

Maternal and Child Health Bureau

# Child Health USA 2002



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## PREFACE

The Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is pleased to present *Child Health USA 2002*, the thirteenth 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 2002* 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.

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## INTRODUCTION

Injuries are the leading cause of death for children over age 1. In 2000, unintentional injuries caused the deaths of 4,658 children between the ages of 1 and 14 and 6,573 adolescents between 15 and 19. The leading cause of injury death in all age groups is motor vehicle crashes, which account for 19 percent of deaths of children and 38 percent of deaths of adolescents. Among young children, the second and third leading causes of injury deaths are drowning and fires and burns; for 5- to 14-year-olds, firearms and drowning are the major causes of injury deaths after motor vehicles. Among adolescents, intentional injury deaths—homicide and suicide—represent the second and third leading causes of injury death, accounting for 27 percent of deaths among 15- to 19-year-olds. In addition to these deaths are the long-term effects on children who survive their injuries, many of which result in lifelong disabilities and special health care needs.

The prevention of injuries among children is a multifaceted problem, requiring significant efforts on the part of parents, schools, policy-makers, and society as a whole. For example, the use of seat belts has contributed greatly to reductions in motor vehicle injuries and deaths

of children over the past decades, and many states require restraints for toddlers and older children as well as infants. Thirteen states and the District of Columbia require the use of seat belts by all occupants of a motor vehicle, and an additional 36 states require all front-seat passengers to wear seat belts. However, adolescents may flout these laws; in 2001, 14 percent of high school students reported that they rarely or never wore seat belts when they were passengers in a car. Furthermore, nearly 31 percent had ridden with a driver who had been drinking at least once in the past month, putting themselves at great risk for injury or death.

Child abuse is another source of injury to children. In 2000, an estimated 879,000 children in the U.S. were victims of abuse or neglect, a rate of 12.2 per 1,000 children under 18. While the majority of victims suffered neglect, 19 percent of cases were of physical abuse. Rates of abuse were highest among the youngest children: among children under age 4, the rate of child abuse was 15.7 cases per 1,000 children, compared to 5.7 cases per 1,000 adolescents aged 16 to 17.

Reducing violence among adolescents is another approach to reducing the rate of death and disability due to injury. In this area, we are making significant progress; between 1993 and

2001, the percent of high school students carrying weapons declined 21 percent and the percent bringing weapons to school declined 46 percent. However, violence among teens remains a problem: nearly 9 percent of students report being threatened or injured with a weapon on school property in 2001, and this rate has increased 22 percent since 1993.

Injury prevention is but one measure we can take to assure the health of America's children. Child health begins before birth, with adequate and high-quality prenatal care during pregnancy. In 2000, over 83 percent of pregnant women began prenatal care in the first trimester, reflecting a significant increase in the use of early prenatal care over the past ten years. However, this percentage is significantly lower for minority women; only 74 percent of African American and Hispanic mothers received early care. African American and Hispanic women are also more likely to begin care late in pregnancy 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. According to preliminary data for 2001, the birth rate among adolescents was 46 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 2001 was 73 births per 1,000 women 15-19, and for Hispanics, the rate was 92 births per 1,000 women.

Another area in which the U.S. has shown consistent progress is reducing the rate of infant mortality, the death of children in the first year of life. In 2000, preliminary data show an infant mortality rate of 6.9 deaths per thousand live births, the lowest rate yet recorded in the United States. However, the rate of death among black infants of 14 deaths per thousand live births is still 2.5 times higher the rate among white infants, and this disparity has not decreased. The rate of neonatal mortality, the death of infants during their first 28 days after birth, is now 4.6 deaths per thousand live births, a decline of 2.5 percent from the rate reported in 1999. 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. 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. Despite these significant improvements, however, the United States still ranks 28th among developed nations in its rate of infant mortality, reflecting the progress that remains to be made.

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 2000 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 in part to increases in the rate of multiple births, as twins and triplets are at particular risk for being small at birth.

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 2000, more than 68 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 breastfeeding their infants at 6 months of age. These rates are even lower among African American women; 51 percent of African American women report breastfeeding in the hospital, and only 21 percent breastfed at 6 months.

Immunization is another critical preventive health service. The percentage of children who receive a full series of immunizations—including those for measles, mumps, rubella (German measles), polio, diphtheria, tetanus, pertussis (whooping cough), and *Haemophilus influenzae* type b, the bacterium that causes meningitis—was reported to be 74 percent in 2001, a slight increase from the rate reported in 2000. However, significant progress is still needed to reach the goal of immunizing at least 90 percent of children by their second birthday,

and some states are even farther from this goal than the nation as a whole.

Health insurance can provide an essential link to critical preventive health services as well as acute care in the case of illness or injury. In 2000, 8.4 million children, or 11.6 percent of children under age 18, had no health insurance, a decrease of 16 percent since 1999. The rise in health insurance rates among children is attributable to both the strong economy of the late 1990s and the expansion of coverage to low-income children under the State Children's Health Insurance Program (SCHIP) implemented in 1997. By the end of Federal Fiscal Year 2001, 4.6 million children were enrolled in SCHIP.

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. While the problem of injury among children is a serious one, most injuries are preventable. By monitoring the health of children throughout their lives, we can identify opportunities for prevention. It is hoped that the data in this book will be one source of the information needed by policy-makers, program planners, and the public to improve the health and safety of children.







## 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.

**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.

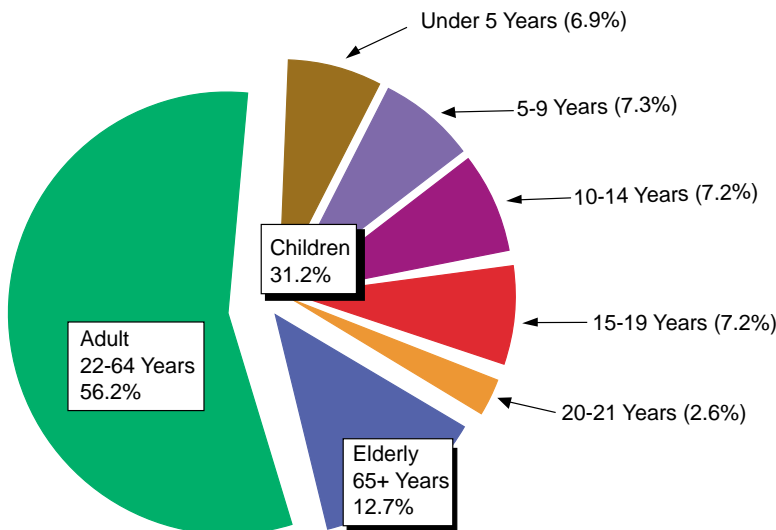
**CHILDREN OF FOREIGN-BORN PARENTS**

Nineteen percent of children in the U.S. have at least one foreign-born parent: 15 percent were born in the U.S. and 4 percent were themselves foreign-born. The proportion of native children of foreign-born parents living in the United States has increased 25 percent from 1994 and the percentage of foreign-born children has increased 33 percent in the same time period. Compared to native born children and parents, children of foreign-born parents are more likely to live below 200 percent of the federal poverty level, are more likely to live in

cities, are more likely to live in two-parent families, and are more likely to have parents with less than a high school education. Immigrant children and children of foreign-born parents face the challenges of acculturation and have health and psychosocial risks at home and at school.

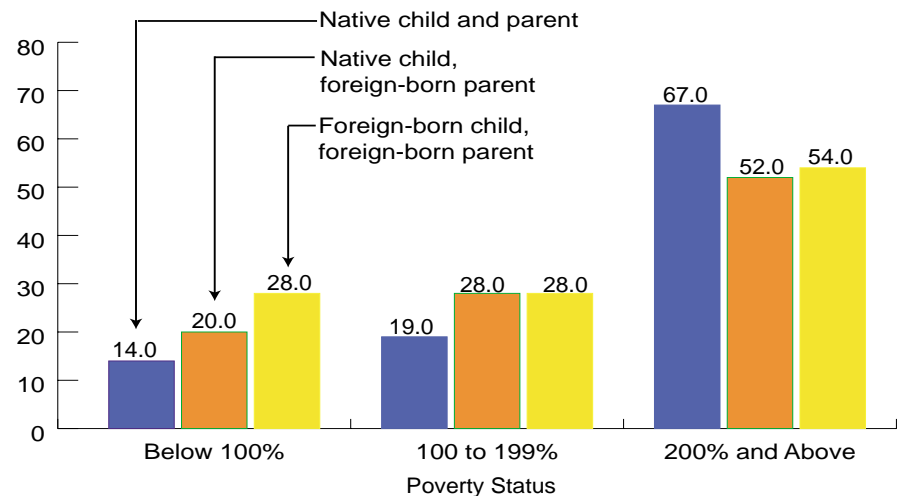
**U.S. RESIDENT POPULATION BY AGE GROUP: NOVEMBER 1, 2000**

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



**PERCENTAGE OF CHILDREN UNDER 18 BY POVERTY STATUS AND NATIVITY OF CHILD AND PARENTS: 2001**

Source (I.2): FIFCFS Analysis of 2001 Current Population Survey



POPULATION CHARACTERISTICS

CHILDREN IN POVERTY

In 2000, there were 11 million related\* children under 18 years of age living in families with income below the Federal poverty threshold (e.g., \$17,603\*\* for a family of four). Children living below the poverty level comprised 15.6 percent of all related children living in families.

While 2000 brought the lowest childhood poverty rate since 1978, childhood poverty continues to exceed that of adults by 71 per-

cent and the elderly by 58 percent. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status. Very young children and black and Hispanic children were particularly vulnerable. Related children under age 6 had a poverty rate of nearly 17 percent. A much higher proportion of black (30.4 percent) and Hispanic (27.3 percent) related children under age 18 were poor compared to related white children (12.3 percent).

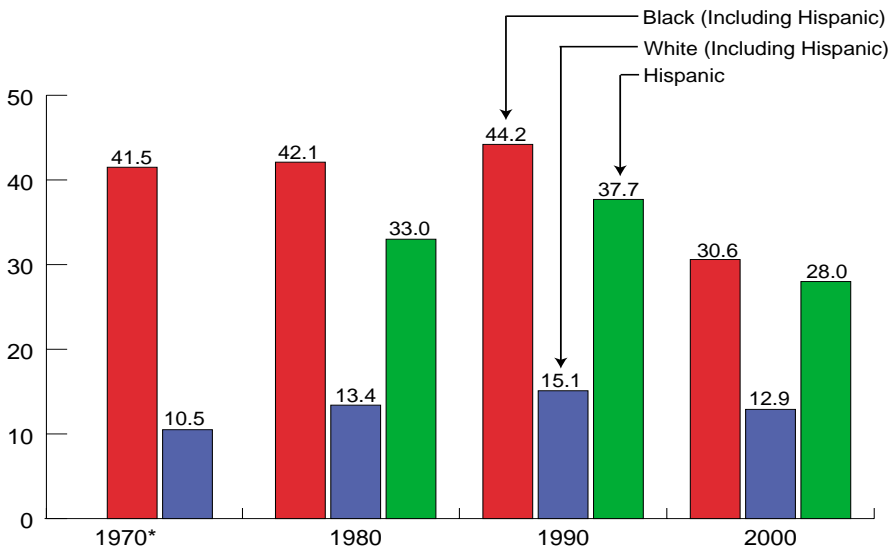
Of the 11 million related children living in poverty, 55.5 percent lived in homes headed by a single mother, 38.3 percent lived in homes headed by married parents, and 6.2 percent lived in families headed by a single father.

\*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: 1970-2000

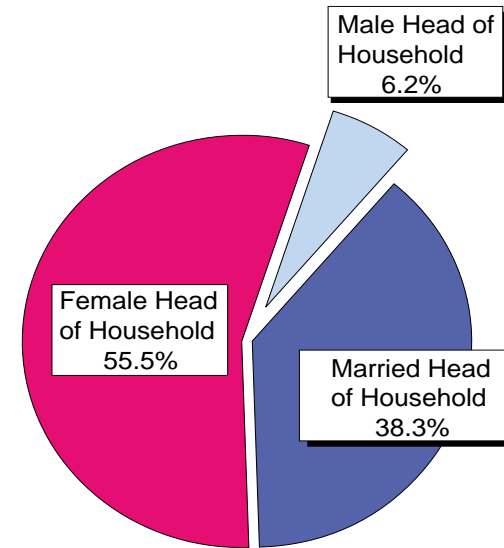
Source (I.3): U.S. Bureau of the Census



\*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: 2000

Source (I.3): U.S. Bureau of the Census



## SCHOOL DROPOUTS

As of October 2000, approximately 488,000 youth aged 15 - 24 dropped out of high school in the previous 12 months. Those who dropped out of high school during this period represented 4.8 percent of students enrolled in high school between October 1999 and 2000. This rate has remained relatively unchanged since 1987.

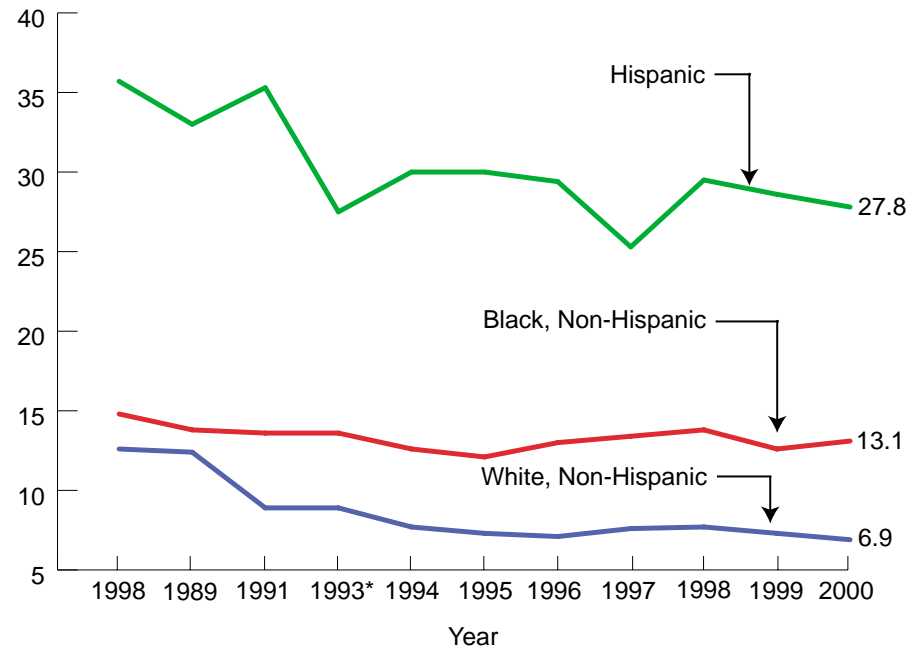
Since 1970, Hispanic students have had the highest dropout rates, representing well over a quarter of Hispanic young adults. In 2000, the dropout rate was significantly higher among foreign-born Hispanics, 44.2 percent, compared to 14.6 percent of first-generation and 15.9 percent of second-generation Hispanics. Although the gap in the dropout rate of blacks and whites narrowed between the 1970s and 1980s, the gap has remained constant since 1990. Asian and Pacific Islander students had the lowest rate of dropouts (3.8).

Those students most likely to ever drop out of school in 2000 were those living in southern and western states, boys, and students over age 18. Students living in low-income families were twice as likely as those in middle-income families and five 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: 2000

Source (I.4): U. S. Department of Education

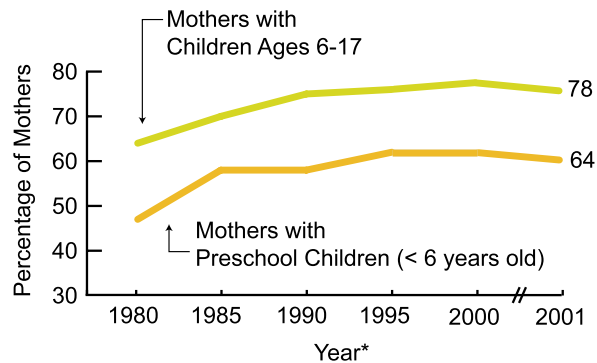


\*Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.

## POPULATION CHARACTERISTICS

**MOTHERS IN THE WORK FORCE: 1980-2001**

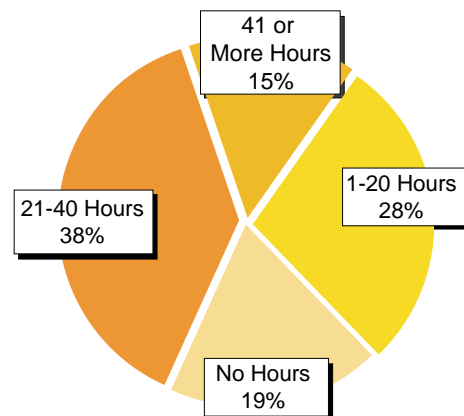
Source (I.5): U.S. Bureau of Labor Statistics



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

**HOURS PER WEEK IN CHILD CARE FOR CHILDREN UNDER THREE WITH MOTHERS EMPLOYED FULL-TIME: 2000**

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

**WORKING MOTHERS**

In 2001, 64 percent of mothers with preschool aged children (younger than 6 years) were in the labor force (either employed or looking for work), and 60 percent were actually employed. Of those mothers, 70 percent worked full-time and 30 percent worked part-time.

Of women with children ages 6-17, 78 percent were in the labor force in 2001 and 75 percent were actually employed. Of employed mothers, 78 percent worked full-time and 23 percent worked part-time.

