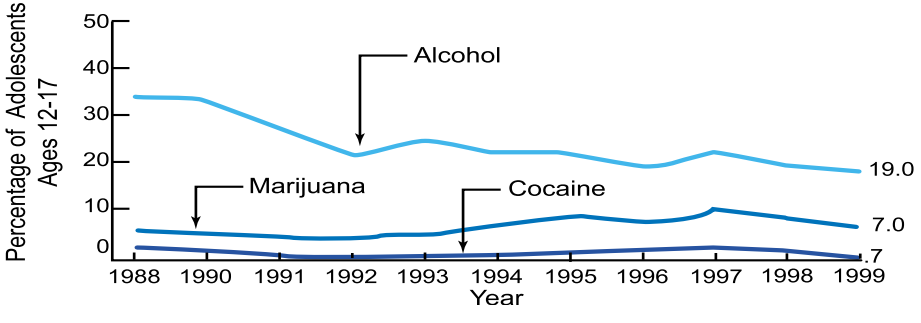
Perception of Risk and Access to Drugs

In 1999, 29 percent of adolescents perceived smoking marijuana to be risky, a decline from 1998, though not a statistically significant change. The percent of adolescents who perceived cocaine use to be risky dropped significantly from 54.3 percent in 1998 to 49.8 percent in 1999.

Fifty-seven percent of the adolescents surveyed in 1999 reported that marijuana was easy to obtain, and approximately 16 percent of respondents reported being approached by someone selling drugs in the month prior to the survey.

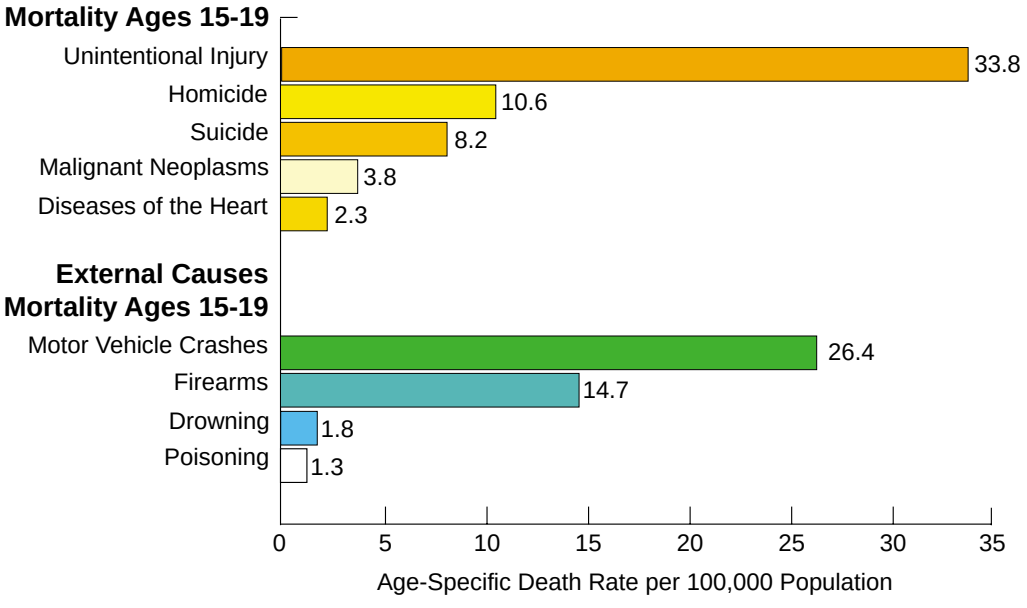
THIRTY-DAY PREVALENCE OF DRUG USE AMONG ADOLESCENTS AGES 12-17: 1988-1999

Source (II.14): National Household Survey on Drug Abuse, SAMHSA



LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15-19: 1999*

Source (II.4): National Center for Health Statistics



*preliminary data

ADOLESCENT MORTALITY

In 1999 preliminary data, there were 13,777 deaths of adolescents aged 15-19 years. In that age group, injury was the leading cause of death. The 6,677 unintentional injury deaths accounted for 48 percent of all deaths of 15- to 19-year-olds in 1999. Homicide and suicide were the next leading causes of death, accounting for 15 and 12 percent, respectively, of all deaths among 15- to 19-year-olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15- to 19-year-olds in the mid-to-late 1980s. The death rate among that age group has decreased almost 20 percent since 1993.

Motor vehicle crashes were the leading cause of injury mortality among 15- to 19-year-olds in 1999, accounting for 79 percent of accidents among teenagers. Firearms were the next leading cause of injury death, representing 27 percent of all injury deaths among 15- to 19-year-olds.

ADOLESCENT DEATHS DUE TO INJURY

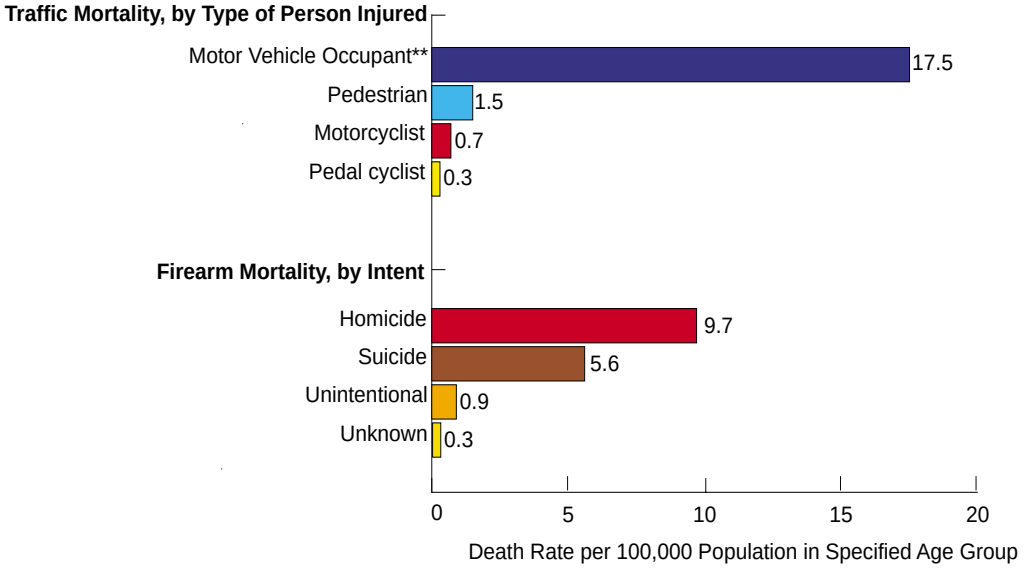
In 1999, motor vehicle crashes caused the deaths of 5,286 15- to 19-year-olds. In previous years the vast majority of those killed were in motor vehicles, either as passengers or the driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among teenagers.

Results of CDC's 1999 Youth Risk Behavior Surveillance System (YRBSS) survey revealed that in the 30 days preceding the survey, 16.4 percent of respondents had rarely or never used a safety belt, and 33.1 percent had ridden with a driver who had been drinking alcohol.

In 1999, 2,895 15- to 19-year-olds were killed by firearms. Homicide accounted for 60 percent of firearm deaths among teenagers, 34.2 percent were suicide, and 4.4 percent were considered to be unintentional.

MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15-19: 1998*

Source (II.5): National Center for Health Statistics



*At the time of this writing detailed data were not available for adolescent injury.

**Includes the driver.

HEALTH SERVICES AND UTILIZATION

The availability of, and access to, quality health care directly affects the health of mothers and children, especially those at high risk due to chronic medical conditions or low socioeconomic status. As more mothers and children become enrolled in Medicaid managed care, monitoring quality assurance has become, and will continue to be, increasingly important.

Every state has begun to implement a State Children's Health Insurance Program (SCHIP), using Federal funds that became available for the first time in 1998. This program will help to provide coverage to the approximately 10 million uninsured children in the U.S. Outreach and consumer education are therefore key components of the expansion of health insurance coverage for children.

The following section presents data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are presented by age, ethnicity, and income.

HEALTH CARE FINANCING

A report from the Employee Benefit Research Institute (EBRI) indicated that 13.9 percent, or 10 million children younger than 18 years of age, had no insurance coverage in 1999, a decrease of nearly 10 percent since 1998.

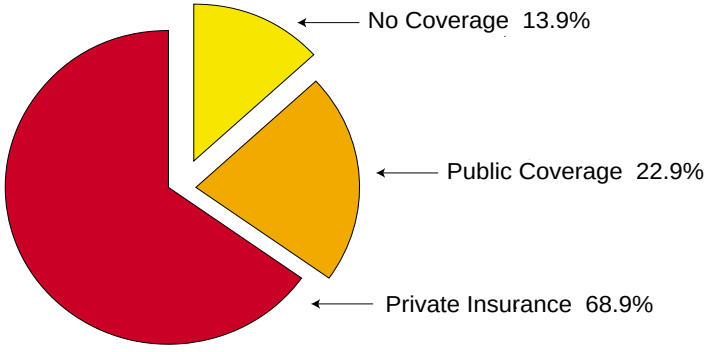
Nearly one quarter of children (22.9 percent) were publicly insured, primarily through Medicaid, and 68.9 percent were covered by private insurance. Most privately insured children (89 percent) received insurance through their parents' employer, but such coverage, when available, is increasingly expensive and requires parental copayments.