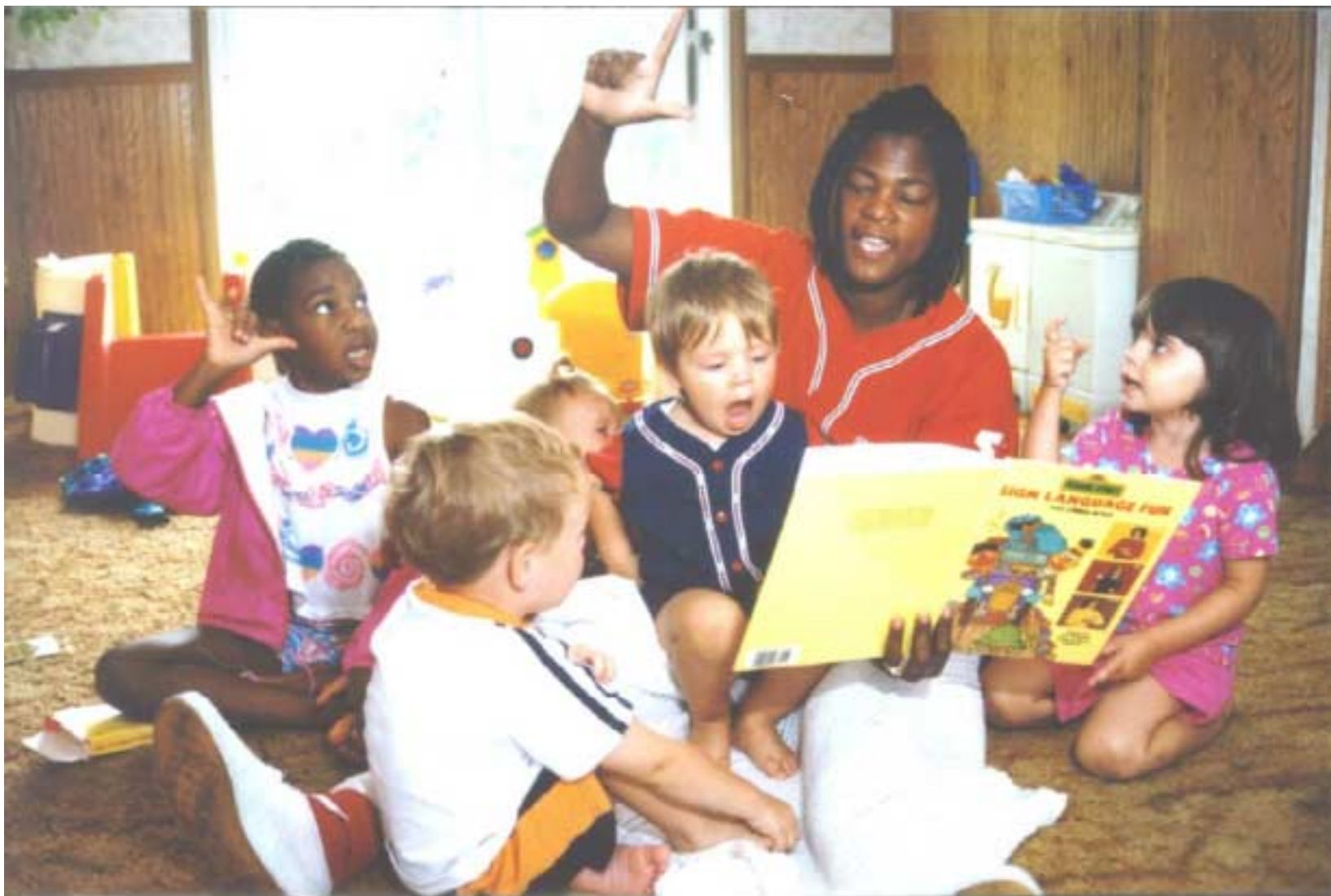
**CHILD CARE**

Data from the 2000 National Survey of Early Childhood Health reveal that 61 percent of all children between 4 months and 3 years of age spend time in non-parental child care. Children whose mothers are employed full-time spend more time in child care than children whose mothers are employed part-time or not at all. Among young children whose mothers are employed full-time, about 38 percent spend between 21-40 hours in child care per week, and 15 percent spend more than 41 hours in care. By comparison, 45 percent of children under 3 whose mothers work part-time

spend less than 20 hours a week in care and 25 percent spend 21-40 hours a week in child care. Children whose mothers are not employed often spend no time in child care.

Generally, children of women employed full-time spend more time in child care when they live in higher-income households. In low-income households where the mother is employed full-time, 44 percent of young children spend 21 hours or more in child care per week, compared with 58 percent of children in middle-income households, and 61 percent of children in high-income households.

An analysis of the 1999 National Survey of America's Families reveals that pre-school children ages 0-4 with a working parent are most often cared for in child care centers (28 percent), by relatives (27 percent), or by a parent (27 percent). The remaining children are cared for in family child care homes (14 percent) and by nannies or babysitters (4 percent).



**MATERNAL AGE**

The overall birth rate declined slightly by less than one percent in 2001. Birth rates for teenagers ages 15-19 declined 26 percent since 1991, reaching a record low. The birth rate among women in their twenties was basically unchanged since 2000; however, the small increase in the 2001 birth rate to women in their thirties and forties resulted in the highest rate for this age group in over 30 years.

Among 2001 births, 11 percent were to women under 19 years of age, over half were to women in their twenties, one-third were to women in their thirties, and the remaining two percent were to women in their forties and early fifties.

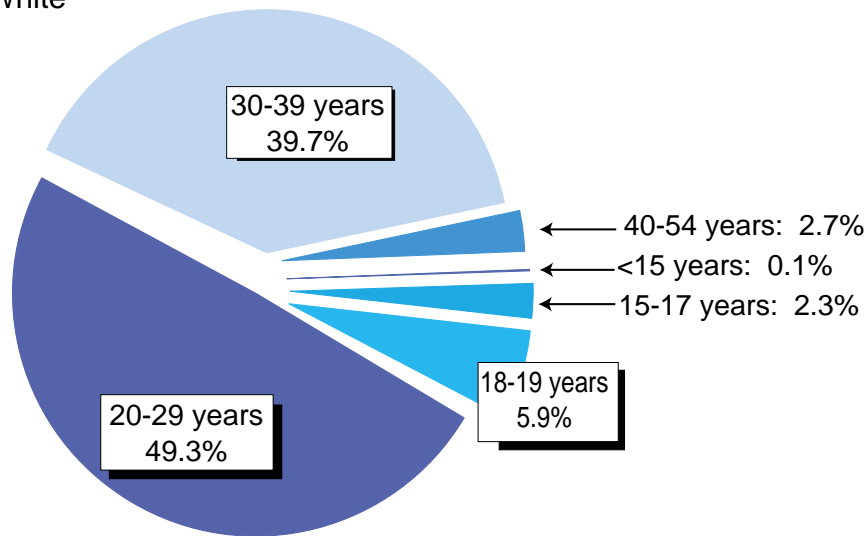
Among both black and white women, half of births in 2001 were to women in their twenties. However, a substantially higher proportion of white births were to women in their

thirties and forties while the percentage of births to teens was twice as high among blacks as among whites.

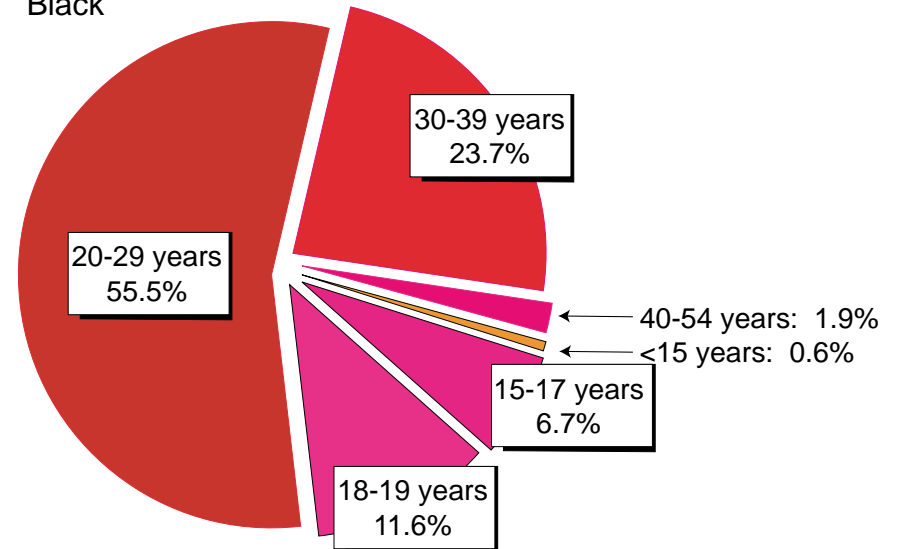
**PERCENT DISTRIBUTION OF BIRTHS BY RACE AND MATERNAL AGE: 2001\***

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

White



Black



\*preliminary data

## 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.

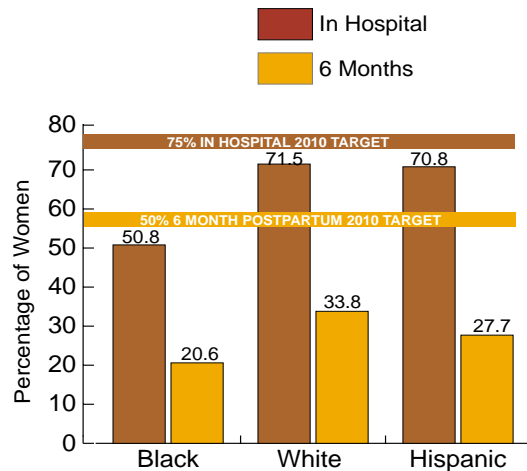
In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal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





**BREASTFEEDING BY RACE: 2000\***

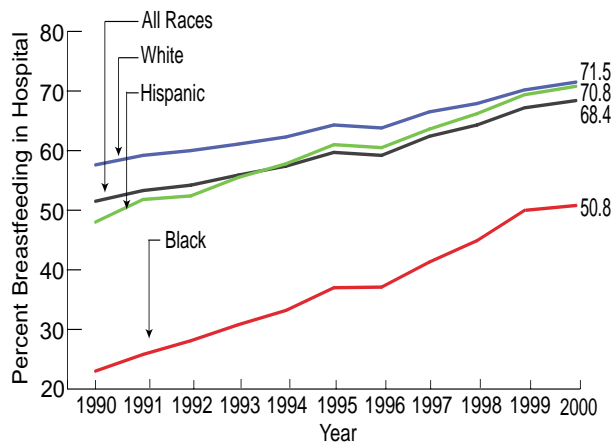
Source (II.1): Abbott Laboratories



\*Includes exclusive and supplemented breastfeeding.

**BREASTFEEDING BY RACE: 1990-2000**

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 2000, breastfeeding rates in the hospital reached 68.4 percent, the highest rate recorded since national breastfeeding data has 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 ten years, the rate of breastfeeding initiation has more than doubled among black women and has increased 48 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 31.4 percent in 2000. At six months postpartum, 33.8 percent, 27.7 percent, and 20.6 percent of white, Hispanic, and black women, respectively were still breastfeeding. These rates represent a sharp decline from rates immediately after delivery of 71.5 percent among whites, 70.8 percent among Hispanics, and 50.8 percent among blacks.

Breastfeeding rates were highest among women over 35 years of age, white, 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 initiate breastfeeding with their first child, but women with more than one child were more likely to continue breastfeeding at 6 and 12 months postpartum. Women least likely to breastfeed were younger than 20 years of age, black, low-income, and/or living in the southeastern United States.



## LOW BIRTH WEIGHT

In 2000, 308,470 babies (7.6 percent of all live births) were of low birth weight, weighing less than 2,500 grams, or 5 pounds 8 ounces, at birth. This rate was unchanged from the previous two years.

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 incidence 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 2000, only 6 percent of singleton newborns weighed less than 2,500 grams, compared to 23 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 by 4 percent from a high of 13.6 percent in 1991, while the rate among infants of white mothers has increased 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

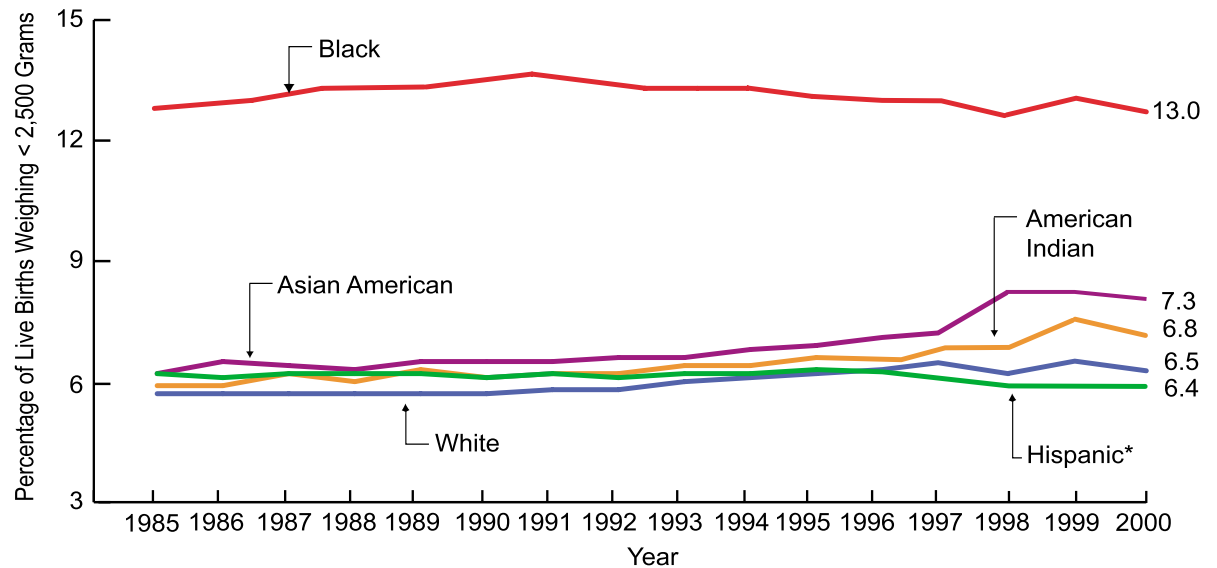
weight infants are more likely to experience long-term disability or to die during the first year of life than are infants of normal weight.

In 2000, the percent of low birth weight infants born to smokers (11.9 percent) was substantially higher than among nonsmokers (7.2 percent). 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 maternal poverty and low levels of educational attainment.

### PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT BY RACE: 1985-2000

Source (II.2) National Center for Health Statistics



\*Hispanic can be of any race.

Note: 1985-1988 data based on race of child; 1989-2000 data based on race of mother.

## VERY LOW BIRTH WEIGHT

In 2000, the rate of very low birth weight remained virtually unchanged at 1.4 percent of live births to U.S. women.

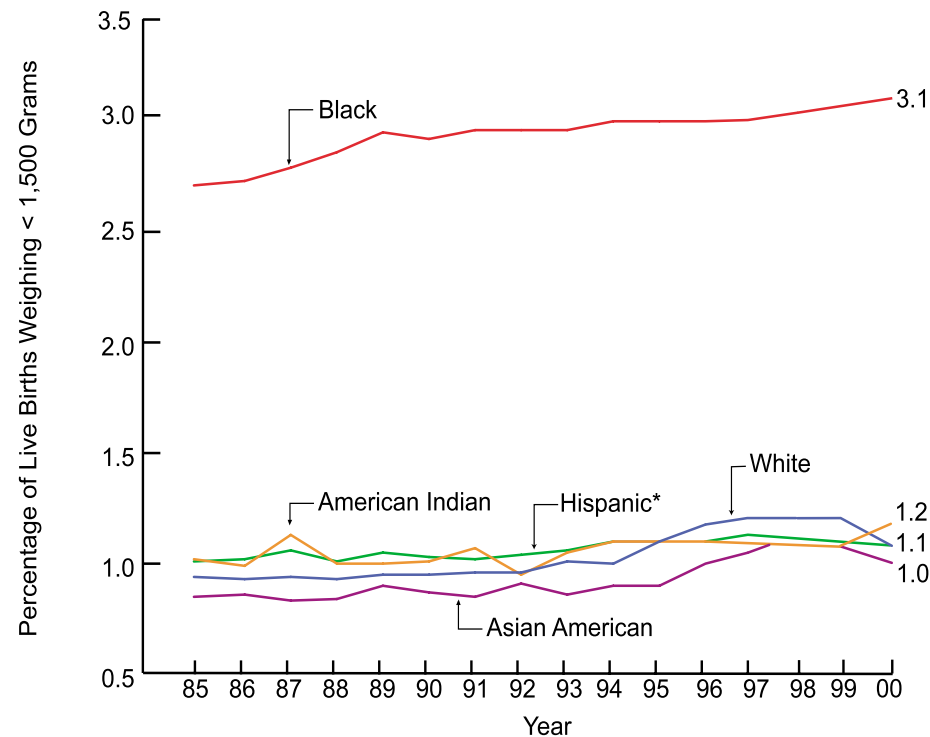
Although infants weighing less than 1500 grams (about 3.3 pounds) account for a small percentage of births, they account for up to half of the deaths of newborns. Approximately 25 percent of all infants weighing less than 1500 grams die by age 1, compared to 2 percent of infants born at 1,500-2,499 grams and 0.03 percent of infants born at 2,500 grams or more.