Of children younger than 18 whose families lived in poverty, 59.2 percent were publicly insured and 23.2 percent had private coverage. However 24.2 percent of children in poverty had no health coverage in 1999. An estimated 85.1 percent of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year.

The percentage of uninsured children living in families slightly above the poverty level decreased significantly from 27.2 percent uninsured in 1998 to 19.7 percent in 1999. Created in response to the growing number of uninsured children in low-income working families, the State Children's Health Insurance Program (SCHIP) enrolled more than 3 million children by the end of Federal Fiscal Year 2000. According to EBRI, the increases in private insurance contributed more to this decline in uninsured children than did the Medicaid and SCHIP expansions.

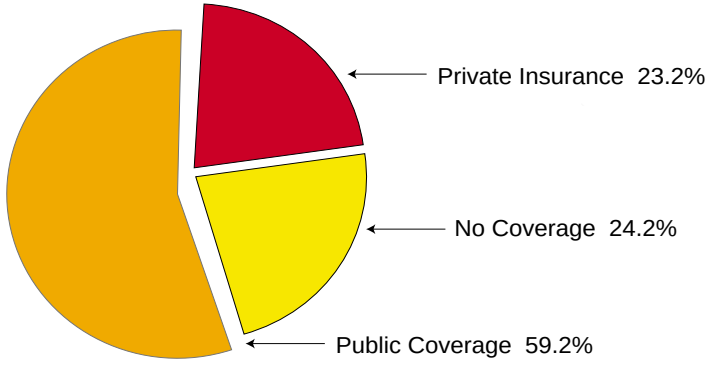
HEALTH INSURANCE COVERAGE: 1999
Source (III.1): Employee Benefit Research Institute

Children Under 18 Years of Age



HEALTH INSURANCE COVERAGE: 1999
Source (III.1): Employee Benefit Research Institute

Children Under 18 Years of Age In Poverty



VACCINATION COVERAGE LEVELS

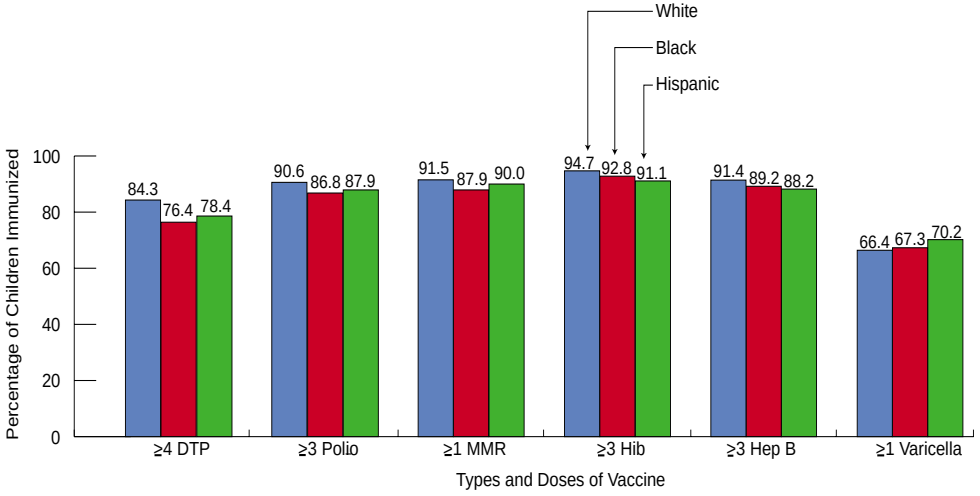
The Year 2010 objective for the complete series of routinely recommended childhood vaccinations is immunization of at least 80 percent of 19 to 35 month-olds with the full series of vaccines. Data released from CDC's 2000 National Immunization Survey revealed that nearly 73 percent of children aged 19-35 months received the recommended vaccines (4 DTaP, 3 polio, 1 MCV, 3 Hib, 3 hepatitis B) in 2000. The greatest progress among children aged 19-35 months was seen in the rate of hepatitis B vaccination, which showed a 32.8 percent increase, from 68 percent in 1995 to 90.3 percent in 2000. The FDA-approved varicella (chicken pox) vaccine, which was added to the schedule in 1996, was administered to 67.8 percent of children aged 19- 35 months in 2000.

However, approximately 1 million children still need one or more of the recommended doses of a series of vaccine to be fully protected. Coverage varies by race and ethnicity and state and urban areas. With the exception of the varicella vaccine, a greater proportion of white children aged 19-35 months receive the recommended immunizations compared to black and Hispanic children.

In January 2001, CDC published an updated immunization schedule (see facing page). The new schedule includes the heptavalent conjugate pneumococcal vaccine (PCV), which is recommended for all children 2-23 months of age. Hepatitis A was added to the schedule in 2000 for states and regions where incidence of this disease is especially high.

ESTIMATED VACCINATION COVERAGE AMONG CHILDREN AGED 19-35 MONTHS BY RACE/ETHNICITY: 2000

Source (III.2): Centers for Disease Control and Prevention



RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, JANUARY–DECEMBER 2001

Source (III.3): Centers for Disease Control and Prevention

VACCINE * / AGE*	Routinely recommended age for vaccination											
	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	14-18 yrs.
Hepatitis B[2]	Hep B #1											
		Hep B #2				Hep B #3					Hep B[2]	
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP[3]			DTaP	Td	
H. influenzae type b[4]			Hib	Hib	Hib	Hib						
Inactivated Polio[5]			IPV	IPV	IPV[5]					IPV[5]		
Pneumococcal Conjugate[6]			PCV	PCV	PCV	PCV						
Measles, Mumps, Rubella[7]						MMR				MMR[7]	MMR[7]	
Varicella[8]						Var					Var[8]	
Hepatitis A[9]									Hep A-in selected areas[9]			

Vaccines[1] are listed under routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

On October 22, 1999, the Advisory Committee on Immunization Practices (ACIP) recommended that Rotashield (RRV-TV), the only U.S.-licensed rotavirus vaccine, no longer be used in the United States (MMWR, Volume 48, Number 43, Nov. 5, 1999). Parents should be reassured that their children who received rotavirus vaccine before July are not at increased risk for intussusception now.

[1]This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of 11/1/00, for children through 18 years of age. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2]Infants born to HBsAg-negative mothers should receive the 1st does of hepatitis B (Hep B) vaccine by age 2 months. The 2nd dose should be at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1at dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months of age.

Infants born to HBsAg status unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

All children and adolescents who have not been immunized against hepatitis B should begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

[3]The 4th dose of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose of the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

[4]Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvacHIB[r] or ComVax[r] [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2,4 or 6 months of age, unless FDA-approved for these ages.

[5]An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years of age. Oral polio vaccine (OPV) should be used only in selected circumstances. (See MMWR May 19, 2000/49(RR-5);1-22).

[6]The heptavalent conjugate pneumococcal vaccine (PCV) is recommended for all children 2-23 months of age. It also is recommended for certain children 24-59 months of age. (See MMWR Oct. 6, 2000/49(RR-9);1-35).

[7]The 2nd dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

[8]Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.

[9]Hepatitis A (Hep A) is shaded to indicate its recommended use in selected states and/or regions, and for certain high risk groups; consult your local public health authority. (See MMWR Oct. 1, 1999/48 (RR-12); 1-37).

DENTAL CARE

Access to oral health care is a significant problem for low-income children. The 1997 National Survey of America's Families conducted by the Urban Institute found that almost one in ten low-income children had an unmet need for dental care. Nearly thirty percent of low-income children had not been to the dentist in the last year, and almost 60 percent had not received the two dental checkups in the last year recommended by the American Academy of Pediatrics.

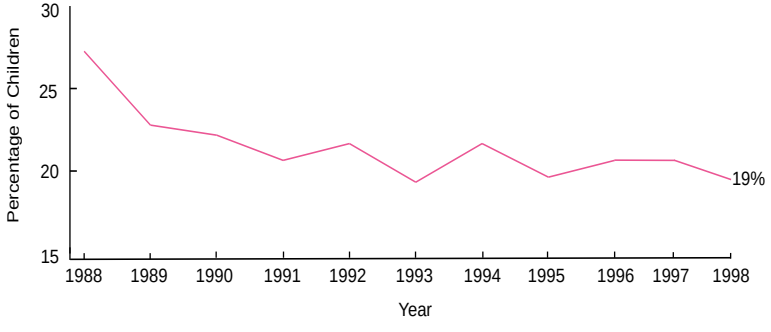
Utilization of dental care among low-income children varies by a number of demographic characteristics. Low-income children who have not had a dental visit in the last year are more likely to be younger, uninsured, in fair or poor health, Hispanic, and born outside the United States. These children are also more likely to have parents who did not graduate from high school or earn a GED, and to live in the southern or western states.

Although many dental problems can be prevented with regular screening and preventive services, these services are not always available to those children who need them most. In Federal Fiscal Year 1998, only 19 percent of children eligible for dental services under the Medicaid Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) program received a preventive dental service.

Forty-nine States and the District of Columbia provide statewide dental coverage for children enrolled in the State Children's Health Insurance Program (SCHIP).

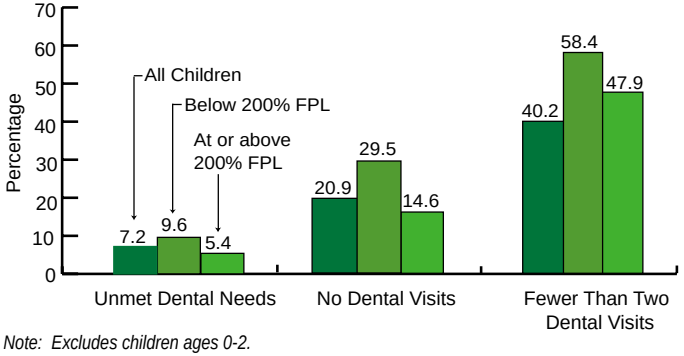
PERCENTAGE OF CHILDREN RECEIVING AN EPSDT PREVENTIVE DENTAL SERVICE: 1988-1998

Source (III.4): Health Care Financing Administration



PERCENTAGE OF CHILDREN WITH DENTAL CARE NEEDS AND THOSE RECEIVING DENTAL CARE IN THE LAST 12 MONTHS BY INCOME: 1997

Source (III.5): National Survey of America's Families, Urban Institute

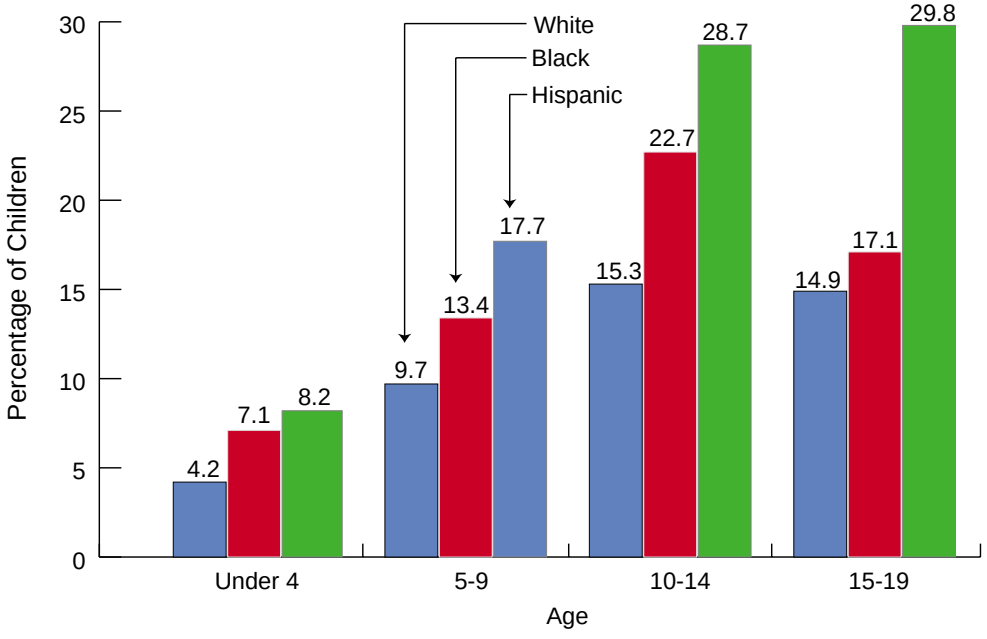


Note: Excludes children ages 0-2.


SAN LORENZO HEALTHY STAT

PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 1998

Source (III.6): National Center for Health Statistics



PHYSICIAN VISITS

In 1998, approximately 6 percent of preschoolers and 12 percent of children aged 5-9 had not been seen by a physician in the past year. In all age groups, Hispanic children were almost twice as likely as whites not to have a physician visit. During 1998, 4.2 percent of white, 7.1 percent of black, and 8.2 percent of Hispanic children under age four were not seen by a physician.

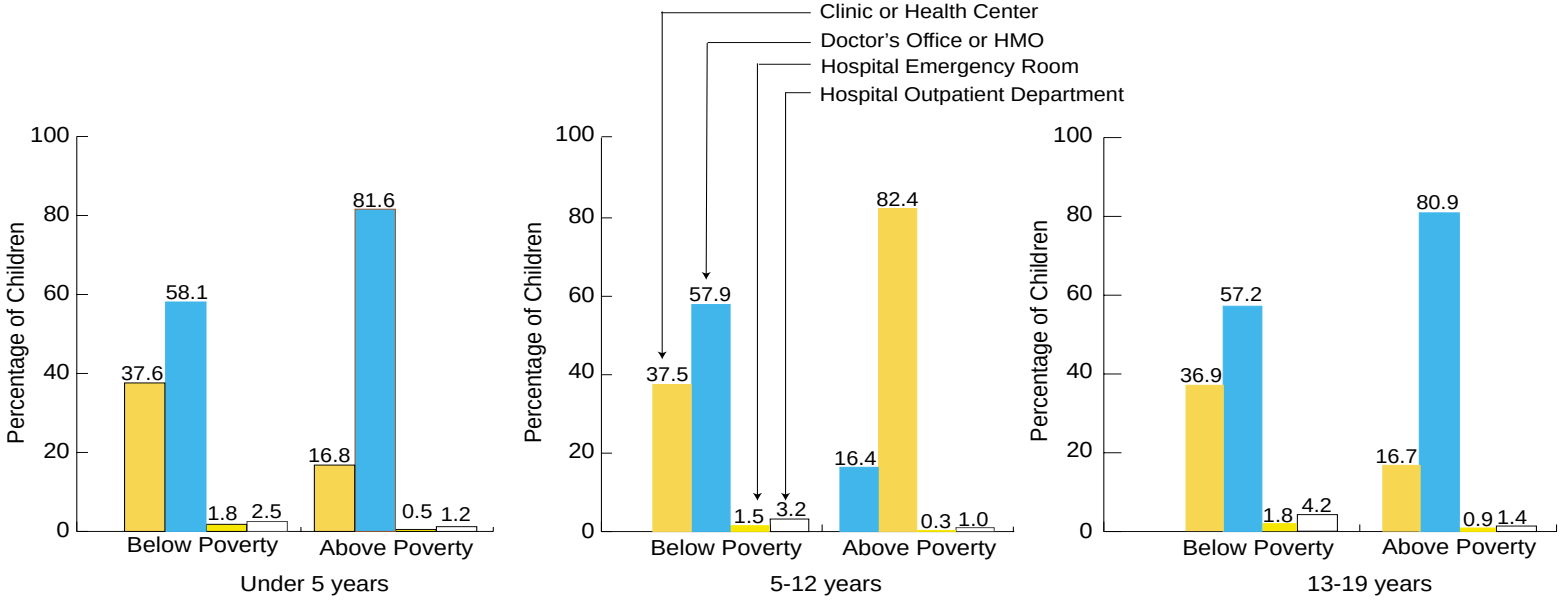
Experts recommend that children see a doctor eight times in their first year, three times in their second year, and once a year until age six. In each age group, a higher percentage of black and Hispanic children compared to white children had not been seen by a physician in the past year.

PLACE OF PHYSICIAN CONTACT

Among children who saw a physician in the past year, higher percentages of children across all age and ethnic groups sought care through doctors' offices and HMOs. Children in families above poverty were approximately five times more likely to seek care through a doctor's office or HMO compared to a clinic or health center. Children in poverty were twice as likely to use a clinic or health center as their usual source of care than were non-poor children. All sub-sets of children reported the hospital emergency room as the least utilized source of acute care.

USUAL SOURCE OF ACUTE CARE: 1998

Source (III.6): National Center for Health Statistics



SERVICE USE BY CHILDREN WITH CHRONIC CONDITIONS

Physician Use

In 1998, 38 percent of children under age five who were limited in their activities** had 13 or more physician visits over the past year, while only 3.6 percent of children under age five who were without limitations reported the same number of visits. Over all age groups, children with activity limitations were three to five times as likely to have ten or more visits than were children without limitations.