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 overall rate of very low birth weight among black babies is nearly three 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: 1985-2000

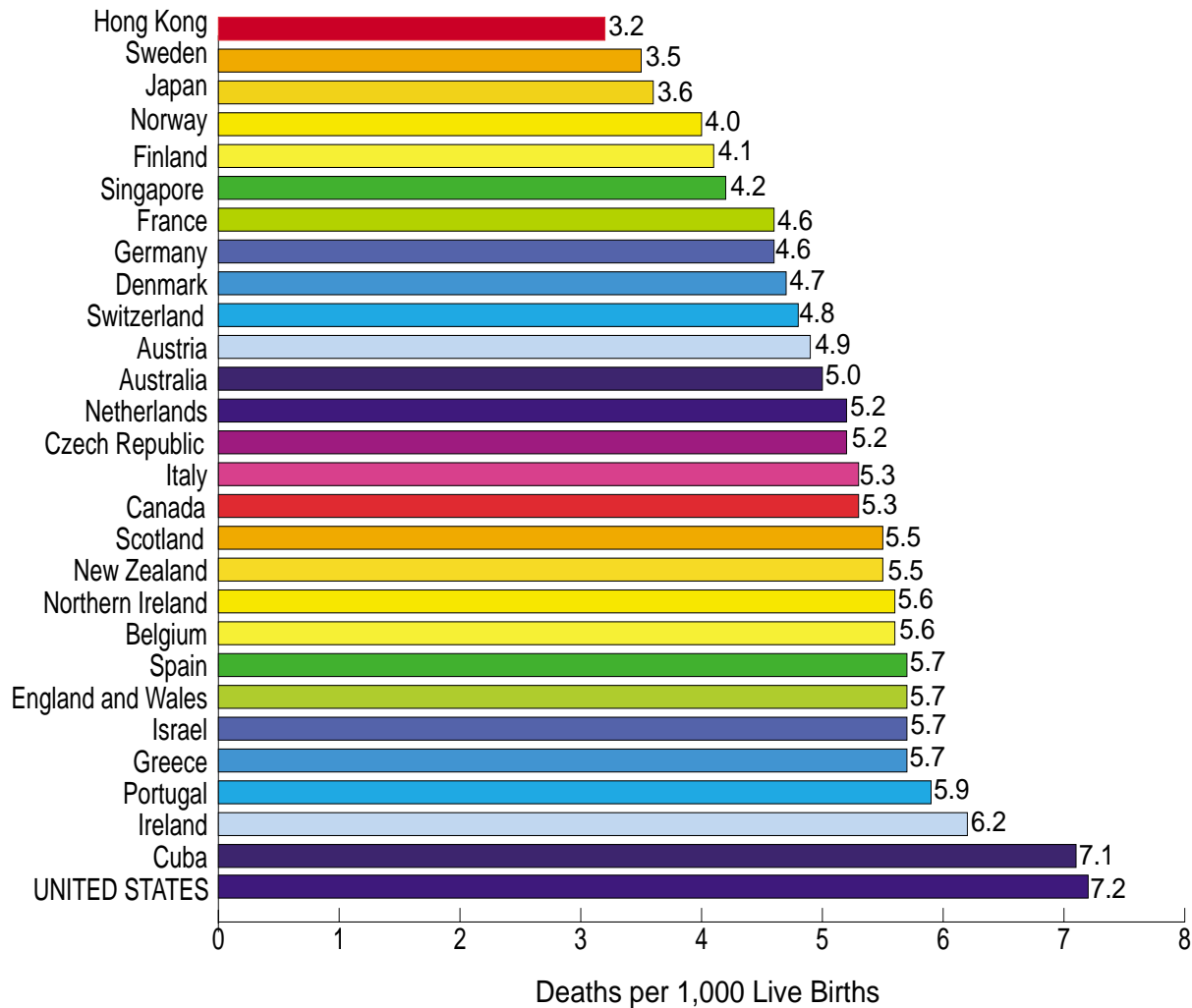
Source (II.2): National Center for Health Statistics



\* Hispanic can be of any race.

**COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1998**

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

**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 28th among industrialized nations in 1998.

This graph comparing "national infant mortality rates" includes countries, territories, cities, or geographic areas with a population of at least 1 million that have complete counts of live births and infants deaths as indicated in the United Nations Demographic Yearbook. In 1998, three of these jurisdictions had infant mortality rates that were half that of the United States.

## INFANT MORTALITY

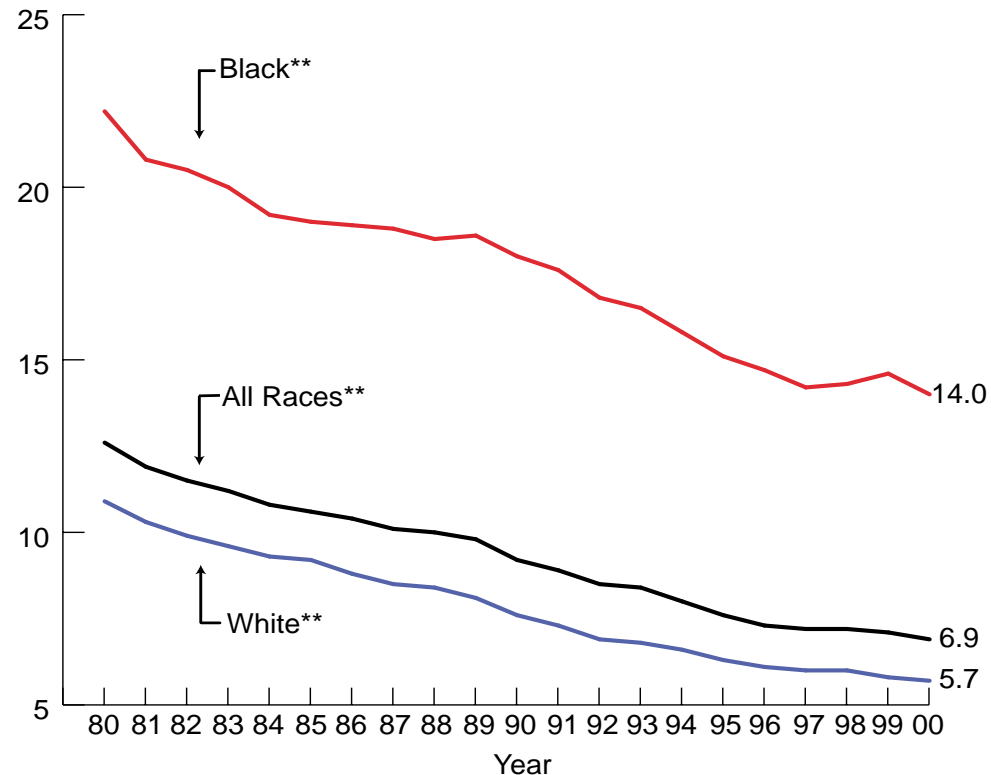
In 2000, 27,987 infants died before their first birthday. The preliminary infant mortality rate was 6.9 deaths per 1,000 live births, representing a statistically significant decline from 1999.

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 1999 and 2000, mortality among black infants decreased 4 percent to 14.0, while the preliminary rate for whites of 5.7 was not statistically different from the reported 1999 rate.

The preliminary 2000 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: 1980-2000\*

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



\*preliminary data

\*\*Includes the ethnic classification of Hispanic.

## NEONATAL AND POSTNEONATAL MORTALITY

### *Neonatal*

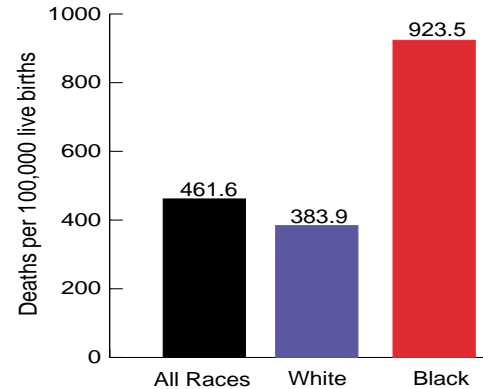
In 2000, 18,737 infants younger than 28 days died, resulting in a preliminary neonatal mortality rate of 461.6 deaths per 100,000 live births. This neonatal mortality rate represents a 2.5 percent decrease from that reported in 1999.

### *Postneonatal*

In 2000, 9,250 infants between 28 days and 1 year of age died; the preliminary postneonatal mortality rate was 227.9 deaths per 100,000 live births. The 2000 rate is not statistically different from the 1999 rate.

### PRELIMINARY NEONATAL MORTALITY RATES BY RACE OF MOTHER: 2000\*

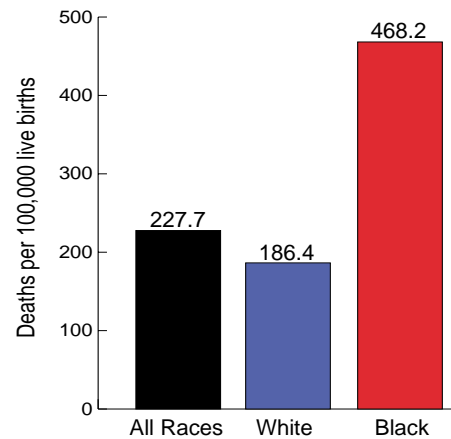
Source (II.4): National Center for Health Statistics



\*preliminary data

### PRELIMINARY POSTNEONATAL MORTALITY RATES BY RACE OF MOTHER: 2000\*

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.

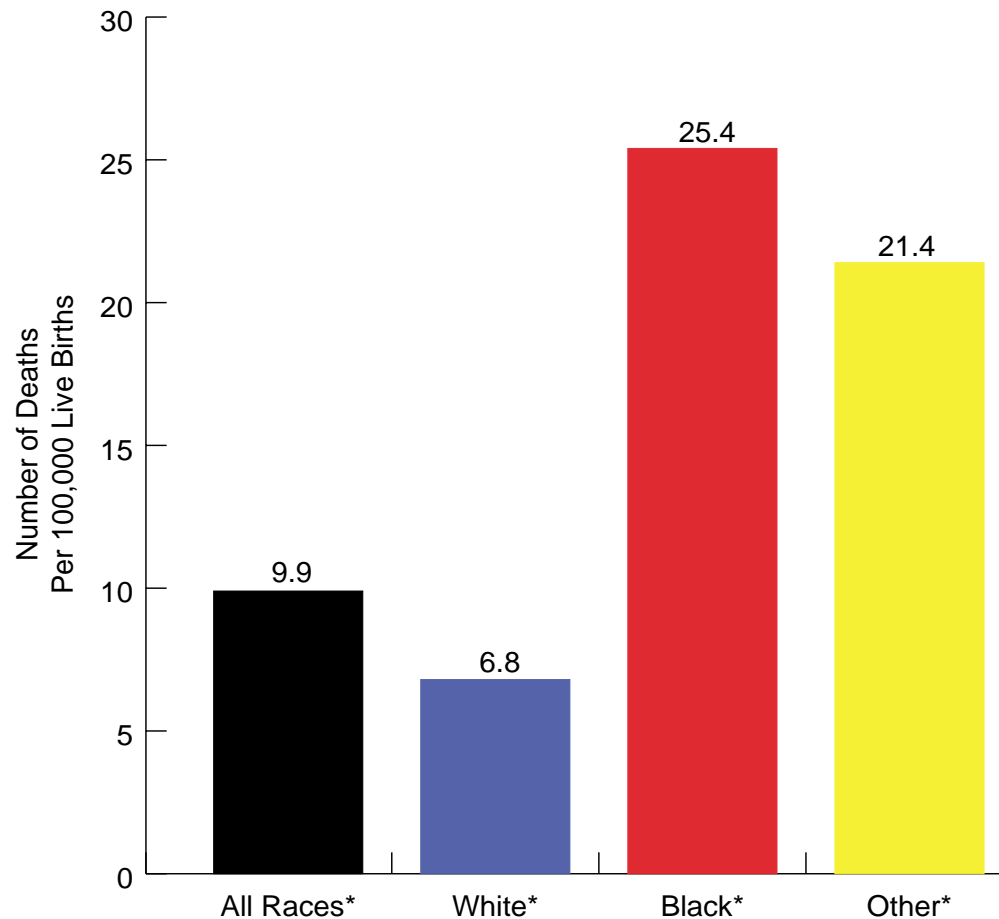
In 1999, there were 391 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

The maternal mortality rate for black women (25.4 per 100,000 live births) is more than 3.5 times the rate for white women (6.8 per 100,000 live births).

According to the National Center for Health Statistics, 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: 1999

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



\*Includes the ethnic classification of Hispanic





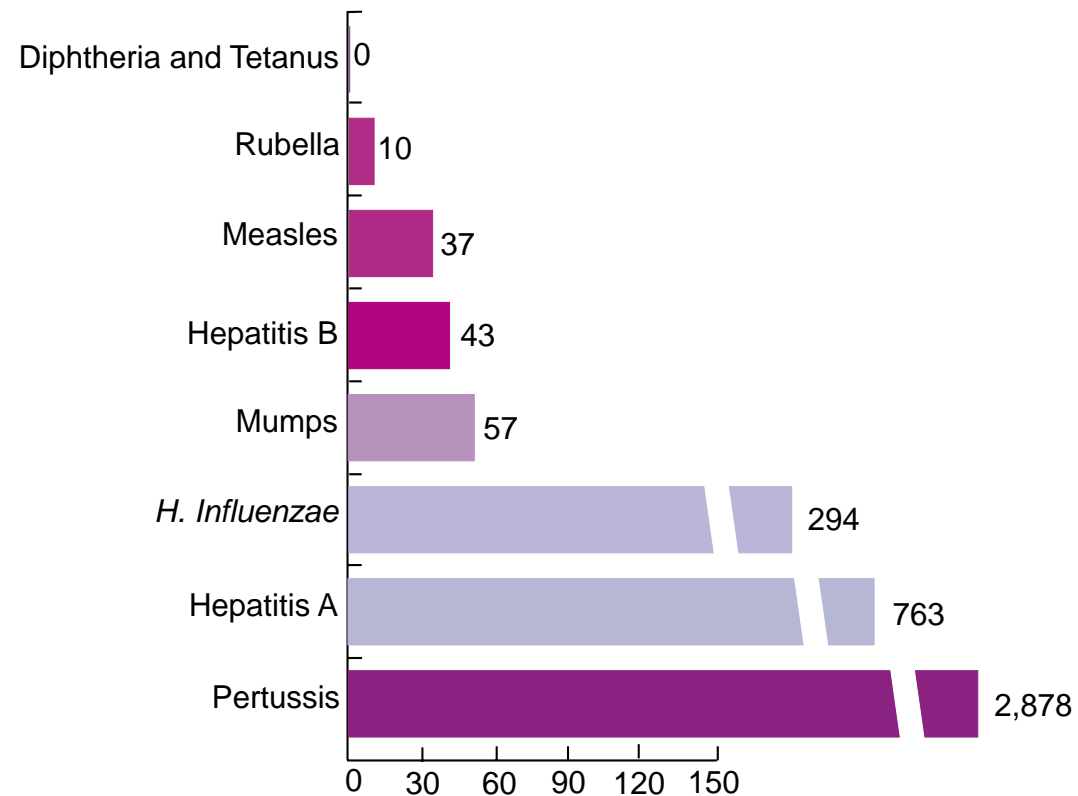
## VACCINE-PREVENTABLE DISEASES

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* increased from 1999 to 2000, cases of rubella, measles, Hepatitis B, mumps, Hepatitis A, and pertussis all decreased among children under 5 between 1999 and 2000. No cases of diphtheria or tetanus were reported for 2000 compared to 1 case in 1999. Almost one quarter of pertussis cases occurred in infants less than 7 months old who were too young to have received all three doses of a pertussis-containing vaccine. Mumps and rubella are at record low levels across all ages.

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. Additionally, since most Hepatitis B infections among infants and young children are asymptomatic, the reported number of cases likely underestimates the incidence of Hepatitis B in young children.

## NUMBER OF CASES OF REPORTABLE VACCINE-PREVENTABLE DISEASES AMONG CHILDREN UNDER 5: 2000

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



**CHILD ABUSE AND NEGLECT**

In 2000, investigations by state child protective services agencies determined that an estimated 879,000 children were victims of abuse or neglect, equivalent to a rate of 12.2 per 1,000 children under 18 years of age. Seventy-nine percent of the perpetrators of child maltreatment were the parents of the victim.

Approximately 63 percent of all victims suffered neglect, 19 percent physical abuse, 10 percent sexual abuse, 8 percent psychological maltreatment, and 17 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 2000 were nearly three times as likely to experience a recurrence during the 6 months following their first 2000 victimization than children without a prior history.

Victimization is highest among the youngest children. In 2000, the victimization rate for children ages 0 to 3 was 15.7 per 1,000, compared to 5.7 per 1,000 among children age 16 to 17. Among the estimated 1,200 children who died of abuse and neglect in 2000, children younger than one year accounted for 44 percent of fatalities and children younger than 6 years accounted for 85 percent. Fatalities were more

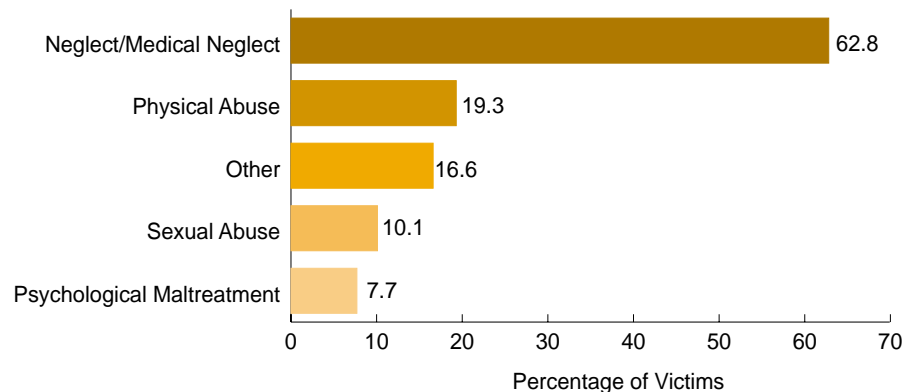
often associated with neglect (35 percent) than with any other type of maltreatment.