Hospital Use

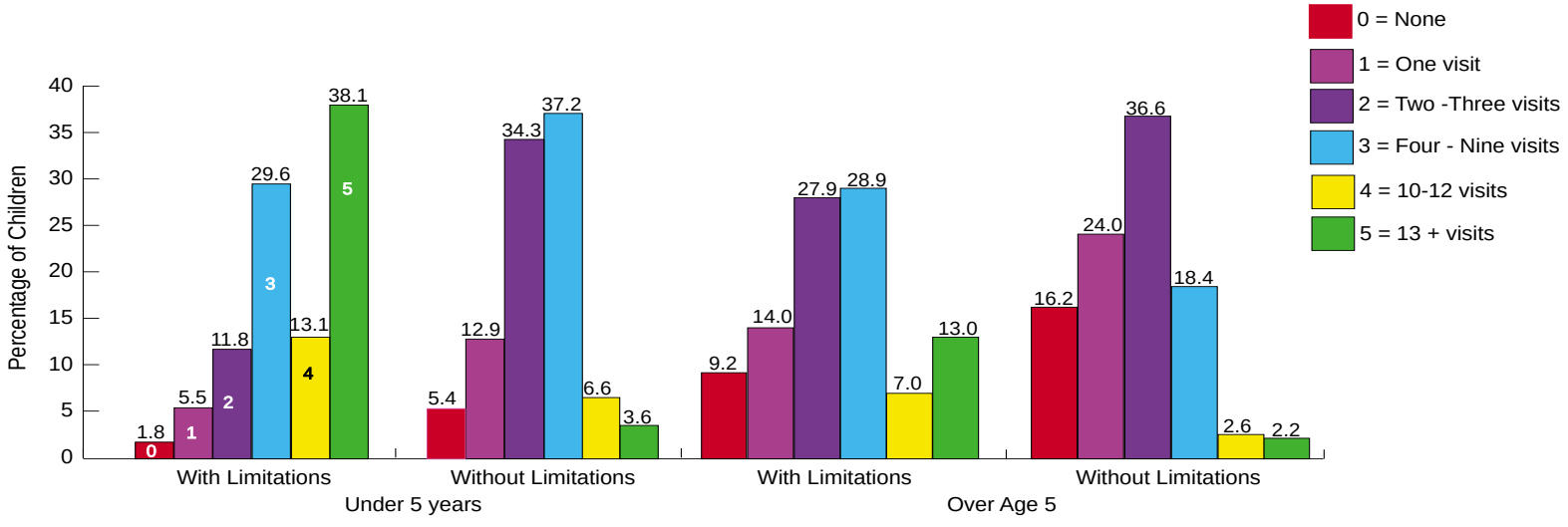
Children with activity limitations spend about four times as many days in the hospital (including deliveries) as children without activity limitations.

**Chronic conditions persist for more than three months. Conditions that are considered chronic regardless of their time of onset include diabetes and heart conditions.*

***In the NHIS, children are categorized as limited in their activities when their ability to perform the usual activities associated with the child's age group, such as school or play, are compromised by a chronic condition.*

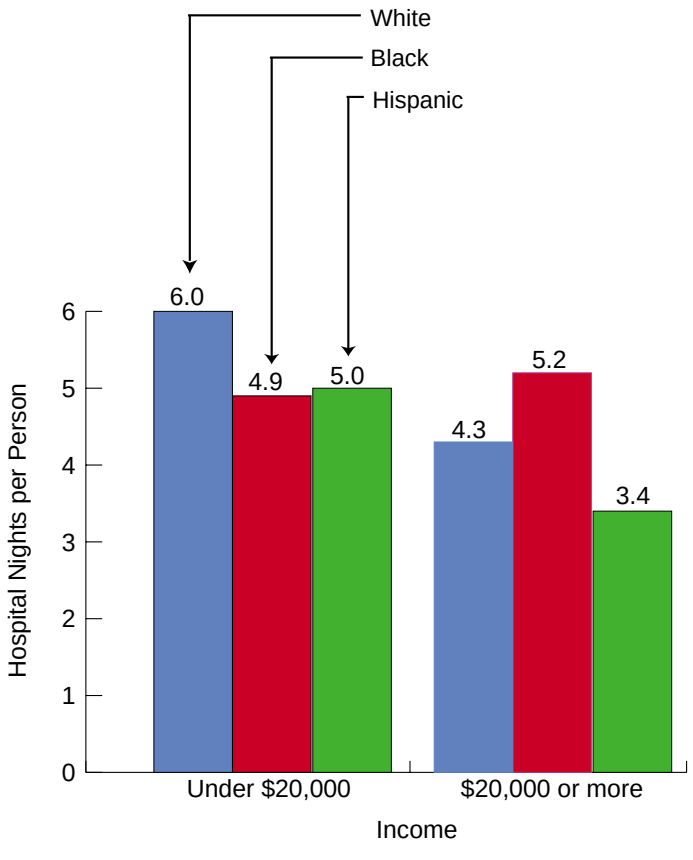
PHYSICIAN UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1998

Source (III.6): National Center for Health Statistics



HOSPITAL UTILIZATION BY INCOME AND RACE: 1998

Source (III.6): National Center for Health Statistics



HOSPITAL UTILIZATION

In 1998, children younger than 18 in families with less than $20,000 averaged slightly more nights in the hospital (including deliveries) than children in higher-income families. Lower-income white and Hispanic children averaged 6.0 and 5.0 nights in the hospital respectively, while higher-income black children averaged 5.2 nights.

PRENATAL CARE

Early Prenatal Care

The proportion of mothers beginning prenatal care in the first trimester of pregnancy increased for the tenth consecutive year, rising from 82.8 percent in 1998 to 83.2 percent in 1999.

However, the racial disparity in early entry into prenatal care persists. In 1999, 85 percent of white mothers, compared to 74 percent of black mothers, received early prenatal care.

Women younger than 20 are much less likely than older women to receive early prenatal care.

Late or No Prenatal Care

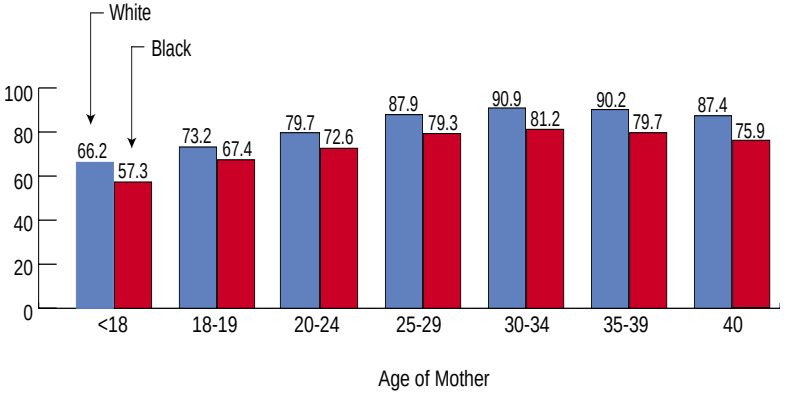
Every year from 1983 to 1991, 6 percent of all mothers initiated care in the third trimester or received no prenatal care at all. However, that figure declined to 4 percent in 1996 and remains at that level in 1999.

Regardless of age, black women are more likely than white women to receive late or no prenatal care.

Risk factors for not using prenatal care include being less than 18 years old, being unmarried, having low educational attainment, and being a member of a racial or ethnic minority.

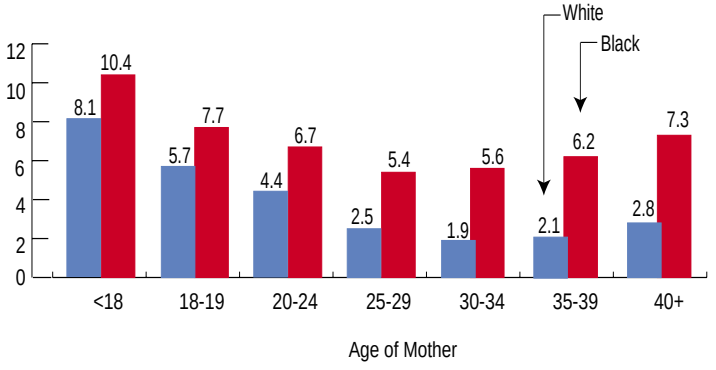
PERCENTAGE OF MOTHERS BEGINNING PRENATAL CARE IN THE FIRST TRIMESTER, BY AGE AND RACE: 1999

Source (III.7): National Center for Health Statistics



PERCENTAGE OF MOTHERS RECEIVING LATE OR NO PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1999

Source (III.7): National Center for Health Statistics



STATE DATA

While the indicators presented in the previous sections of this book are representative of the U.S. as a whole, the next section presents state-level health status indicators, data on infant, neonatal, and perinatal mortality, low birth weight, early prenatal care, births to women under 18, health care financing for children, Medicaid enrollment and expenditures, and SCHIP enrollment.

The following pages reveal stark disparities in the health status of children living in different states. Women living in the District of Columbia, Louisiana, and Mississippi were more likely to give birth to low birth weight babies (less than 2,500 grams or 5.5 pounds) than women in other regions of the country. These same states along with Alabama, Arkansas, New Mexico, South Carolina, and Texas also had the highest rates of births to women under 18 years of age.

Poverty in the U.S. has continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) assures that children living in poverty receive adequate health care services. In 1999, the District of Columbia had the greatest proportion of children with Medicaid coverage (42.9 percent), while Utah had the smallest proportion (9.0 percent). The national average was 19.8 percent. The proportion of children with private or employer-based coverage significantly increased by 2 percent between 1997 and 1999, driven by growth in 13 states. Fifteen states also experienced a significant decline in their proportion of uninsured children. In 19 states, 10 percent or fewer of children were uninsured, while eight states had 19 percent or more uninsured. New Mexico led the states with the highest proportion of uninsured children at 27.8 percent, while Missouri had the lowest at 5.9 percent. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status.

The challenge to health care providers and policy-makers continues to be eliminating the disparities among states while improving the health status of children throughout the entire Nation.

PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT, WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE, AND BIRTHS TO WOMEN UNDER 18, BY RACE OF MOTHER AND STATE: 1999

Source (IV.1): National Center for Health Statistics

State	Percentage at Low Birth Weight			Percentage with Early Prenatal Care			Percentage of Births to Women < 18			
	All***	White	Black	All***	White	Black	All***	White	Black	Hispanic
UNITED STATES†	**7.6**	**6.6**	**13.1**	**83.2**	**85.1**	**74.1**	**4.4**	**3.7**	**8.2**	**6.7**
ALABAMA	9.3	7.3	13.6	83.2	88.9	71.4	6.0	4.3	9.3	6.5
ALASKA	5.8	5.3	10.5	79.4	82.2	83.6	4.2	2.8	5.7	4.6
ARIZONA	6.9	6.6	12.1	75.9	76.6	74.5	5.5	5.3	8.7	8.3
ARKANSAS	8.6	7.4	13.0	79.0	81.7	69.4	6.0	4.7	11.1	5.7
CALIFORNIA	6.1	5.5	11.7	83.6	83.6	81.0	4.1	4.3	6.0	6.0
COLORADO	8.3	8.0	13.8	81.7	82.0	75.4	4.3	4.2	7.1	8.6
CONNECTICUT	7.6	6.8	13.1	89.3	90.6	81.0	2.9	2.5	6.2	8.8
DELAWARE	8.6	6.8	13.8	83.7	86.4	75.5	5.0	3.5	9.7	6.3
DC	13.1	6.4	16.1	71.9	82.7	67.1	6.3	2.1	8.2	5.3
FLORIDA	8.2	6.9	12.2	83.9	87.1	73.6	4.7	3.7	8.3	5.0
GEORGIA	8.7	6.7	12.7	87.3	90.4	81.1	5.3	4.0	8.0	5.3
HAWAII	7.6	5.4	9.8	85.7	91.0	91.2	3.5	1.2	2.8	6.7
IDAHO	6.2	6.1	*	80.5	80.7	73.7	4.1	4.0	6.4	9.5
ILLINOIS	8.0	6.5	14.2	82.5	85.4	70.0	4.3	3.1	10.0	5.9
INDIANA	7.9	7.2	12.9	80.6	82.2	67.3	4.3	3.7	9.5	6.0
IOWA	6.2	5.9	12.6	87.7	88.3	74.8	3.3	3.1	9.5	7.8
KANSAS	7.1	6.7	12.2	85.8	86.7	76.9	4.0	3.6	9.3	7.6
KENTUCKY	8.2	7.6	14.0	86.6	87.4	78.3	4.9	4.6	8.1	5.7
LOUISIANA	10.0	6.9	14.5	82.9	89.7	73.2	6.4	4.0	10.1	4.3
MAINE	6.0	6.0	*	89.2	89.5	83.0	2.8	2.8	4.8	6.7
MARYLAND	9.0	6.7	13.5	87.0	91.4	78.0	3.9	2.3	7.2	3.5
MASSACHUSETTS	7.1	6.6	10.9	89.4	90.8	80.0	2.4	2.1	4.7	8.0
MICHIGAN	8.0	6.5	14.6	84.0	87.0	69.9	3.8	2.9	8.0	7.7
MINNESOTA	6.1	5.6	11.0	84.5	87.0	66.4	2.9	2.1	8.2	6.9
MISSISSIPPI	10.3	7.4	13.8	81.5	89.1	72.7	7.4	4.4	11.1	4.9
MISSOURI	7.7	6.7	13.7	87.1	89.0	76.4	4.5	3.7	9.3	5.8
MONTANA	6.8	6.8	*	83.8	85.8	85.7	3.8	3.1	11.4	5.0
NEBRASKA	6.7	6.4	12.9	84.4	85.4	73.8	3.5	3.0	11.2	7.5
NEVADA	7.6	7.0	12.4	75.2	75.5	69.6	4.8	4.6	8.6	6.7
NEW HAMPSHIRE	6.2	6.2	*	90.7	91.0	72.9	2.0	2.0	3.6	4.8
NEW JERSEY	8.2	6.9	13.4	81.3	85.1	64.8	2.6	1.9	6.3	5.3
NEW MEXICO	7.7	7.6	12.3	66.8	68.1	62.6	7.1	7.1	8.3	9.6
NEW YORK	7.8	6.8	11.7	81.0	84.2	71.0	3.0	2.5	5.5	5.2
NORTH CAROLINA	8.9	7.2	13.7	85.0	88.4	76.1	5.0	3.6	8.6	5.5
NORTH DAKOTA	6.2	6.2	*	86.3	88.3	72.1	2.7	2.2	5.8	5.0
OHIO	7.9	6.9	13.7	86.6	88.4	76.3	4.1	3.3	9.3	7.5
OKLAHOMA	7.4	7.0	11.9	80.5	82.6	73.1	5.5	4.8	9.0	7.7
OREGON	5.4	5.3	10.7	80.9	81.2	76.0	4.2	4.1	8.0	7.3
PENNSYLVANIA	7.9	6.8	14.3	85.2	87.6	71.6	3.6	2.7	9.4	9.6
RHODE ISLAND	7.3	6.8	11.3	91.3	92.4	83.2	3.5	3.0	5.8	7.2
SOUTH CAROLINA	9.8	7.2	14.7	80.7	85.9	70.9	6.0	4.0	9.6	6.3
SOUTH DAKOTA	5.9	5.9	*	83.4	87.0	74.2	3.5	2.4	3.4	7.3
TENNESSEE	9.2	7.9	14.2	84.3	87.0	74.6	5.3	4.2	9.4	6.0
TEXAS	7.4	6.6	12.6	79.3	79.3	76.7	6.1	6.0	8.5	8.2
UTAH	6.8	6.7	13.6	80.5	81.5	63.7	3.0	3.0	8.3	7.1
VERMONT	5.7	5.7	*	87.9	88.0	81.6	2.5	2.5	7.5	2.5
VIRGINIA	7.8	6.4	12.0	85.3	88.6	74.5	3.5	2.4	7.2	4.1
WASHINGTON	5.8	5.5	10.4	82.8	83.6	75.7	3.6	3.5	5.6	7.4
WEST VIRGINIA	8.0	7.9	12.3	85.1	85.6	70.7	4.5	4.4	8.8	10.4
WISCONSIN	6.7	5.9	13.4	84.1	86.6	69.1	3.7	2.6	12.3	7.8
WYOMING	8.4	8.1	*	83.0	83.4	76.4	4.6	4.5	2.8	8.3

** figure does not meet standards of reliability or precision*
† excludes data for the territories
**** includes races other than white and black*

MEDICAID ENROLLEES, EXPENDITURES, AND REPORTED EPSDT UTILIZATION FOR CHILDREN UNDER AGE 21: FY 1998 AND FY 1999

Source (IV.2): Centers for Medicare and Medicaid Services

State	Medicaid Enrollees*	Per Enrollee Expenditures**	Participant Ratio ***
ALABAMA	364,832	$750	.40
ALASKA	52,428	$2,361	.49
ARIZONA	412,367	$1,606	.60
ARKANSAS	236,727	$2,193	.21
CALIFORNIA	3,438,056	$1,079	.66
COLORADO	200,408	$1,822	.44
CONNECTICUT	213,695	$1,608	.51
DELAWARE	58,513	$2,138	.67
DC	81,278	$1,851	.52
FLORIDA	1,137,381	$1,194	.45
GEORGIA	746,845	$1,133	.44
HAWAII	87,249	$1,325	.64
IDAHO	74,589	$1,153	.42
ILLINOIS	1,045,873	$1,516	.69
INDIANA	371,973	$1,428	.48
IOWA	172,238	$1,914	.91
KANSAS	NA	$1,402	NA
KENTUCKY	335,619	$1,938	.41
LOUISIANA	430,065	$1,466	.61
MAINE	NA	$1,831	NA
MARYLAND	338,566	$1,871	.40
MASSACHUSETTS	564,560	$1,421	.46
MICHIGAN	781,009	$1,081	.40
MINNESOTA	333,186	$2,017	.47
MISSISSIPPI	298,274	$1,235	.42
MISSOURI	467,499	$1,182	.45
MONTANA	51,466	$1,762	.41
NEBRASKA	132,063	$1,408	.66
NEVADA	80,747	$2,042	.88
NEW HAMPSHIRE	58,861	$2,179	.73
NEW JERSEY	460,440	$1,731	.31
NEW MEXICO	231,378	$1,662	.49
NEW YORK	1,621,869	$2,571	.91
NORTH CAROLINA	674,006	$1,605	.67
NORTH DAKOTA	32,657	$1,817	.40
OHIO	796,056	$1,506	.33
OKLAHOMA	327,768	NA	.35
OREGON	255,894	$1,475	.45
PENNSYLVANIA	882,877	$1,732	.50
RHODE ISLAND	77,751	$2,046	.77
SOUTH CAROLINA	369,983	$1,371	.35
SOUTH DAKOTA	52,925	$1,871	.36
TENNESSEE	669,063	$987	.27
TEXAS	NA	$1,210	NA
UTAH	126,290	$1,544	.53
VERMONT	62,282	$1,412	.56
VIRGINIA	412,235	$1,238	.50
WASHINGTON	NA	$840	NA
WEST VIRGINIA	209,341	$1,223	.40
WISCONSIN	299,364	$1,582	.52
WYOMING	31,697	$1,502	.40

**Unduplicated number of individuals under the age of 21 determined to be eligible for EPSDT services (FY 1999 416 Report)*
***Represents total Medicaid vendor payments by age divided by Medicaid eligibles under 21 (FY 1998 2082 Report)*
****This ratio indicates the extent to which Medicaid eligibles receive any initial and periodic screening services during the year (FY 1999 416 Report)*

STATE CHILDREN'S HEALTH INSURANCE PROGAM (SCHIP) AGGREGATE ENROLLMENT STATISTICS: FY 2000

Source (IV.3): Health Care Financing Administration

State	Type of SCHIP Program*	Date Implemented	Upper** Eligibility	Total SCHIP Enrollment
ALABAMA	COMBO	02/01/98	200%	37,587
ALASKA	MEDICAID	03/01/99	200%	13,413
ARIZONA	SEPARATE	11/01/98	200%	60,803
ARKANSAS	MEDICAID	10/01/98	100%	1,892
CALIFORNIA	COMBO	03/01/98	250%	477,615
COLORADO	SEPARATE	04/22/98	185%	34,889
CONNECTICUT	COMBO	07/01/98	300%	18,804
DELAWARE	SEPARATE	02/01/99	200%	4,474
DC	MEDICAID	10/01/98	200%	2,264
FLORIDA	COMBO	04/01/98	200%	227,463
GEORGIA	SEPARATE	11/01/98	200%	120,626
HAWAII	MEDICAID	07/01/00	200%	2,256
IDAHO	MEDICAID	10/01/97	150%	12,449
ILLINOIS	MEDICAID	01/05/98	185%	62,507
INDIANA	COMBO	10/01/97	200%	44,373
IOWA	COMBO	07/01/98	200%	19,958
KANSAS	SEPARATE	01/01/99	200%	26,306
KENTUCKY	COMBO	07/01/98	200%	55,593
LOUISIANA	MEDICAID	11/01/98	150%	49,995
MAINE	COMBO	07/01/98	185%	22,742
MARYLAND	MEDICAID	07/01/98	200%	93,081
MASSACHUSETTS	COMBO	10/01/97	200%	113,034
MICHIGAN	COMBO	05/01/98	200%	37,148
MINNESOTA	MEDICAID	10/01/98	280%	24
MISSISSIPPI	COMBO	07/01/98	200%	20,451
MISSOURI	MEDICAID	09/01/98	300%	73,825
MONTANA	SEPARATE	01/01/99	150%	8,317
NEBRASKA	MEDICAID	05/01/98	185%	11,400
NEVADA	SEPARATE	10/01/98	200%	15,946
NEW HAMPSHIRE	COMBO	05/01/98	300%	4,272
NEW JERSEY	COMBO	03/01/98	350%	89,034
NEW MEXICO	MEDICAID	03/31/99	235%	6,106
NEW YORK	COMBO	04/15/98	192%	769,457
NORTH CAROLINA	SEPARATE	10/01/98	200%	103,567
NORTH DAKOTA	COMBO	10/01/98	140%	2,573
OHIO	MEDICAID	01/01/98	200%	111,436
OKLAHOMA	MEDICAID	12/01/97	185%	57,719
OREGON	SEPARATE	07/01/98	170%	37,092
PENNSYLVANIA	SEPARATE	05/28/98	200%	119,710
RHODE ISLAND	MEDICAID	10/01/97	250%	11,539
SOUTH CAROLINA	MEDICAID	10/01/97	150%	59,853
SOUTH DAKOTA	COMBO	07/01/98	200%	5,888
TENNESSEE	MEDICAID	10/01/97	100%	14,861
TEXAS	COMBO	07/01/98	200%	130,519
UTAH	SEPARATE	08/03/98	200%	25,294
VERMONT	SEPARATE	10/01/98	300%	4,081
VIRGINIA	SEPARATE	10/22/98	185%	37,681
WASHINGTON	SEPARATE	02/01/00	250%	2,616
WEST VIRGINIA	COMBO	07/01/98	150%	21,659
WISCONSIN	MEDICAID	04/01/99	185%	47,140
WYOMING	SEPARATE	12/01/99	133%	2,547

**Program type as of September 30, 2000.*

***Reflects upper eligibility level approved and in effect as of September 30, 2000.*

HEALTH INSURANCE STATUS FOR CHILDREN UNDER AGE 19: 1999

Source (IV.4): American Academy of Pediatrics' Analysis of 1998 and 2000 Current Population Survey

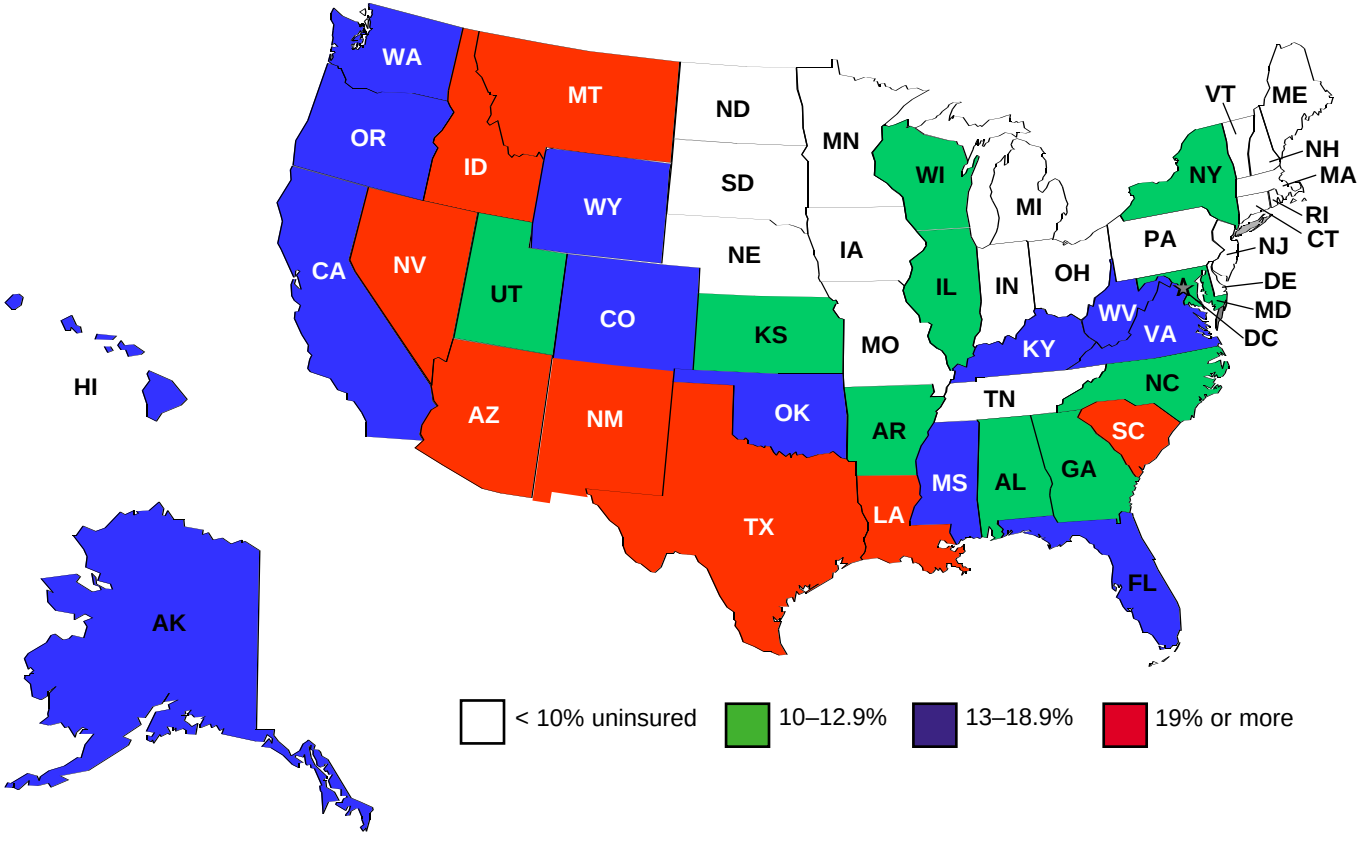
State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid	Percent Uninsured*
UNITED STATES	**66.0**	**19.8**	**14.1**
ALABAMA	63.1	25.4	11.6
ALASKA	61.6	21.5	16.9
ARIZONA	59.0	18.6	22.4
ARKANSAS	65.7	21.5	12.8
CALIFORNIA	56.9	24.5	18.6
COLORADO	74.1	9.4	16.5
CONNECTICUT	80.0	11.1	8.9
DELAWARE	63.8	28.8	7.4
DC	39.6	42.9	17.5
FLORIDA	63.4	19.1	17.5
GEORGIA	62.4	24.9	12.6
HAWAII	69.6	19.2	11.2
IDAHO	64.9	14.7	20.5
ILLINOIS	70.6	17.0	12.4
INDIANA	72.0	19.2	8.8
IOWA	80.6	13.2	6.2
KANSAS	74.7	12.5	12.8
KENTUCKY	66.7	19.8	13.5
LOUISIANA	52.5	23.0	24.5
MAINE	75.6	17.9	6.5
MARYLAND	78.9	10.5	10.6
MASSACHUSETTS	63.7	27.2	9.1
MICHIGAN	70.3	20.1	9.6
MINNESOTA	79.2	13.5	7.3
MISSISSIPPI	62.1	23.2	14.7
MISSOURI	73.7	20.4	5.9**
MONTANA	60.8	20.2	19.0
NEBRASKA	76.9	14.4	8.7
NEVADA	66.7	10.4	22.9
NEW HAMPSHIRE	77.4	17.0	5.6**
NEW JERSEY	75.5	14.4	10.1
NEW MEXICO	43.8	28.4	27.8
NEW YORK	59.4	28.4	12.2
NORTH CAROLINA	68.2	19.3	12.5
NORTH DAKOTA	72.3	17.5	10.2
OHIO	72.7	18.1	9.3
OKLAHOMA	65.5	17.1	17.4
OREGON	64.7	21.9	13.4
PENNSYLVANIA	74.3	18.1	7.7
RHODE ISLAND	75.9	17.5	6.6**
SOUTH CAROLINA	61.2	19.5	19.2
SOUTH DAKOTA	76.9	13.7	9.4
TENNESSEE	66.0	24.2	9.8
TEXAS	57.6	17.8	24.6
UTAH	79.5	9.0	11.5
VERMONT	53.5	38.2	8.3
VIRGINIA	75.8	10.5	13.8
WASHINGTON	68.8	17.6	13.6
WEST VIRGINIA	52.3	34.0	13.7
WISCONSIN	74.3	14.5	11.2
WYOMING	67.9	17.7	14.4