State child protective services received reports alleging the maltreatment of approximately 3 million children in 2000. Over 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: 2000**

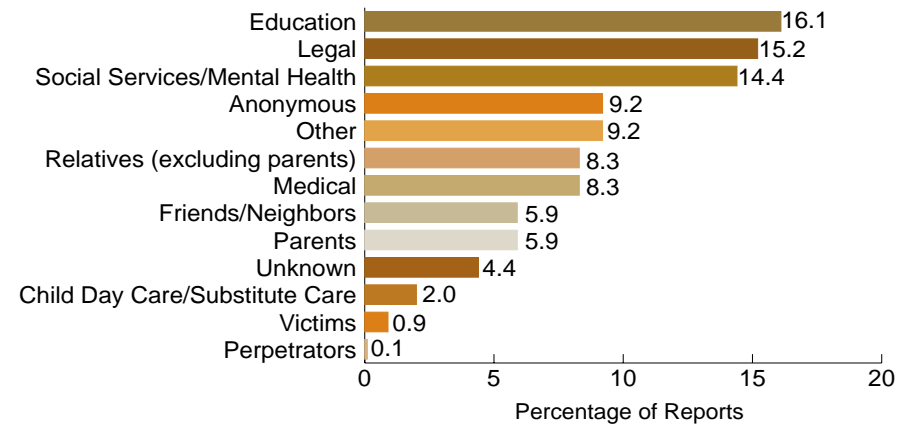
Source (II.7): U.S. Department of Health and Human Services



Note: Percentage totals more than 100% because children may have been victims of more than one type of maltreatment. Includes victims in 49 states.

**SOURCES OF MALTREATMENT REPORTS: 2000**

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



Note: 1,695,550 reports from 46 states.

## PEDIATRIC AIDS

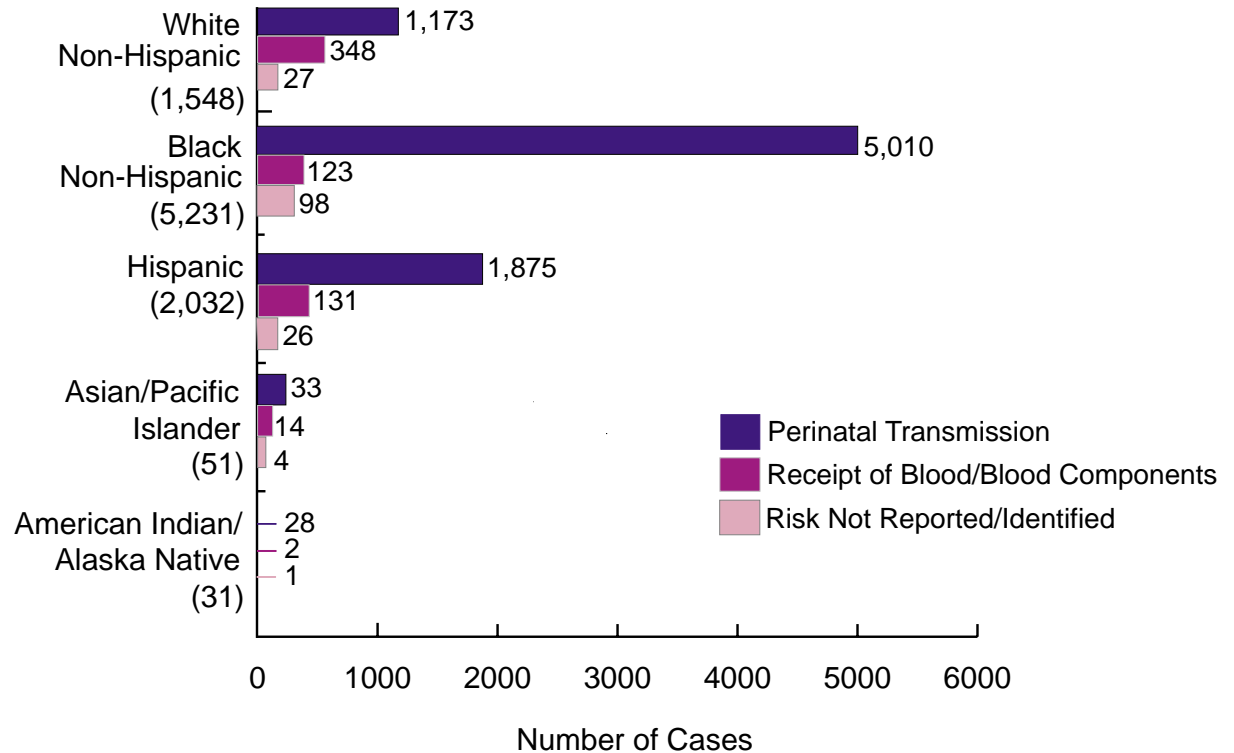
As of December 31, 2000, 8,908 cases of AIDS in children younger than 13 had been reported in the U.S.; this total includes 196 newly reported cases in 2000. Pediatric AIDS cases represented less than 1.2 percent of all cases reported to date.

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 was 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\*

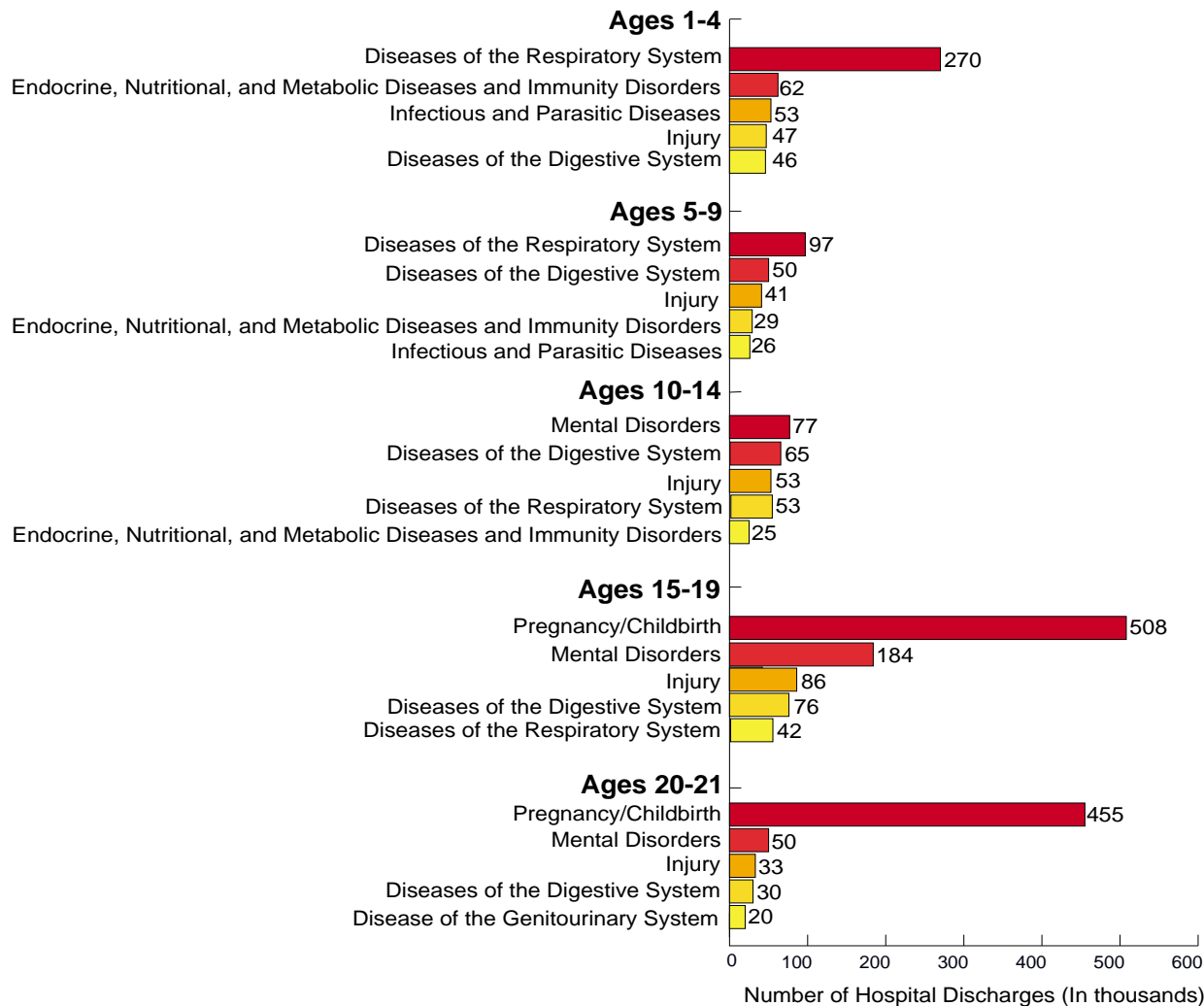
Source (II.8): Centers for Disease Control and Prevention



\*Graph does not include 15 children of unknown race/ethnicity.

**MAJOR CAUSES OF HOSPITALIZATION BY AGE: 2000**

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

**HOSPITALIZATION**

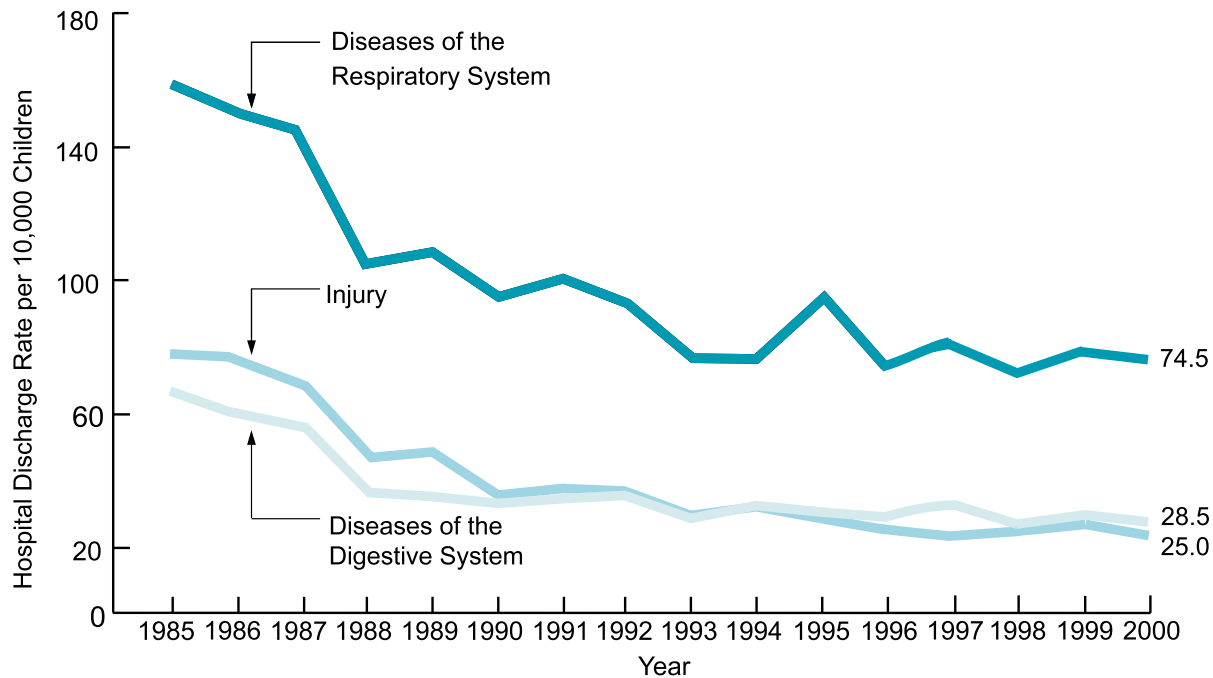
In 2000, there were 3.4 million hospital discharges of children 1 through 21 years old, or 4.0 discharges per 100 children that year.

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 2000. Pregnancy and childbirth accounted for 68 percent of discharges of young women ages 15-21. Mental disorders were the second leading cause of hospitalization for adolescent.

## DISCHARGE RATE OF PATIENTS 1-14 YEARS OLD FOR SELECTED DIAGNOSES: 1985-2000

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



## HOSPITAL DISCHARGE TRENDS

Since 1985, there has been a 38 percent decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1985 and 2000, there was a 44 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 45 percent of the discharges of children aged 1-14 years in 2000.

## CHILD MORTALITY

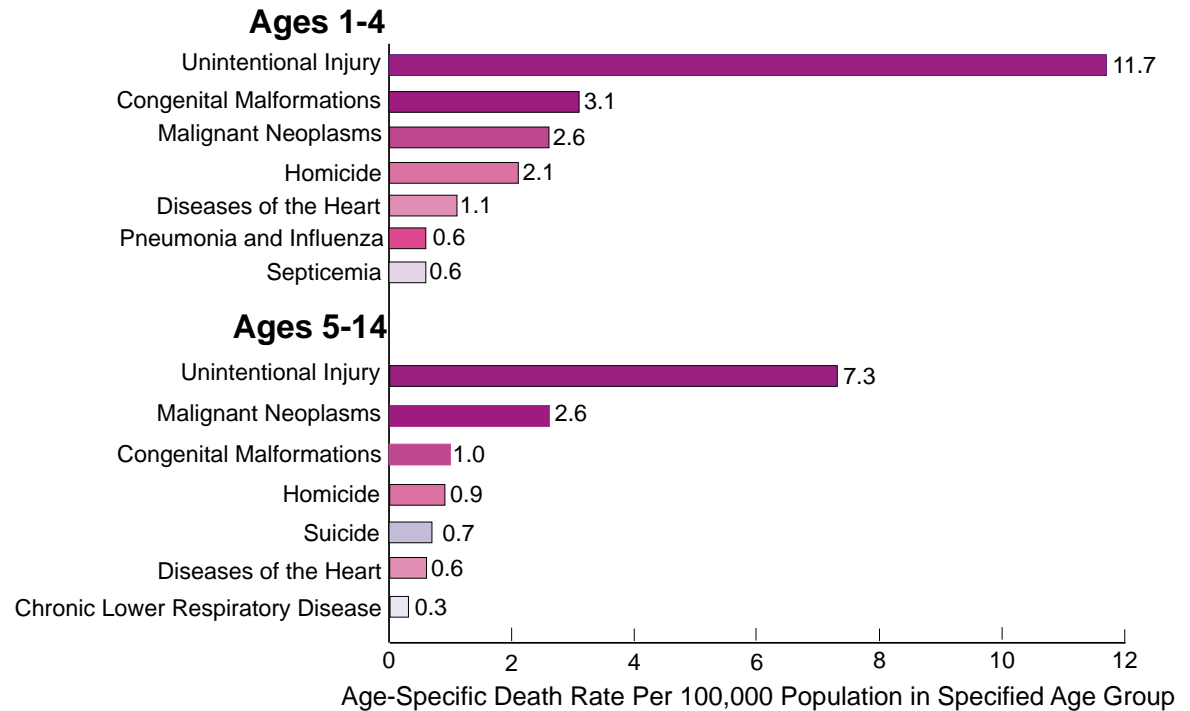
There were 12,282 deaths of children ages 1-14 in 2000, based on preliminary data. Injury, regardless of intent, was the primary cause of death in that age group. Among 1- to 4-year-old children, injuries accounted for 42 percent of all deaths, followed by deaths due to congenital malformations (birth defects), malignant neoplasms (cancer), homicide, and diseases of the heart.

Unintentional injuries comprised 39 percent of all deaths among 5- to 14-year-old children, followed by malignant neoplasms, congenital malformations, homicides, suicides, and diseases of the heart.

Childhood death rates have declined substantially over the past several decades. Preliminary death rates for children 1-4 years of age decreased 5.5 percent from those reported in 1999, while those for children aged 5-14 years were not statistically different.

## LEADING CAUSES OF DEATH IN CHILDREN AGES 1-14: 2000\*

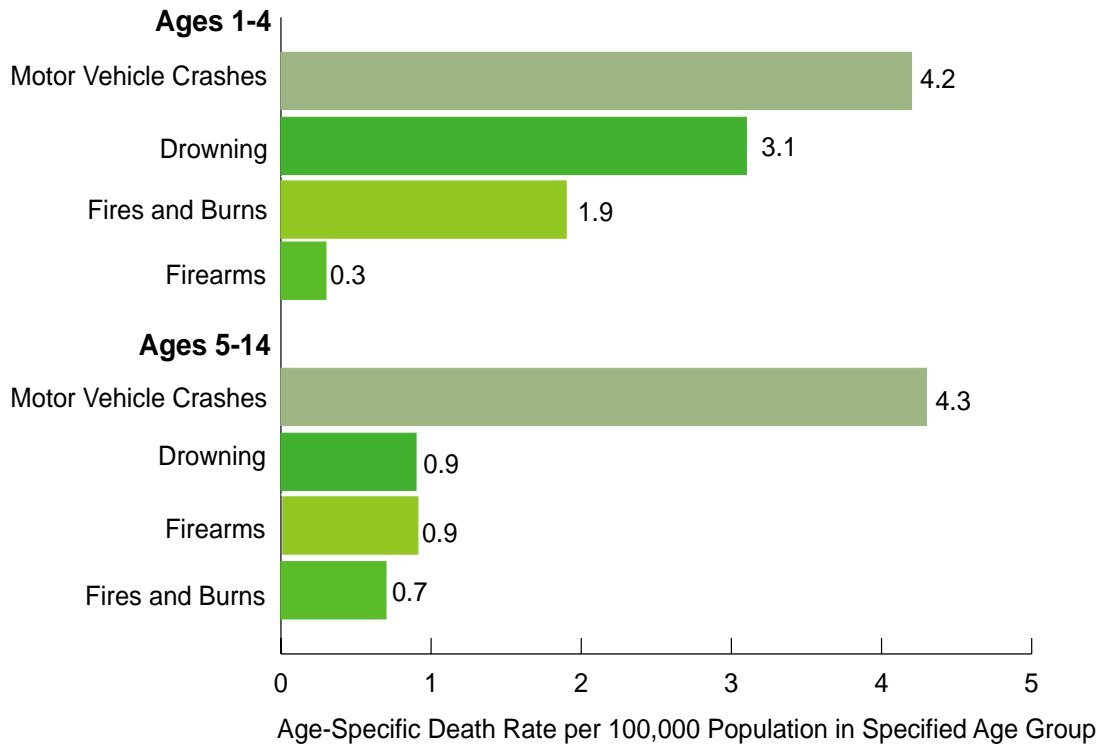
Source (II.4): National Center for Health Statistics



\*preliminary data

**CHILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 2000\***

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



\*preliminary data

**CHILDHOOD DEATHS DUE TO INJURY**

In 2000, unintentional injuries caused the deaths of 1,780 1- to 4-year-old children and 2,878 5- to 14-year-old children. In addition, 318 children ages 1 to 4 were the victims of homicide and 664 children 5 to 14-years of age were victims of homicide or suicide.

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 and drowning 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, be 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 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 adolescents.

## ADOLESCENT CHILDBEARING

Birth rates among adolescents continued to decline in 2001, reaching a record low for ages 15-19. The live birth rate per 1,000 15-19 year old adolescent females declined by 26 percent since 1991, to 45.9 per 1,000 in 2001. The birth rate for the youngest teens, those aged 10-14, also declined by 11 percent since 2000, to 0.8 per 1,000. Birth rates are highest among the oldest adolescents, at 75.8 births per 1,000 ado-

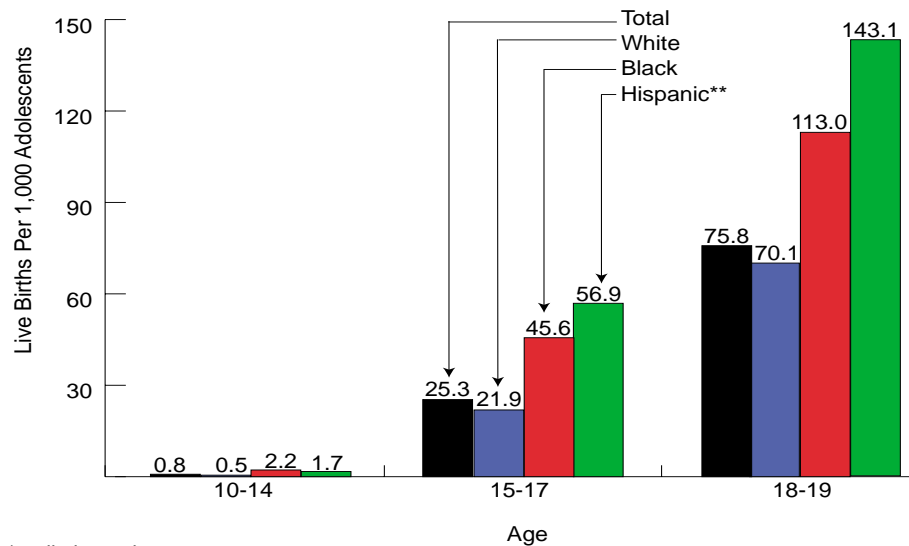
lescent females ages 18-19, compared to younger adolescents, at 25.3 births per 1,000 adolescent females ages 15-17.

In addition to age, birth rates among adolescents vary considerably by race and ethnicity. Birth rates for adolescents 15-19 were 41.7 for whites, 73.1 for blacks, 92.4 for Hispanics, 65.7 for American Indians, and 20.5 for Asian or Pacific Islanders. All race and ethnic groups saw a decline in adolescent births between 2000 and 2001. Although the birth rate among black ado-

lescents is high compared to most other racial and ethnic groups, the largest decline in adolescent birth rates between 1991 and 2001 has been among black teens. The overall rate of adolescent childbearing by black teens ages 15-19 fell by 37 percent over the last ten years. The birth rate among Hispanic adolescents fell the least from 1991-2001, by 13 percent, leaving Hispanic teens with the highest birth rate among the five racial and ethnic groups.

### ADOLESCENT BIRTH RATES, BY AGE AND RACE OF MOTHER: 2001\*

Source (II.10): National Center for Health Statistics

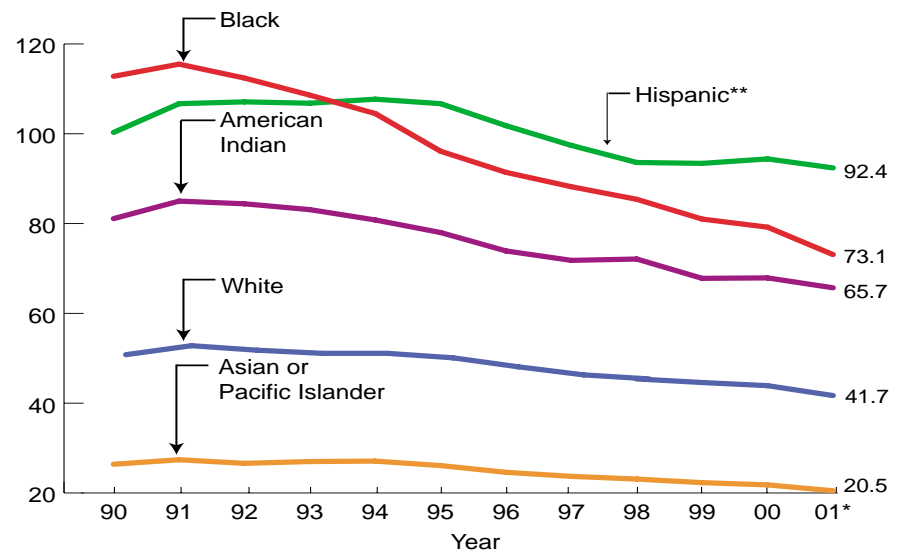


\*preliminary data

\*\*Hispanics can be of any race and those in any racial group may also be Hispanic

### ADOLESCENT BIRTH RATES, BY RACE OF MOTHER: 1990-2001

Source (II.11): National Center for Health Statistics



\*preliminary data

\*\*Hispanics can be of any race and those in any racial group may also be Hispanic

## SEXUAL INTERCOURSE

In 2001, 45.6 percent of students had ever had sexual intercourse, representing a nearly 9 percent decrease since 1999. Though black students (60.8 percent) had a higher prevalence of ever having had sexual intercourse than Hispanic (48.4 percent) and white students (43.2 percent), the percent of black students ever having had sexual intercourse dropped by 14 percent from 1999 with smaller declines seen for Hispanic and white students.

Approximately 48 percent of 12th grade students reported having sexual intercourse during the three months preceding the survey. The prevalence rate of current sexual activity increased significantly from grades 9 through 12 among both females (19.9 percent to 51.0 percent) and males (25.9 percent versus 44.6 percent). Overall, male students were more likely than female students (17.2 percent versus 11.4 percent) to have had four or more sex partners during their lifetime.

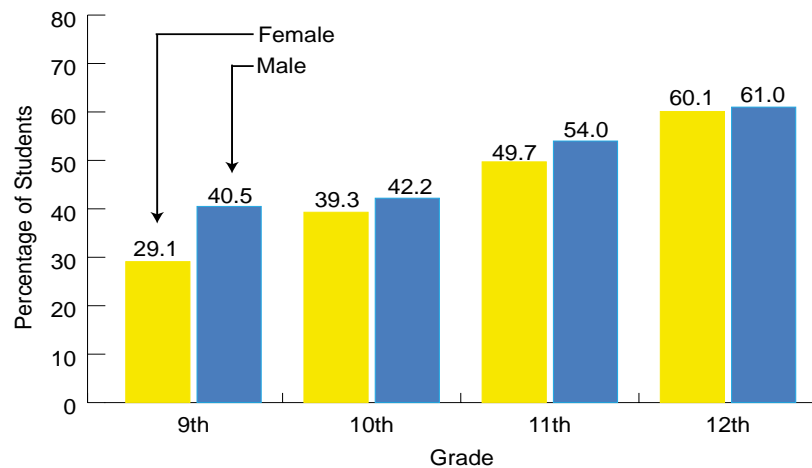
## CONDOM USE

In 2001, more than half (57.9 percent) of sexually active students reported condom use during their last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used. Black students were significantly 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.

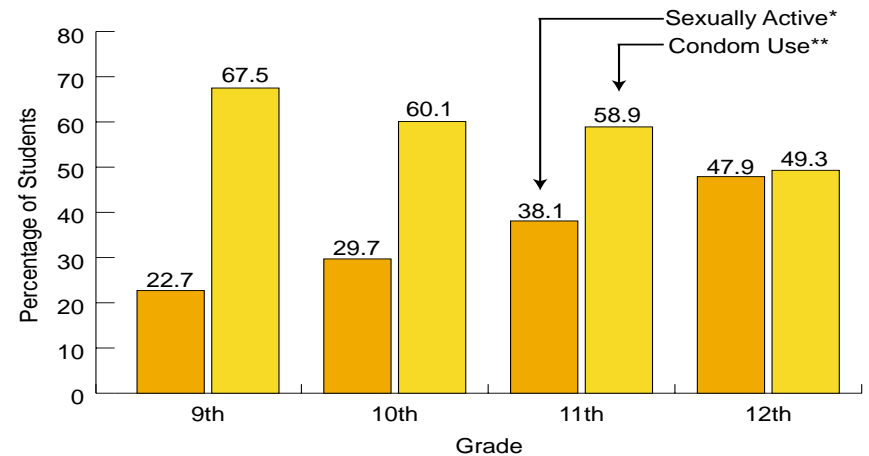
### PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 2001

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



### SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS, BY GRADE: 2001

Source (II.12): 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 2000 was chlamydia, with 1,373

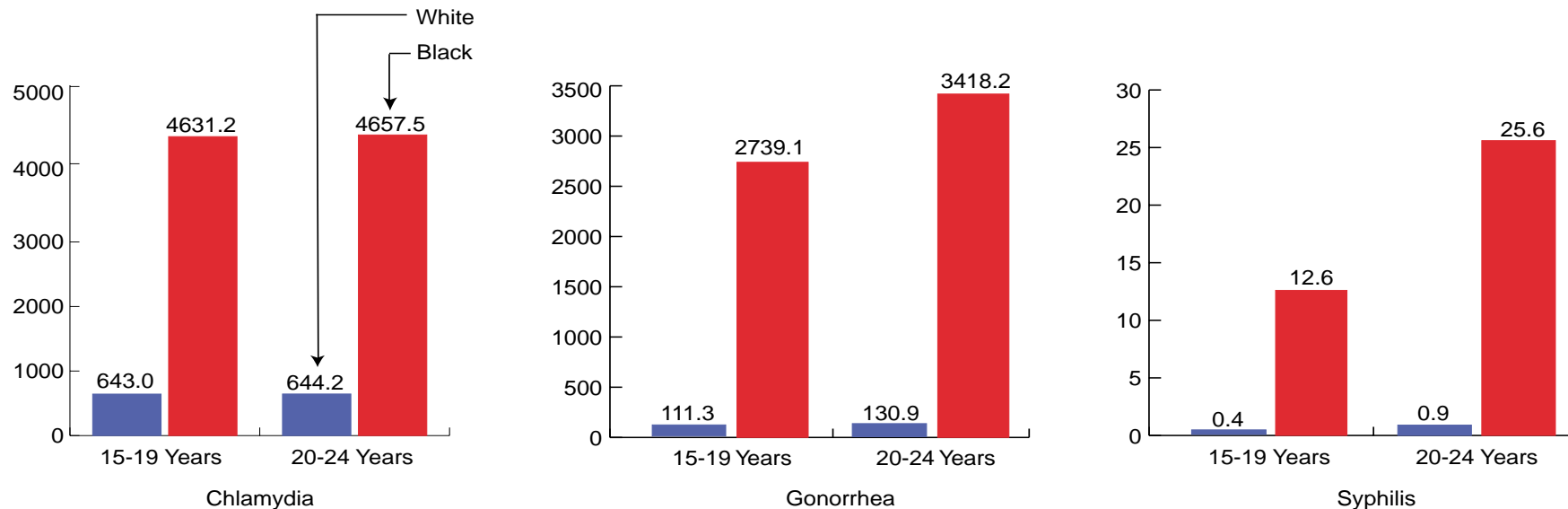
cases per 100,000 adolescents and 1,404 per 100,000 young adults. Gonorrhea followed in prevalence with 516 cases per 100,000 adolescents and 623 cases per 100,000 young adults. Infection rates for chlamydia decreased slightly for adolescents, but increased for young adults from 1999. Gonorrhea among adolescents declined slightly while the rate for young adults increased. Syphilis is much rarer among young people, with only 2.3 cases per 100,000 adolescents and 4.9 cases per 100,000 young adults in

2000, a slight decline in both age groups from 1999.

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.

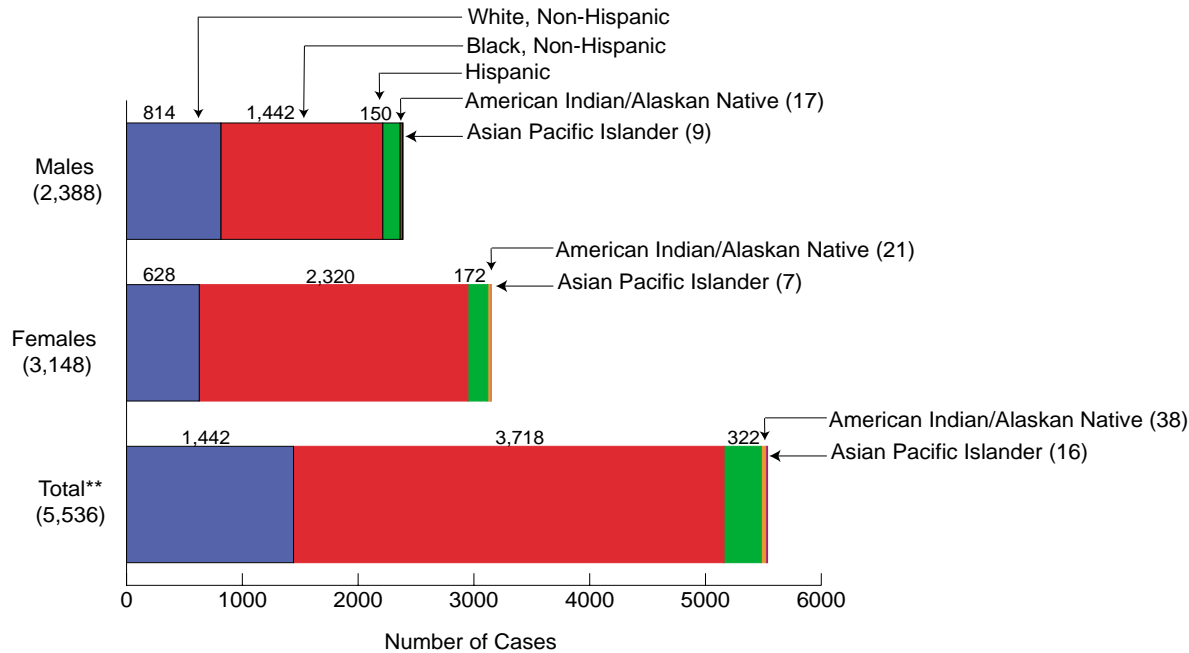
### RATES OF SEXUALLY TRANSMITTED DISEASES PER 100,000 ADOLESCENTS BY AGE AND RACE: 2000

Source (II.13): Centers for Disease Control and Prevention



### ADOLESCENT HIV INFECTION CASES, BY GENDER AND RACE/ETHNICITY FOR AGES 13-19 AT DIAGNOSIS: 1981-2000\*

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



\*Includes persons reported with HIV infection who have not developed AIDS in the 36 areas with confidential HIV infection reporting.

\*\*Graph does not include 24 males and 19 females of unknown race/ethnicity and 1 person of unknown sex.

### ADOLESCENT HIV INFECTION

Males comprise 43 percent of the 5,580 HIV infection cases ever reported among adolescents diagnosed at ages 13-19 and represent 40 percent of the new HIV infection cases reported among adolescents in 2000. Over 60 percent of these new cases were transmitted by men having sex with men. The risk category was not reported or identified for 32 percent of adolescent male HIV infection cases reported in 2000. From 1981 through 2000, black adolescent males were 1.7 times more likely to report HIV infection than white adolescent males, and 9.3 times more likely than Hispanic adolescent males.

Fifty-seven percent of adolescent HIV infection cases ever reported were among females. The proportion of HIV infection cases that are new in adolescent females has been increasing in recent years. Of the new cases in 2000, 38 percent acquired HIV infection through heterosexual contact and 5 percent were injecting drug users. The risk category was not reported for 57 percent of new adolescent female cases in 2000. From 1981 through 2000, black adolescent females were 3.7 times more likely to report HIV infection than white adolescent females, and 13.5 more likely than Hispanic adolescent females.

**ADOLESCENT AIDS**

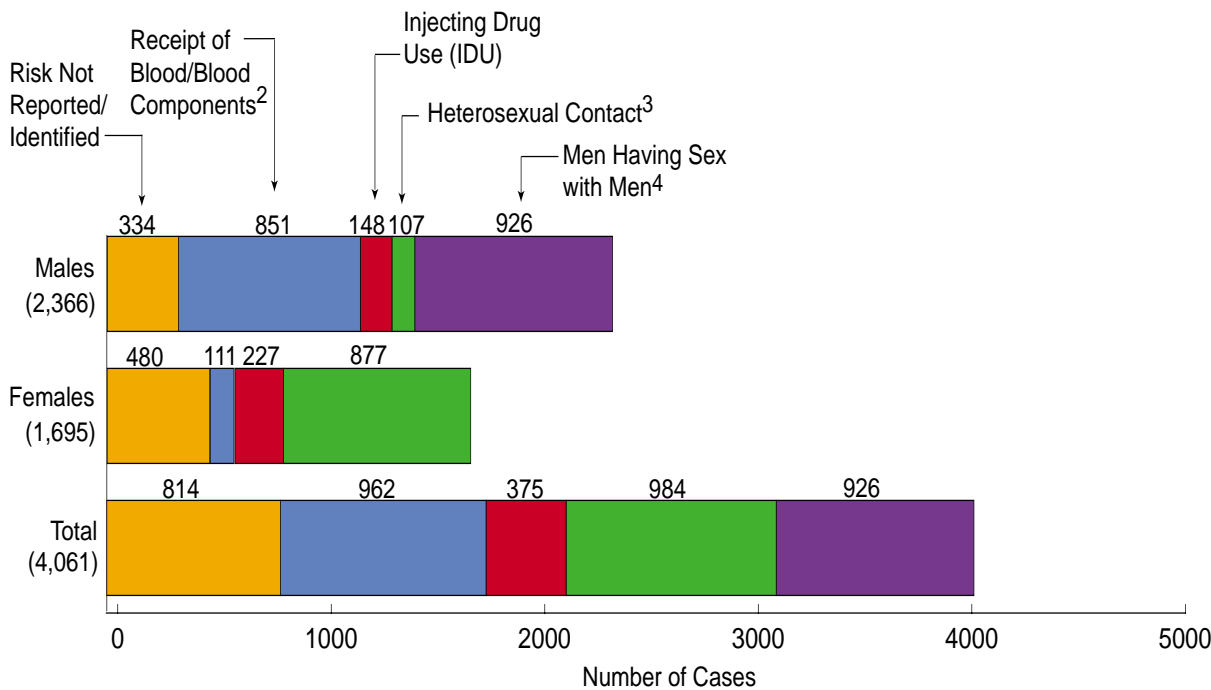
Males comprise 58 percent of the 4,061 AIDS cases ever reported among adolescents aged 13-19 years old and represent 46 percent of the new AIDS cases reported among adoles-

cents 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.