*See map on facing page

** Standard error is greater than 20% of estimate due to small state sample size.

PERCENTAGE OF CHILDREN UNDER THE AGE OF 19 WHO ARE UNINSURED: 1999

Source (IV.4): American Academy of Pediatrics' Analysis of 1998 and 2000 Current Population Survey



INFANT AND NEONATAL MORTALITY RATES, BY RACE OF MOTHER AND STATE: 1998

Source (IV.5): National Center for Health Statistics

State	Infant Mortality[1]			Neonatal Mortality[2]		
	All***	White	Black	All***	White	Black
UNITED STATES	**7.2**	**6.0**	**14.3**	**4.8**	**4.0**	**9.5**
ALABAMA	10.2	7.7	15.5	6.7	4.5	11.1
ALASKA	5.9	4.7	*	2.9	*	*
ARIZONA	7.5	6.9	20.0	4.8	4.5	13.9
ARKANSAS	8.9	7.6	14.0	5.5	4.7	8.5
CALIFORNIA	5.8	5.3	13.7	3.8	3.6	8.2
COLORADO	6.7	6.4	16.0	4.4	4.3	10.8
CONNECTICUT	7.0	5.6	17.4	5.1	4.2	12.5
DELAWARE	9.6	6.9	18.7	6.9	4.2	15.6
DC	12.5	*	15.5	7.2	*	8.6
FLORIDA	7.2	5.9	12.3	4.5	3.9	8.1
GEORGIA	8.5	6.0	13.4	5.8	4.0	9.4
HAWAII	6.9	5.3	*	5.1	*	*
IDAHO	7.2	7.1	*	4.6	4.5	*
ILLINOIS	8.4	6.4	17.2	5.6	4.5	10.5
INDIANA	7.6	6.5	17.3	5.2	4.3	12.0
IOWA	6.6	6.2	18.3	4.6	4.3	*
KANSAS	7.0	7.0	10.0	4.6	4.7	*
KENTUCKY	7.5	6.8	15.4	4.9	4.5	9.3
LOUISIANA	9.1	5.7	14.0	5.9	3.8	9.1
MAINE	6.3	6.4	*	4.2	4.2	*
MARYLAND	8.6	5.2	15.3	6.2	3.8	11.1
MASSACHUSETTS	5.1	4.9	8.3	3.9	3.7	6.5
MICHIGAN	8.2	6.3	16.8	5.3	4.1	11.0
MINNESOTA	5.9	5.1	13.4	4.0	3.6	8.7
MISSISSIPPI	10.1	6.3	14.8	6.2	3.3	9.7
MISSOURI	7.7	6.1	16.8	4.9	4.0	10.9
MONTANA	7.4	7.2	*	4.2	4.2	*
NEBRASKA	7.3	6.7	19.4	4.8	4.4	*
NEVADA	7.0	6.0	17.3	3.5	2.8	9.8
NEW HAMPSHIRE	4.4	4.3	*	3.4	3.3	*
NEW JERSEY	6.4	5.0	12.8	4.5	3.6	8.8
NEW MEXICO	7.2	6.9	*	4.4	4.3	*
NEW YORK	6.3	5.3	10.9	4.5	3.8	7.3
NORTH CAROLINA	9.3	6.5	17.6	6.4	4.4	12.6
NORTH DAKOTA	8.6	8.2	*	5.4	5.5	*
OHIO	8.0	7.0	14.2	5.4	4.8	8.9
OKLAHOMA	8.5	8.1	13.5	5.4	5.2	8.3
OREGON	5.4	5.3	*	3.2	3.1	*
PENNSYLVANIA	7.1	5.8	15.4	5.0	4.2	10.1
RHODE ISLAND	7.0	6.2	*	5.2	4.8	*
SOUTH CAROLINA	9.6	6.0	16.2	6.7	3.9	12.1
SOUTH DAKOTA	9.1	7.5	*	4.6	4.2	*
TENNESSEE	8.2	6.3	15.0	5.6	4.1	10.8
TEXAS	6.4	5.8	11.6	4.0	3.6	6.8
UTAH	5.6	5.7	*	3.6	3.6	*
VERMONT	7.0	6.8	*	5.8	5.7	*
VIRGINIA	7.7	5.7	14.9	5.4	3.8	11.1
WASHINGTON	5.7	5.2	13.5	3.6	3.3	8.7
WEST VIRGINIA	8.0	8.0	*	4.6	4.4	*
WISCONSIN	7.2	6.0	18.7	5.1	4.2	13.3
WYOMING	7.2	5.8	*	4.5	3.6	*

** Figure does not meet standards of reliability or precision*
*** Quantity zero*
**** Includes races other than white or black*

1 Rates are deaths less than one year per 1,000 live births in specified group.
2 Rates are deaths under 28 days per 1,000 live births in specified group.

CITY DATA

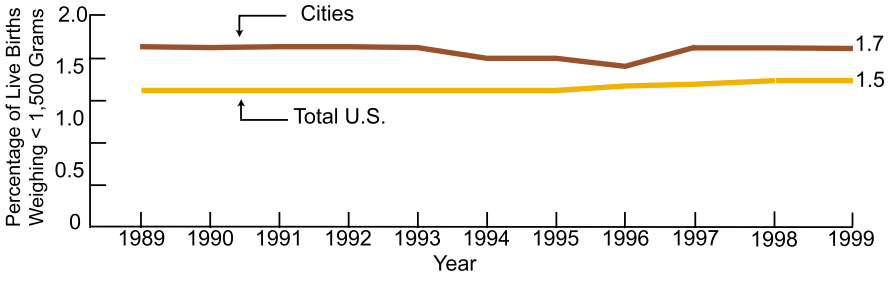
How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight, and prenatal care for women and children who reside in the Nation's central cities with populations over 100,000.

As the following data indicate, the health status of children living in large U.S. cities is generally inferior to that of children in the Nation as a whole. While the infant mortality rate has decreased in both cities and the Nation, a disparity in rates remains. Higher rates of low birth weight contributed to the 1998 city infant mortality rate of 7.9 deaths per 1,000 live births; the national rate for 1999 was 7.1. The percentage of pregnant women receiving first trimester prenatal care is lower in cities (79.7 percent) as compared to the Nation (83.2 percent). The percentage of women receiving late or no prenatal care is nearly one third higher in cities than in the Nation as a whole (5.0 percent versus 3.8 percent).

The challenge for health care providers and special initiatives is to eliminate these disparities by improving the health status of children in the Nation's cities.

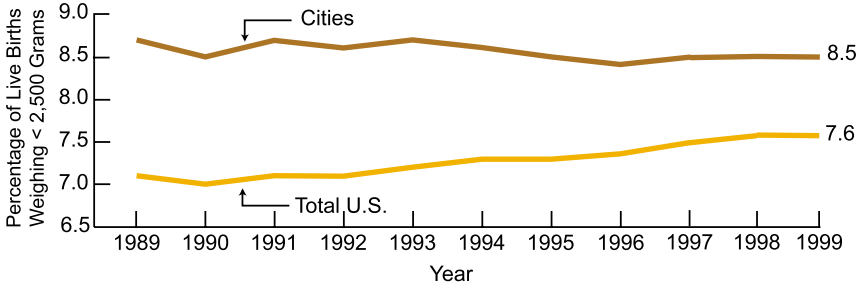
PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1989-1999

Source (V.1): National Center for Health Statistics



PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1989-1999

Source (V.1): National Center for Health Statistics



BIRTH WEIGHT

Low Birth Weight

Disorders related to short gestation and low birth weight are the second leading cause of neonatal mortality.* In 1999, 101,980 babies (8.5 percent of all live births) born to residents of U.S. cities with populations over 100,000 were of low birth weight (weighing less than 2,500 grams or 5.5 pounds). The 1999 percentage of urban infants born at low birth weight was 12 percent higher than the national rate of 7.6 percent.