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**

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:

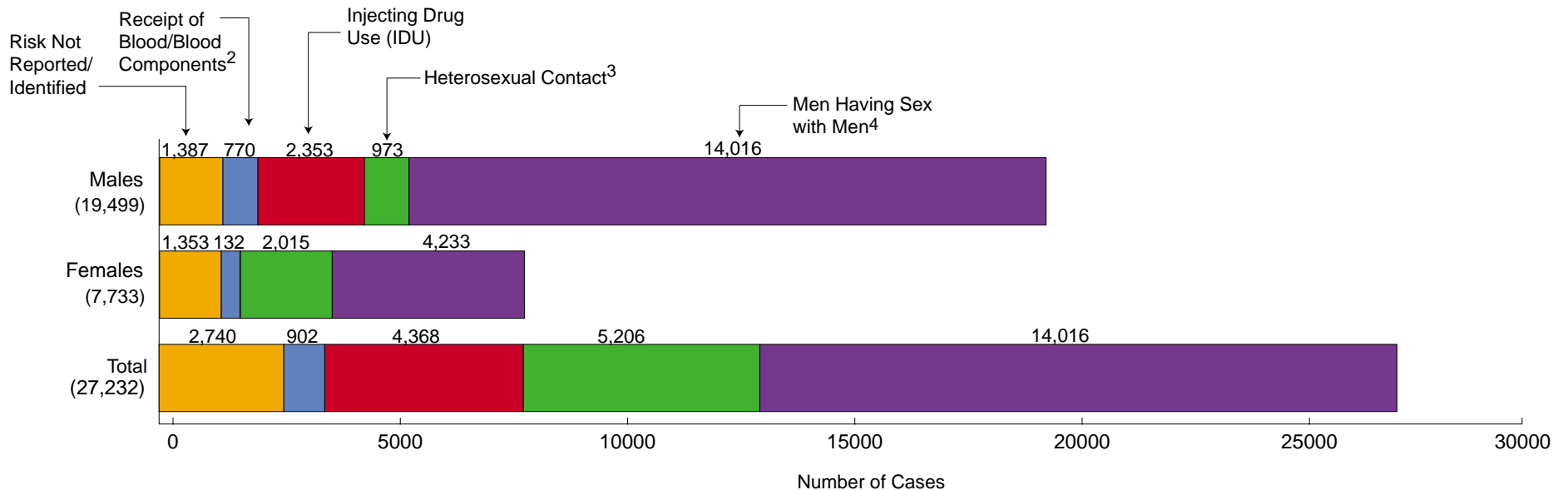
- Received clotting factor for hemophilia coagulation disorder
- Received blood transfusions, blood components, or tissue

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 is a critical public health issue in the United States: homicide was the second leading cause of death among persons aged 15-24 in 2000.

Results from the 2001 Youth Risk Behavior Survey reveal that 17.4 percent of students had carried a weapon, such as gun, knife, or club, on one or more days in the last 30 days; nearly 6 percent had carried a gun. Boys (29.3 per-

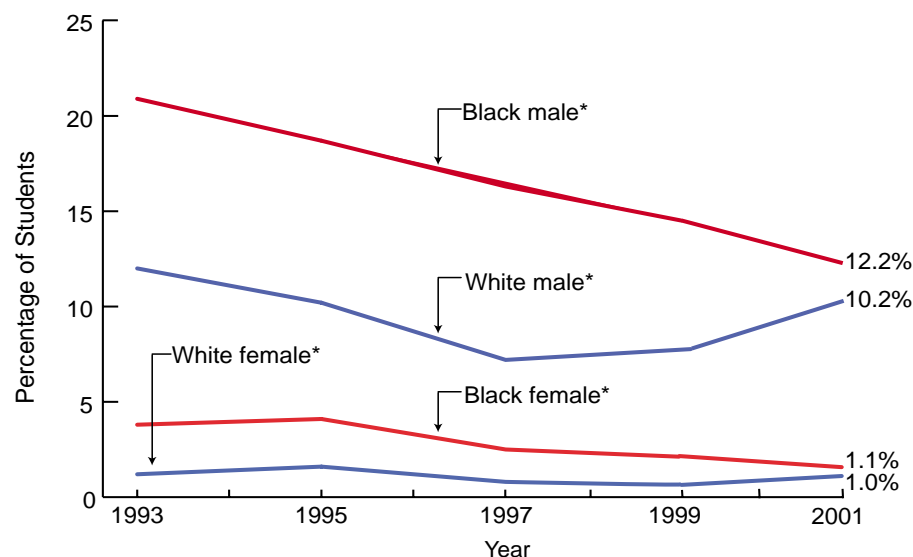
cent) were significantly more likely to carry a weapon than girls (6.2 percent). The percent of high school students who carry weapons had decreased significantly since 1991 but has remained level since 1997.

Some high school students also reported taking weapons to school. In 2001, 6.4 percent of students had carried a weapon on school property in the last thirty days — a 46 percent decrease since 1993. However, despite this

decline, nearly 9 percent of students reported being threatened or injured with a weapon on school property in 2001. In addition, 6.6 percent of students had missed one or more days of school because they felt unsafe at school or on their way to school. 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: 1993-2001

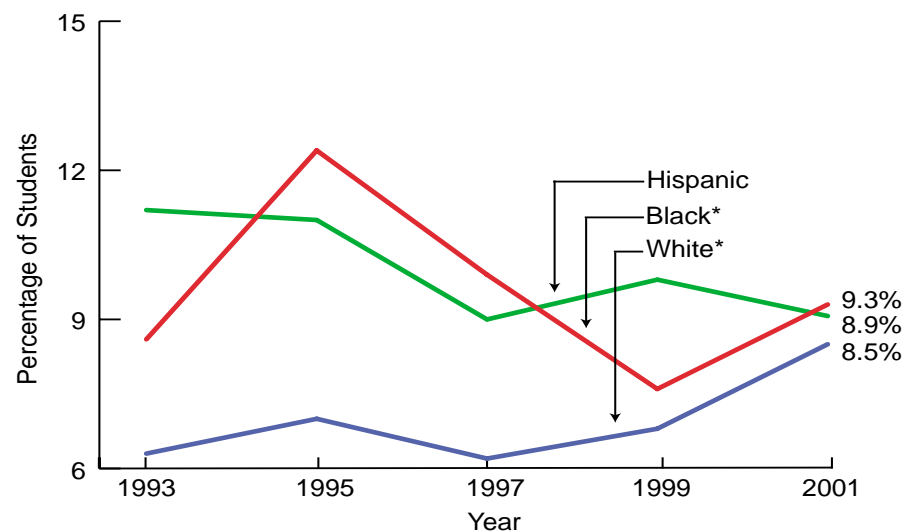
Source (II.12): Centers for Disease Control and Prevention



\*Non-Hispanic

### PERCENTAGE OF HIGH SCHOOL STUDENTS WHO WERE THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY, BY RACE: 1993-2001

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



\*Non-Hispanic



## PHYSICAL ACTIVITY AND OVERWEIGHT

Results from the 2001 national Youth Risk Behavior Survey show that over two-thirds of high school students regularly participate in vigorous physical activity and one quarter participate in moderate physical activity. Furthermore, 53 percent participate in regular strengthening exercises, while 55 percent play on one or more sports teams. Nationwide, 52 percent of high school students were enrolled in a physical education class, though students in

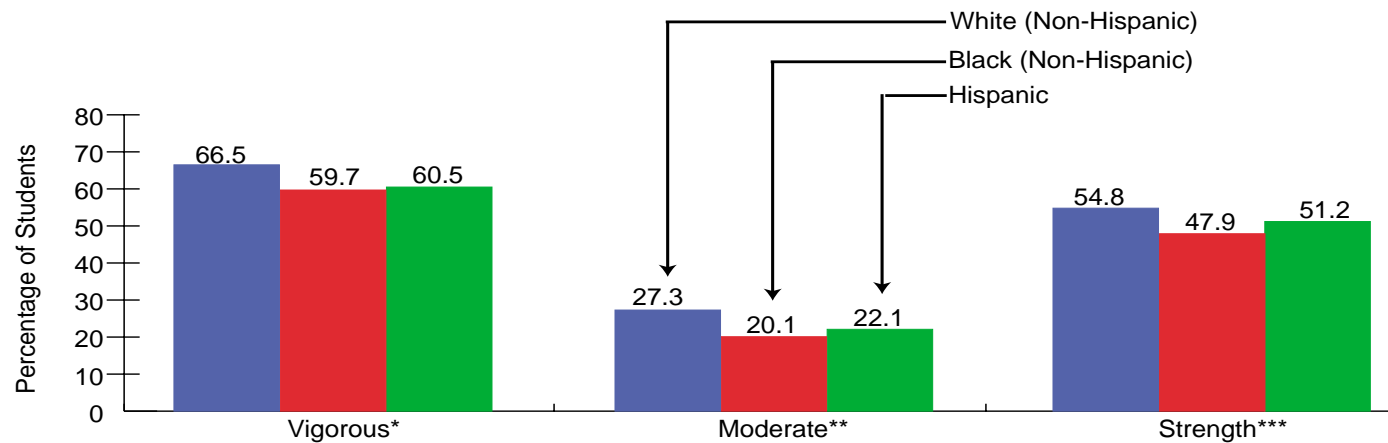
the 9th grade were significantly more likely to be enrolled than students in higher grades. The percentage of students enrolled in daily physical education has declined over the past decade, from 42 percent in 1991 to 32 percent in 2001.

While 29 percent of high school students thought they were overweight, 46 percent were trying to lose weight. Female students were more than twice as likely as male students to be attempting weight loss (62 percent versus 29 percent). Female students were also signifi-

cantly more likely than male students to perceive themselves as overweight, although males were more likely to be overweight. In an effort to lose weight or keep from gaining weight, 44 percent of students had eaten less food, fewer calories, or foods low in fat and nearly 60 percent had exercised. However, a substantial minority had also attempted weight control using potentially unhealthy behaviors—14 percent had fasted for 24 hours or more, 9 percent had taken diet aids without a doctor's advice, and 5 percent had vomited or taken laxatives.

### PERCENT OF HIGH SCHOOL STUDENTS WHO PARTICIPATE IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 2001

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



\*Activities that caused sweating and hard breathing for at least 20 minutes on  $\geq 3$  of the 7 days preceding the survey.

\*\*Activities that did not cause sweating or hard breathing for at least 30 minutes on  $\geq 5$  of the 7 days preceding the survey.

\*\*\*Such as push-ups, sit-ups, or weight lifting on  $\geq 3$  of the 7 days preceding the survey.



## CIGARETTE SMOKING

Cigarette smoking continued to decline among eighth, tenth, and twelfth graders in 2001 as reported by the University of Michigan's Monitoring the Future Study. All three grades showed a decrease from the peak levels of 1996 and 1997 in current smoking, current daily smoking, and current half-pack-a-day smoking. While 12 percent, 21 percent, and 30 percent of eighth, tenth, and twelfth

graders, respectively, reported smoking during the 30 days prior to the survey, these figures represent a 42 percent, 30 percent, and 19 percent decrease in current smoking since the peak levels in 1996 and 1997. The younger age groups have shown the largest improvement over this time period. Researchers speculate that these declines result from an increase in the perceived risk and disapproval of smoking, increases in cigarette price, and declining acces-

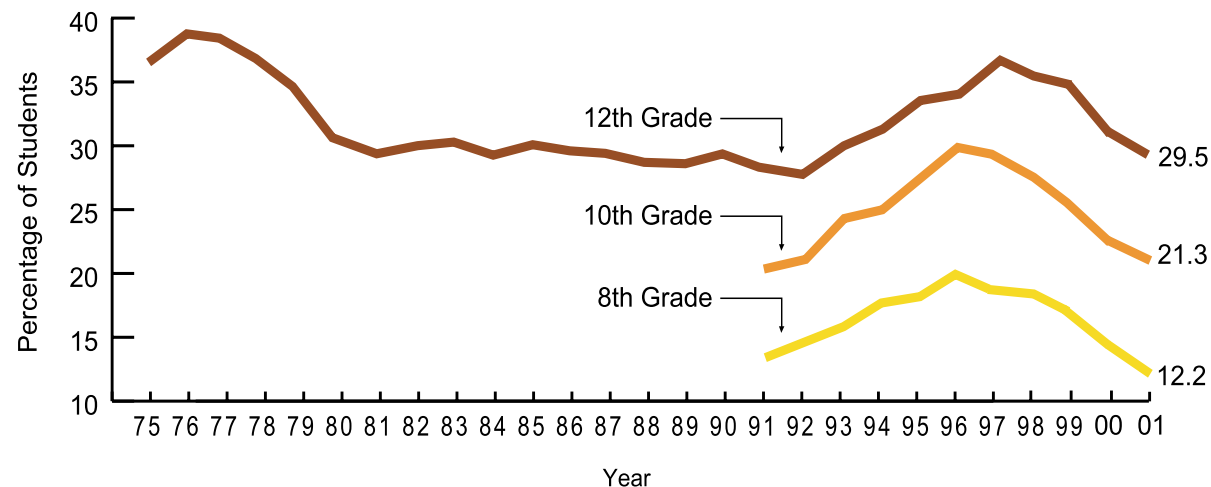
sibility to cigarettes. These improvements are likely to have significant long-term health consequences for this generation of adolescents.

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 2001 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: 1975-2001

Source (II.14): The Monitoring the Future Study, University of Michigan



## SUBSTANCE ABUSE

### *Prevalence and Incidence*

Results of the Substance Abuse and Mental Health Services Administration's 2000 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. Since 1997, the rate of adolescent use of any illicit drugs has declined 15 percent, from 11.4 percent in 1997 to 9.7 percent in 2000.

There was no statistically significant change in the reported use of alcohol, marijuana, cocaine, hallucinogens, or inhalants from 1999 to 2000. However, the proportion of adoles-

cents reporting using heroin in the past month decreased from 0.2 percent in 1999 to 0.1 percent in 2000. Sixteen percent of adolescents age 12-17 are current drinkers. Of these, 10.4 percent reported binge drinking, and 2.6 percent reported heavy alcohol use.

Nearly 1.4 million Americans under the age of 18 were estimated to be first-time users of marijuana in 1999, a 15 percent decline from 1998. However, the youth rates of marijuana initiation have increased considerably since 1990. Also, about a third of those who reported smoking, sniffing, or snorting heroin for the first time in 1999 were persons under the age of 18, representing approximately 34,000 youth.

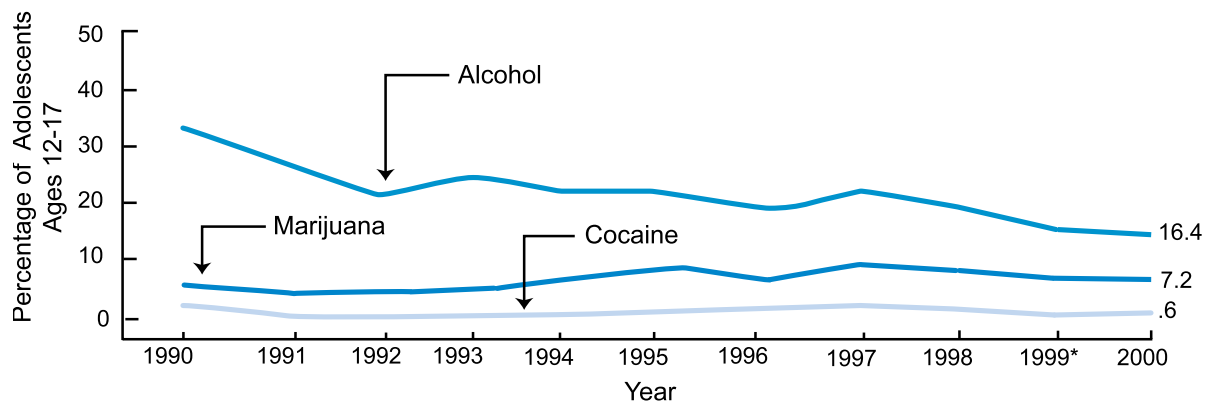
### *Perception of Risk and Access to Drugs*

In 2000, 38 percent of adolescents perceived smoking marijuana to be risky, which is a slight increase from 1999, though not a statistically significant change. The percent of adolescents who perceived cocaine use to be risky also slightly increased from 55.3 percent in 1999 to 55.4 percent in 2000 (though this was also not a statistically significant change).

Fifty-four percent of the adolescents surveyed in 2000 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: 1990-2000

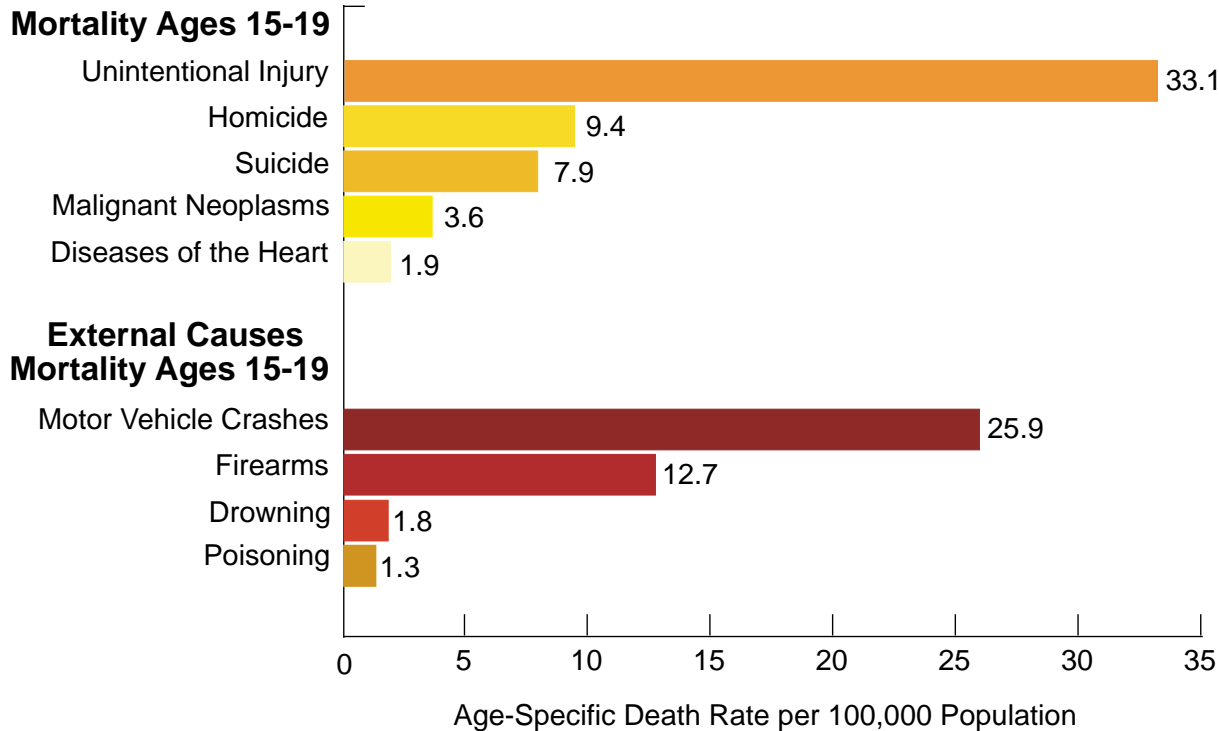
Source (II.15): National Household Survey on Drug Abuse, SAMHSASA



\*Revised estimates

**LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15-19: 2000\***

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



\*preliminary data

**ADOLESCENT MORTALITY**

In 2000, based on preliminary data, there were 13,463 deaths of adolescents aged 15-19 years. In that age group, injury was the leading cause of death. The 6,573 injury deaths accounted for 49 percent of all deaths of 15- to 19-year-olds in 2000. 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 22 percent since 1993.

Motor vehicle crashes were the leading cause of injury mortality among 15- to 19-year-olds in 2000, accounting for 78 percent of unintentional injuries among teenagers. Firearms were the next leading cause of injury death, representing 38 percent of all unintentional injury deaths in this age group.

## ADOLESCENT DEATHS DUE TO INJURY

The National Center for Health Statistics reports that the two leading causes of deaths due to external causes among adolescents are motor vehicle crashes and firearms. In 2000, motor vehicle crashes caused the deaths of 5,149 15- to 19-year-olds. 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 the 2001 Youth Risk Behavior Survey revealed that 14.1 percent of students had rarely or never worn seat belts when riding in a car driven by someone else. Additionally, 30.7 percent of students had ridden on one or more occasions with a driver who had been drinking alcohol in the 30 days preceding the survey.

In 2000, 2,524 15- to 19-year-olds were killed by firearms. Of these, homicide accounted for 59 percent of firearm deaths among teenagers, 35 percent were suicide, and 4 percent were considered to be unintentional.

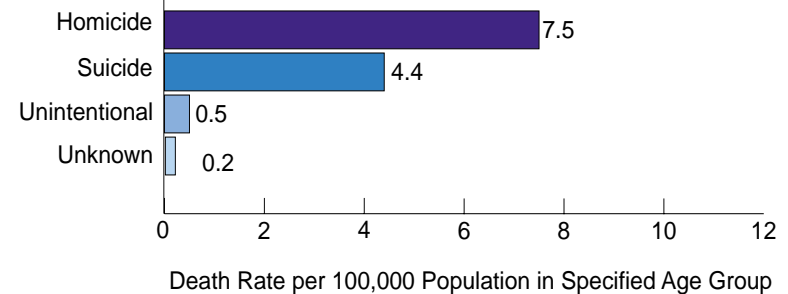
## MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15-19: 1999 and 2000

Source (II.12): National Center for Health Statistics

### Traffic Mortality, by Type of Person Injured (1999)\*



### Firearm Mortality, by Intent (2000)



\*At the time of this writing, detailed 2000 data were not available for traffic mortality.

\*\*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 socio-economic status.

Every state implemented a State Children's Health Insurance Program (SCHIP), using Federal funds that became available for the first time in 1998. This program helps to provide coverage to the approximately 8.4 million uninsured children in the U.S. Outreach and consumer education are 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 recent 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 11.6 percent (8.4 million) children younger than 18 years of age had no insurance coverage in 2000, a decrease of 16.5 percent since 1999. Decreasing rates of uninsurance among children have been attributed to small gains in coverage through Medicaid and SCHIP and employment-based insurance as well as a strong economy and low unemployment.

In 2000, nearly one quarter of all children (23.3 percent) were publicly insured, primarily

through Medicaid, and 70.6 percent were covered by private insurance. By comparison, children living in families with income below the federal poverty more likely to have public insurance (59.6 percent) and be uninsured (22.3 percent).<sup>\*</sup> Far fewer low-income children had private coverage (24.5 percent). Also, individuals in single parent families were more likely to be uninsured than those in families composed of married couples with children (19.0 percent versus 11.4 percent respectively).

Most privately insured children (89.5 percent) received insurance through their parents' employer; however, even when parents are

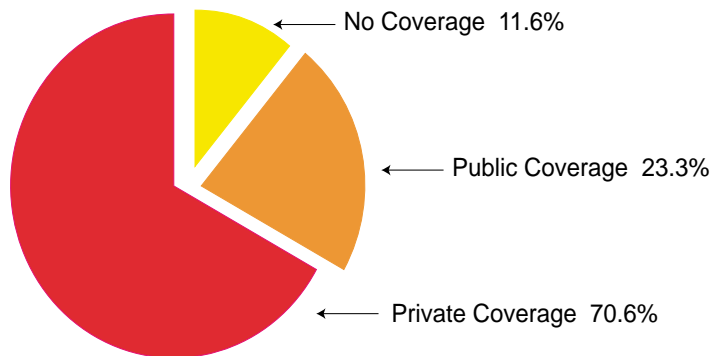
employed, coverage may not be offered or may be prohibitively expensive. Nearly 86 percent of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year.

Created in response to the growing number of uninsured children in low-income working families, the State Children's Health Insurance Program (SCHIP) enrolled 4.6 million children by the end of Federal Fiscal Year 2001. As of 2001, in 36 states and the District of Columbia, children with family income at or above 200 percent of the federal poverty level qualify for coverage.

**HEALTH INSURANCE COVERAGE: 2000**

Source (III.1): Employee Benefit Research Institute

Children Under 18 Years of Age

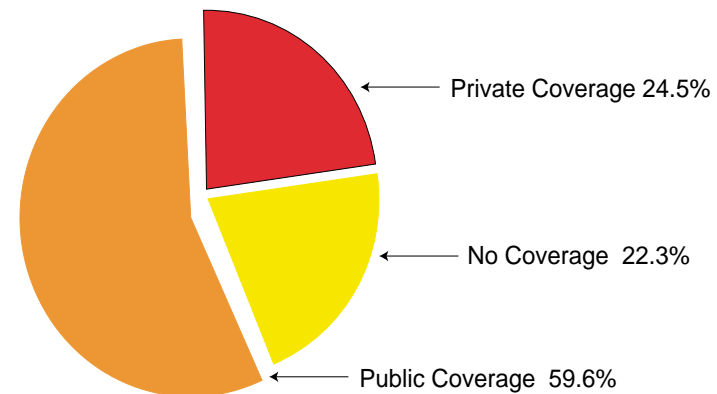


*\*Percents may not add to 100 because children may have more than one source of coverage.*

**HEALTH INSURANCE COVERAGE: 2000**

Source (III.1): Employee Benefit Research Institute

Children Under 18 Years of Age In Poverty



*\*Percents may not add to 100 because children may have more than one source of coverage.*



## 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 2001 National Immunization Survey revealed that 74.2 percent of children aged 19-35 months received the recommended vaccines (4 DTaP, 3 polio, 1 MCV, 3 Hib, 3 hepatitis B) in 2001. The greatest progress among children aged 19-

35 months was seen in the rate of hepatitis B vaccination, which showed a 10.5 percent increase, from 81.8 percent in 1996 to 90.4 percent in 2001. The FDA-approved varicella (chicken pox) vaccine, which was added to the schedule in 1996, was administered to 72.8 percent of children aged 19-35 months in 2001.

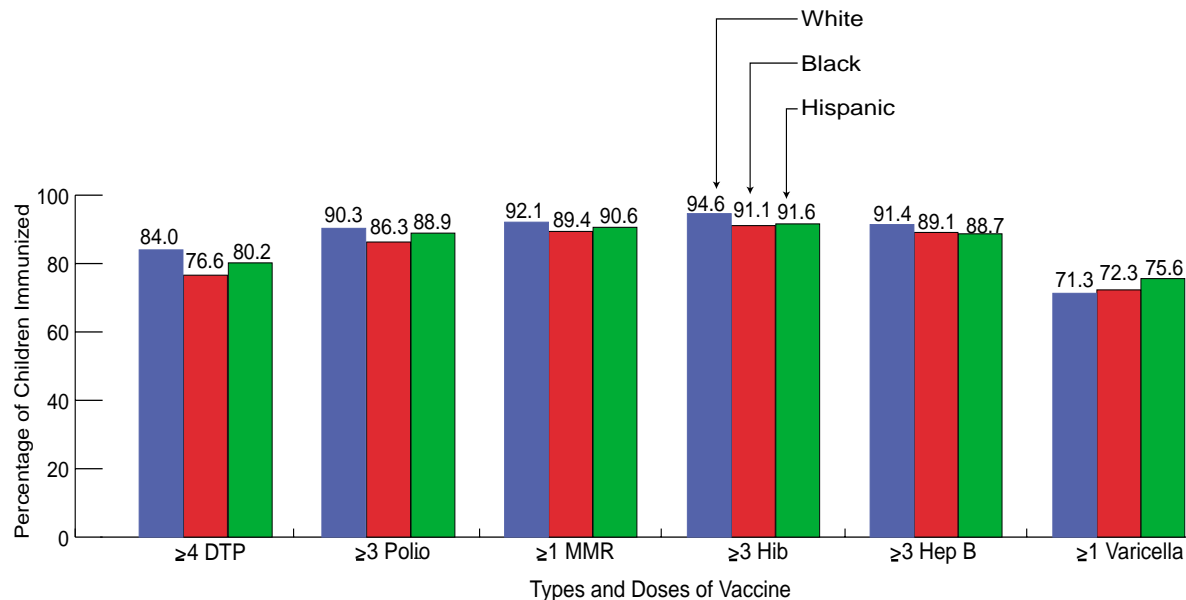
However, approximately 1 million children still need one or more of the recommended doses of a series of vaccine to be fully protected. Coverage varies by race and ethnicity and state and urban areas. With the exception of the varicella vaccine, a greater proportion of

white children aged 19-35 months receive the recommended immunizations compared to black and Hispanic children.

In January 2002, CDC published an updated immunization schedule (see facing page). The new schedule reflects several changes. The schedule moved the first administration of the hepatitis B vaccine to before hospital discharge, though it is appropriate to administer the first dose at two months of age for some infants. Two new vaccines were added to the childhood schedule for the first time in 2002—influenza and pneumococcal polysaccharide. These appear in a new section of the schedule dedicated to selected populations. The hepatitis A vaccine is also included in this section. A new column highlights the need to reassess the vaccine status of 11- to 12-year-olds at their well child visit. And, finally, new catch-up bars underscore the importance of updating children's vaccinations through 18 years of age.

### ESTIMATED VACCINATION COVERAGE AMONG CHILDREN AGED 19-35 MONTHS BY RACE/ETHNICITY: 2001

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



## RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, 2002

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

VACCINE ↓	AGE↓	Range of recommended ages				Catch-up vaccination				Preadolescent assessment			
		Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	13-18 yrs.
Hepatitis B <sup>1</sup>	Hep B #1	only if mother HBsAg(-)									Hep B series		
Diphtheria, Tetanus, Pertussis <sup>2</sup>		Hep B #2		DTaP	DTaP	DTaP		DTaP			DTaP	Td	
<i>H. influenzae</i> type b <sup>3</sup>			Hib	Hib	Hib		Hib						
Inactivated Polio <sup>4</sup>			IPV	IPV			IPV				IPV		
Measles, Mumps, Rubella <sup>5</sup>							MMR#1				MMR #2	MMR #2	
Varicella <sup>6</sup>							Varicella				Varicella		
Pneumococcal <sup>7</sup>			PCV	PCV	PCV		PCV			PCV		PPV	
Hepatitis A <sup>8</sup>		Vaccines below this line are for selected populations									Hepatitis A series		
Influenza <sup>9</sup>											Influenza (yearly)		

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2001, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. ■■■■■ Indicates age groups that warrant special effort to administer those vaccines not previously given. 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 the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

<sup>1</sup> **Hepatitis B vaccine (Hep B).** All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent hepatitis B vaccine can be used for the birth dose. Monovalent or combination vaccine containing Hep B may be used to complete the series; four doses of vaccine may be administered if combination vaccine is used. The second dose should be given at least 4 weeks after the first dose, except for Hib containing vaccine which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months. 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 second dose is recommended at age 1-2 months and the vaccination series should be completed (third or fourth dose) at age 6 months. Infants born to mothers whose HBsAg status is unknown should receive the first dose of the hepatitis B vaccine series 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 age 1 week).

<sup>2</sup> **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at

age 15-18 months. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

<sup>3</sup> **Haemophilus influenzae type b (Hib) conjugate vaccine.** Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

<sup>4</sup> **Inactivated polio vaccine (IPV).** An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at ages 2 months, 4 months, 6-18 months, and 4-6 years.

<sup>5</sup> **Measles, mumps, and rubella vaccine (MMR).** The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

<sup>6</sup> **Varicella vaccine.** Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children, i.e. those who lack a reliable history of chickenpox. Susceptible persons aged >13 years should receive two doses, given at least 4 weeks apart.

<sup>7</sup> **Pneumococcal vaccine.** The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups. See MMWR. 2000;49(RR-9):1-35.

<sup>8</sup> **Hepatitis A vaccine.** Hepatitis A vaccine is recommended for use in selected states and regions, and for certain high-risk groups; consult your local public health authority. See MMWR. 1999;48(RR-12):1-37.

<sup>9</sup> **Influenza vaccine.** Influenza vaccine is recommended annually for children age > 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes; see MMWR. 2001;50(RR-4):1-44), and can be administered to all others wishing to obtain immunity. Children aged 12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if age 3 years). Children aged 8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

For additional information about vaccines, vaccine supply, and contraindications for immunization, please visit the National Immunization Program Web site at [www.cdc.gov/nip](http://www.cdc.gov/nip) or call the National Immunization Hotline at (800) 232-2522 (English) or (800) 232-0233 (Spanish).

## DENTAL CARE

Access to oral health care is a significant problem for low-income children. Analysis of the 1999 National Survey of America's Families found that nearly one in ten low-income children had an unmet need for dental care. Slightly more than 30 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 as recommended by the American Academy of Pediatrics.

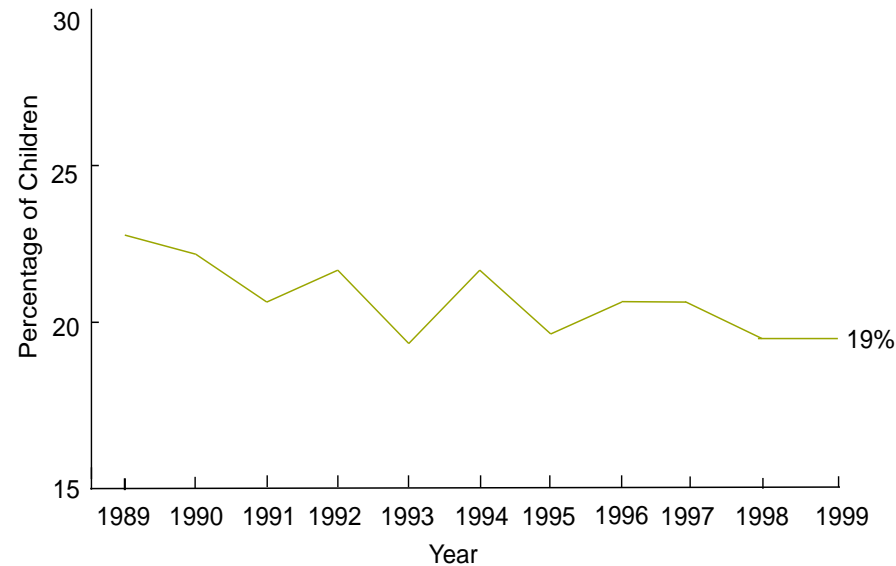
Use of dental care among low-income children varies by a number of demographic characteristics. Low-income children who have not had a dental visit in the last year are more likely to be younger, uninsured, Hispanic, and born outside of the United States. These children are also more likely to have parents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

Although many dental problems can be prevented with regular screening and preventative services, these services are not always

available to those children who need them most. In Federal Fiscal Year 1999, 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.