Very Low Birth Weight

Infants born at very low birth weight (less than 1,500 grams or 3 pounds, 5 ounces) are at highest risk for poor health outcomes. In 1999, 1.7 percent of live births in cities with populations over 100,000 were of very low birth weight. This rate exceeded the national very low birth weight rate by 13 percent.

**Congenital anomalies are the leading cause of neonatal mortality.*

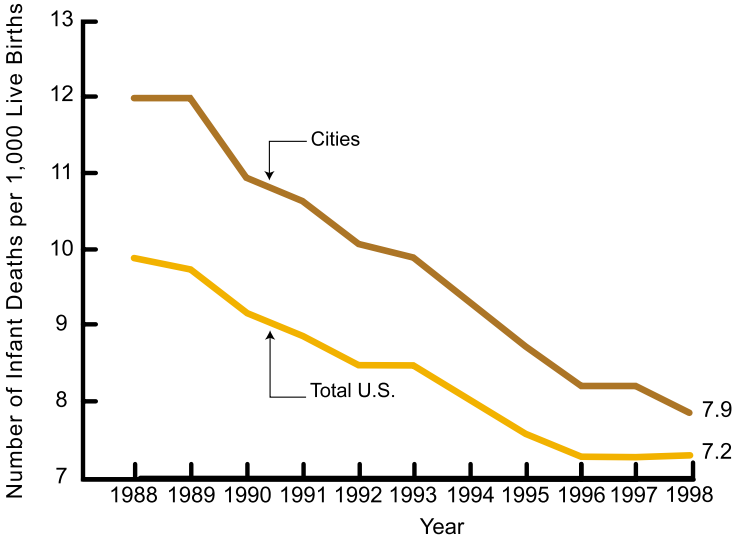
INFANT MORTALITY

In 1998, 9,488 infants born to residents of U.S. cities with populations over 100,000 died in the first year of life. The city infant mortality rate was 7.9 deaths per 1,000 live births, 10 percent higher than the rate of 7.2 for the Nation as a whole. The 1998 rate of 7.9 represents an almost 9 percent decrease in the 1995 city infant mortality rate of 8.7.

Although the infant mortality rate in cities has routinely been higher than the rate in the Nation as a whole, it has steadily declined over the past decade. Between 1988 and 1998, infant mortality in cities declined by roughly one third; the decline nationwide in the same period was 28 percent.

INFANT MORTALITY RATES IN U.S. CITIES WITH POPULATION OVER 100,000: 1988-1998

Source (V.2): National Center for Health Statistics



PRENATAL CARE

Early Prenatal Care

Women living in U.S. cities with a population of over 100,000 are less likely to begin prenatal care in the first three months of pregnancy than women nationwide. The gap in early entry into prenatal care between urban women and the nation as a whole has narrowed since 1993.

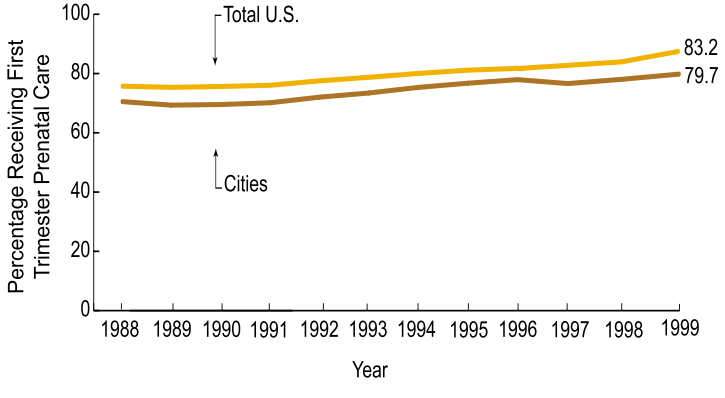
In 1999, 79.7 percent of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 83.2 percent nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The Healthy People 2010 Objective is to have 90 percent of pregnant women begin prenatal care in the first trimester.

Late or No Prenatal Care

In 1999, 5 percent of pregnant women living in U.S. cities with a population of over 100,000 began prenatal care in the 3rd trimester or received no prenatal care. The percentage of women receiving late or no prenatal care is 32 percent higher among women living in cities than among the overall U.S. population.

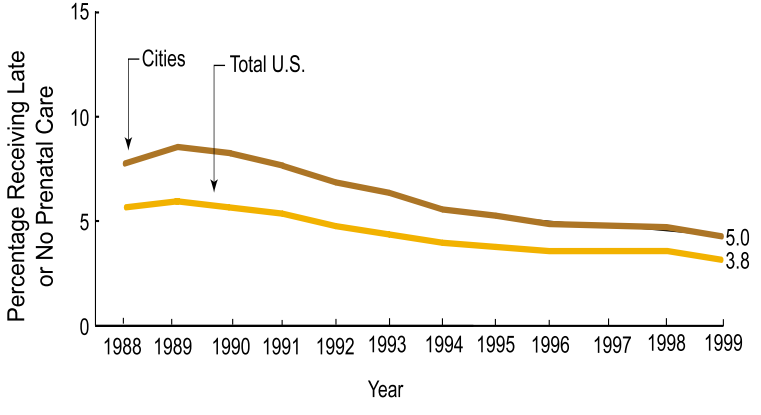
PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1999

Source (V.1): National Center for Health Statistics



PERCENTAGE OF PREGNANT WOMEN RECEIVING LATE OR NO PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-1999

Source (V.1): National Center for Health Statistics



TEN YEAR ACTION PLAN FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Source (VI.1): Maternal and Child Health Bureau

The Maternal and Child Health Bureau (MCHB), together with Family Voices, the American Academy of Pediatrics, the March of Dimes, and numerous other partners, is working on a new initiative called The 2010 Express. These agencies are working together to create a Ten Year Action Plan to Achieve Community-Based Systems of Services for Children with Special Health Care Needs and Their Families. This action plan is meant to serve as a guide for building partnerships among the various constituencies involved in delivering health care to children and youth with special needs. The plan will also map a course for the organization, financing and delivery of services for children with special health care needs to be achieved by the year 2010. The plan is organized around the following core goals:

- All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.
- All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.
- All children will be screened early and continuously for special health care needs.
- Families of children with special health care needs will partner in decision making at all levels and will be satisfied with the services they receive.
- Community-based service systems will be organized so families can use them easily.
- All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

The Ten Year Action Plan is featured in a companion monograph to Healthy People 2010, *Achieving Success for All Children and Youth With Special Health Care Needs.*

TITLE V PERFORMANCE AND OUTCOME MEASURES

Source (VI.2): Maternal and Child Health Bureau

The Title V Information System (Title V IS) evaluates and tracks States' progress in implementing maternal and child health programs to improve the health status of U.S. women and their children under the Title V Maternal and Child Health Block Grant. Collected annually by the Title V IS, these measures consist of 18 Performance Measures and 6 Outcome Measures that examine indicators leading to better health outcomes and long-term goals of Title V program initiatives, respectively. All Title V grantees are required to report on the standard measures and the data are accessible to States, communities, policymakers, and health care professionals on the Internet at http://www.mchdata.net to assist them in addressing the health care needs of U.S. women and children.

As seen below, a number of the Title V Information System National Core Measures correspond closely with Child Health USA 2001 indicators:

Title V Information System Performance Measures	**Page No.**
Performance Measure 01: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program	
Performance Measure 02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients	
Performance Measure 03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"	
Performance Measure 04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell disease) (combined)	
Performance Measure 05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B	**[see page 50]**
Performance Measure 06: The rate of birth (per 1,000) for teenagers aged 15 through 17 years	**[see page 35]**
Performance Measure 07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth	

Title V Information System Performance Measures (Cont'd.)	**Page No.**
Performance Measure 08: The rate of death to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children	
Performance Measure 09: Percentage of mothers who breastfeed their infants at hospital discharge	**[see page 18]**
Performance Measure 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge	
Performance Measure 11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care	
Performance Measure 12: Percent of children without health insurance	**[see pages 49, 66-67]**
Performance Measure 13: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program	**[see page 64]**
Performance Measure 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program	
Performance Measure 15: Percent of very low birth weight live births	**[see pages 21, 70]**
Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19	**[see page 46]**
Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates	
Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	**[see pages 60, 63, 72]**

Title V Information System Outcome Measures (Cont'd.)

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CONTRIBUTORS

This publication was prepared for the Health Resources and Service Administration's Maternal and Child Health Bureau and produced by its Maternal and Child Health Information Resource Center.

Federal and non-government contributors include: The National Center for Health Statistics, the U.S. Bureau of the Census, the Centers for Disease Control and Prevention, the U.S. Bureau of Labor Statistics, the U.S. Department of Education, the Centers for Medicare and Medicaid Services, the National Center on Child Abuse and Neglect, the University of Michigan Institute for Social Research, the Employee Benefit Research Institute, Abbott Laboratories, The Urban Institute, and the American Academy of Pediatrics.

 Other photos contributed by Loren Bell, Stephanie Toomer, Lynda Hornberg, Michael Kogan, Amy Saylor, and the family of Karen Etchison.