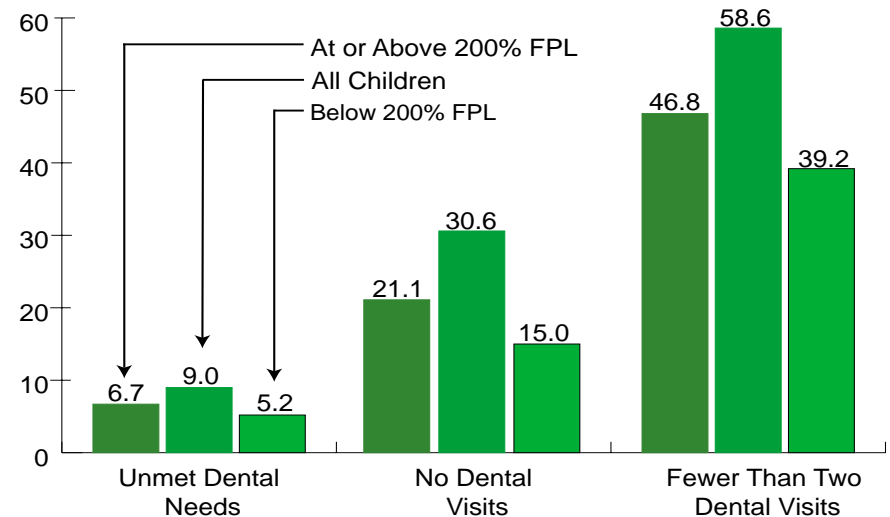
### PERCENTAGE OF CHILDREN RECEIVING AN EPSDT PREVENTIVE DENTAL SERVICE: 1989-1999

Source (III.4): Health Care Financing Administration



### PERCENT OF CHILDREN WITH DENTAL CARE NEEDS AND THOSE RECEIVING DENTAL CARE IN THE LAST 12 MONTHS BY INCOME: 1999

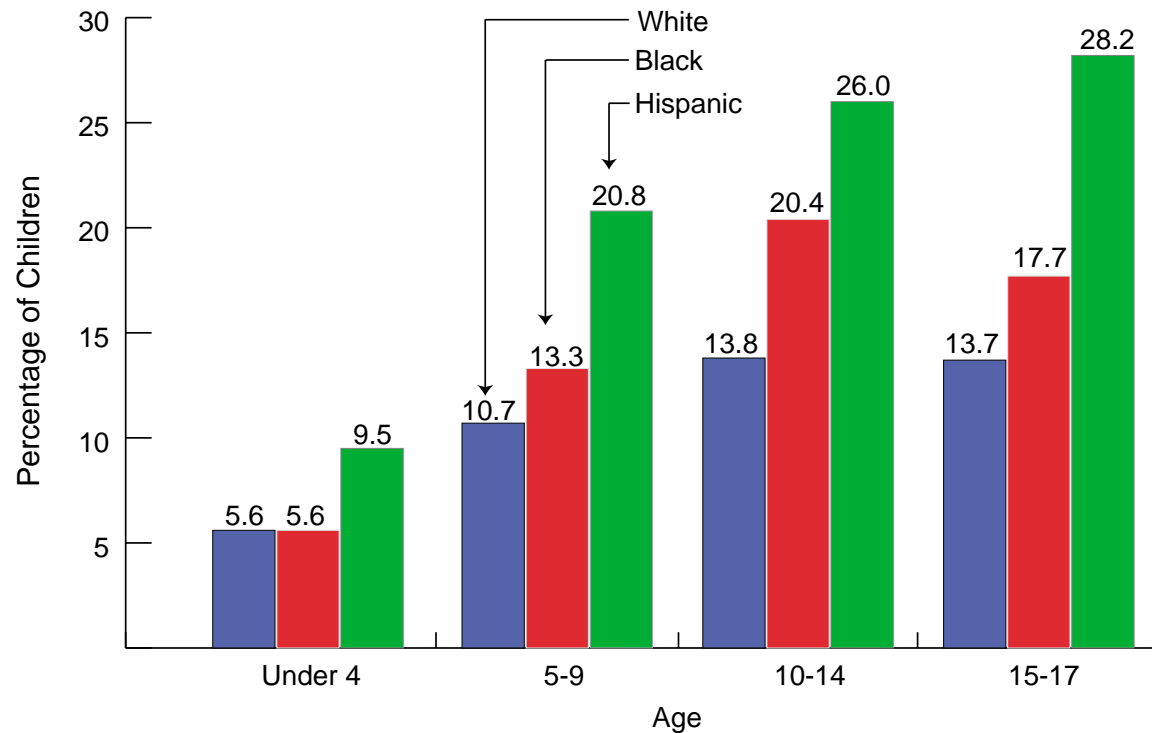
Source (III.5): National Survey of America's Families





### PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 2000

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



### PHYSICIAN VISITS

In 2000, approximately 13 percent of children under age 18 had not seen a physician in the past year. Older children were more likely to go without a physician visit compared to younger children. Nearly 17 percent of children between 10-17 years had not had a physician visit in the past year compared to 13 percent of children ages 5-9 and 6.5 percent under age 5. In all age groups, Hispanic children were nearly twice as likely as white children not to have a physician visit. During 2000, 5.6 percent of white, 5.6 percent of black, and 9.5 percent of Hispanic children age 4 or under were not seen by a physician; this gap widened with age. Black children were more likely than white but less likely Hispanic children to have a physician visit in the past year.

The American Academy of Pediatrics recommends that children have eight health care visits in their first year, three times in their second year, and once a year, generally, from middle childhood throughout adolescence.

**PLACE OF PHYSICIAN CONTACT**

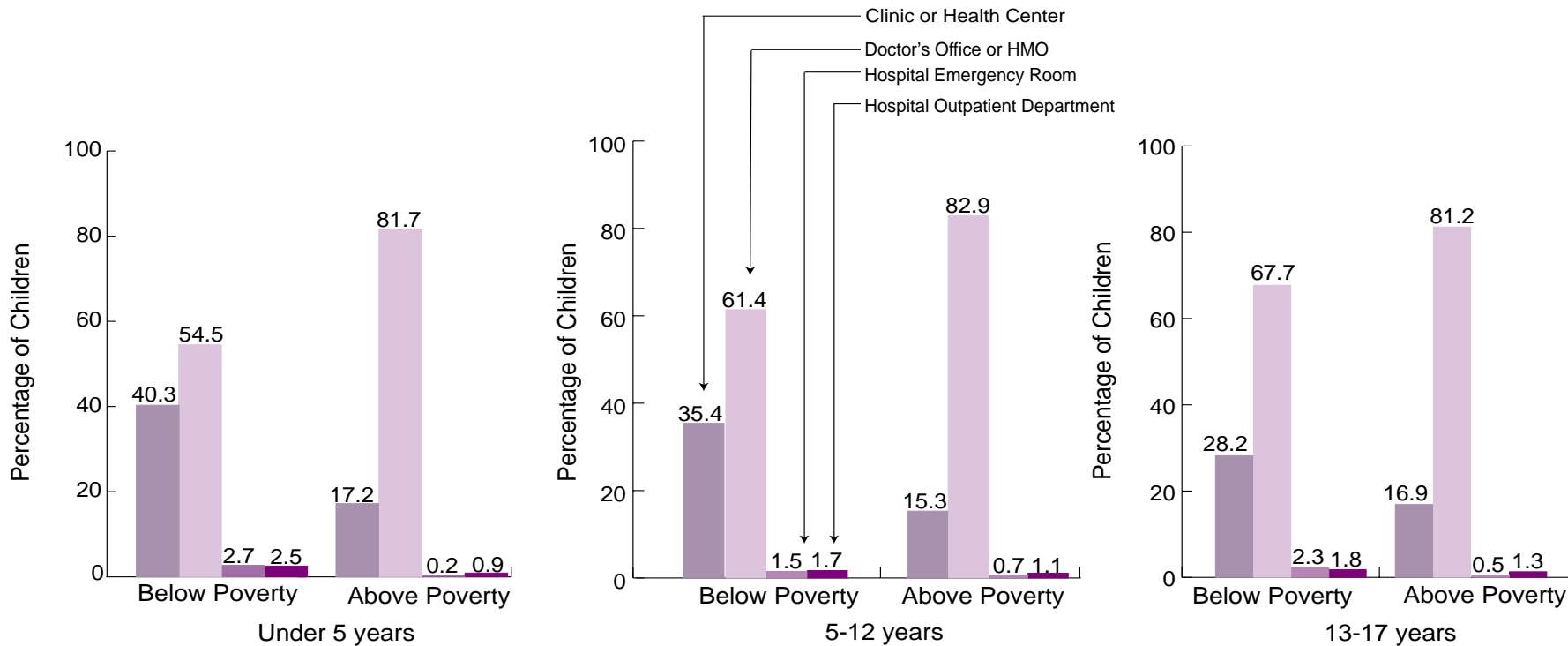
Most children with a usual source of care, regardless of age and racial and ethnic group, went to physicians' offices and HMOs for health care in 2000. Children with family income above poverty were approximately five times more

likely to seek care through a physician's office or HMO compared to a clinic or health center. Children with family income below poverty were more likely to use a clinic or health center as their usual source of care than were non-poor children. A greater proportion of younger low-income children attended clinics and health

centers than adolescents. Most children reported the hospital emergency department as the least utilized source of care.

**USUAL SOURCE OF ACUTE CARE: 2000**

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



## SERVICE USE BY CHILDREN WITH ACTIVITY LIMITATIONS

### *Physician Use*

In 2000, nearly 30 percent of children under age five who were limited in their activities\* had 10 or more physician visits over the year.

In comparison, only 10 percent of children under five who were without limitations reported the same number of visits. Children over 5 years of age with activity limitations were four times as likely to have 10 or more visits than were children without limitations.

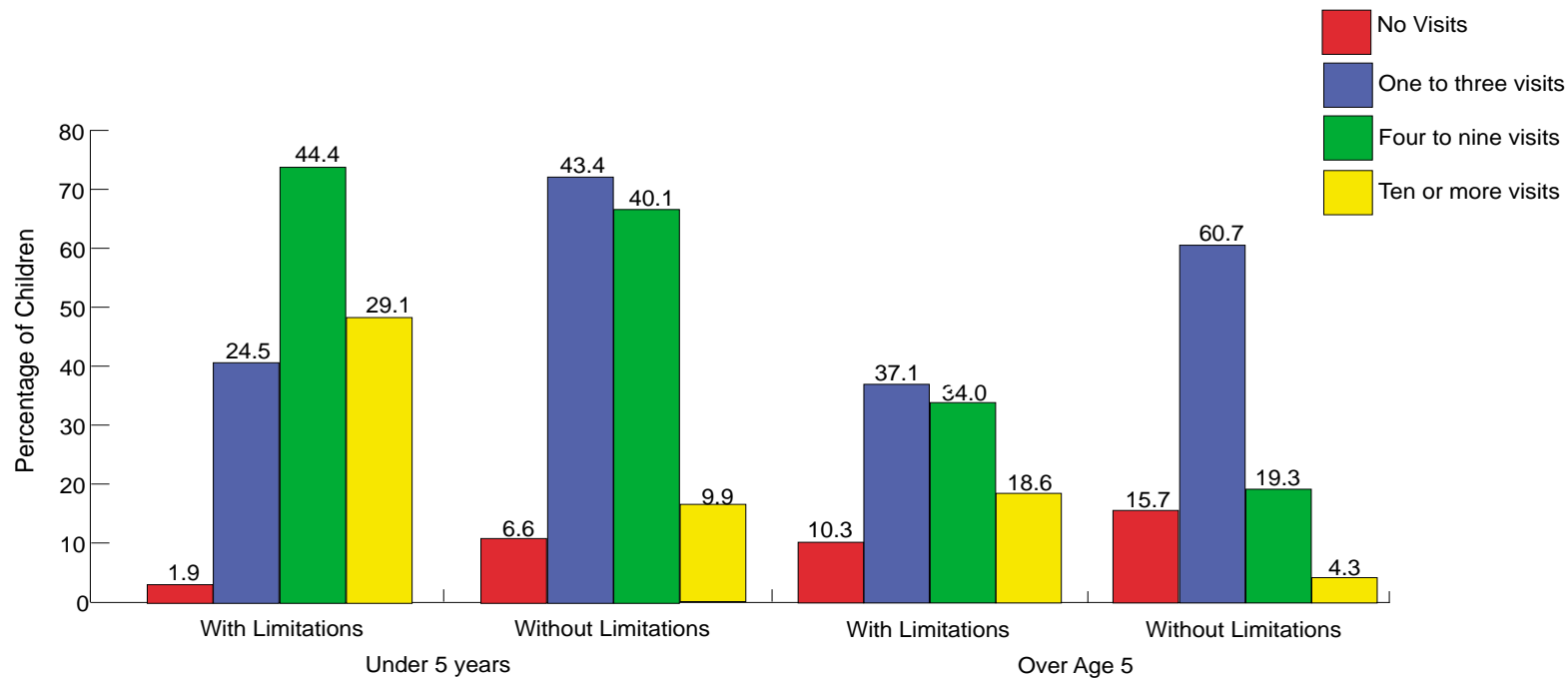
### *Hospital Use*

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

*\*The National Health Interview Survey identifies children as limited in their activities when they are limited in the kind or amount of play activities, receive Special Education or Early Intervention Services, or require assistance with activities of daily living*

## PHYSICIAN UTILIZATION BY CHILDREN WITH ACTIVITY LIMITATIONS, BY AGE: 2000

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

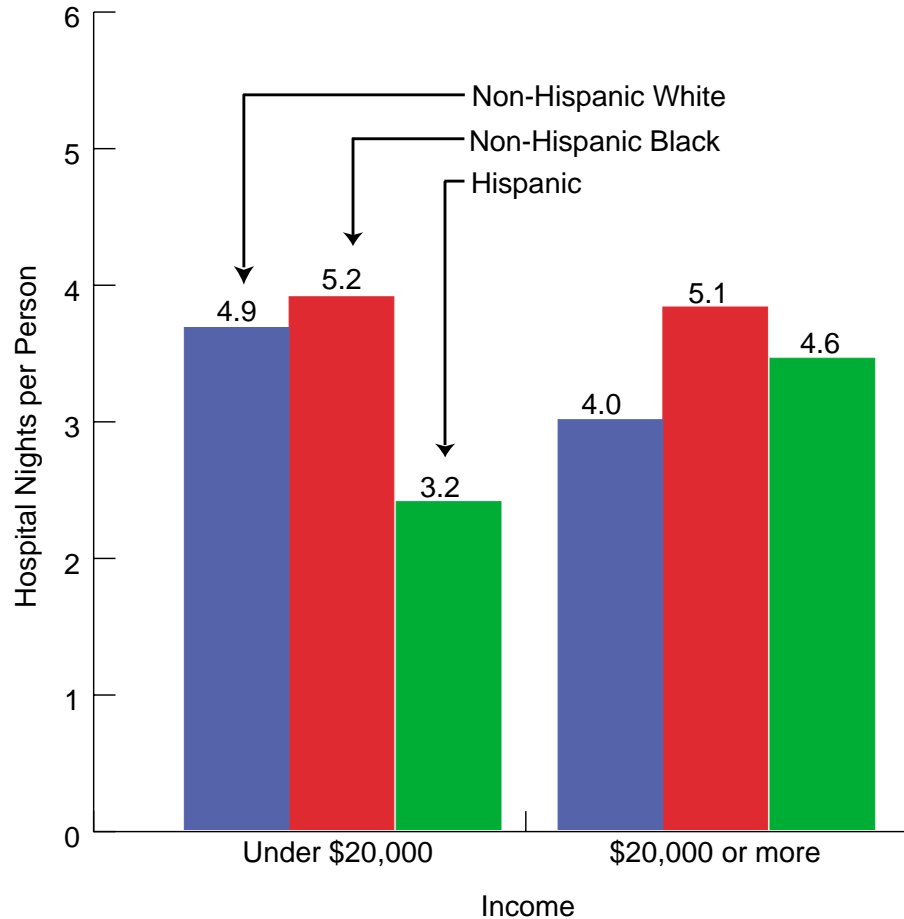






**HOSPITAL UTILIZATION BY INCOME AND RACE: 2000**

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

**HOSPITAL UTILIZATION**

In 2000, children younger than 18 living in families with annual income less than \$20,000 averaged slightly more nights in the hospital (including deliveries) than children in higher income families, 4.4 to 4.1 nights respectively. Hispanic children in low-income families had shorter average hospital stays than did Hispanic children from higher-income families. By comparison, white and black children living in low-income families had about the same average length or longer hospital stays than white and black children from higher-income families.



## PRENATAL CARE

### *Early Prenatal Care*

The proportion of mothers beginning prenatal care in the first trimester was 83.2 percent in 2000, unchanged from 1999. However, the proportion of women receiving timely care has increased steadily from 75.8 percent in 1990.

Though the majority of women received early prenatal care, racial disparities persist. In 2000, 88.5 percent of white women and 84.0 percent of Asian or Pacific Islander women received early prenatal care compared to 74.3 percent of black, 74.4 percent of Hispanic, and

69.3 percent of American Indian women. However, differences by race are narrowing. The proportion of black, Hispanic, and American Indian women receiving early prenatal care increased by 20 percent or more between 1990 and 2000.

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

### *Late or No Prenatal Care*

Women beginning prenatal care in the third trimester or going without prenatal care

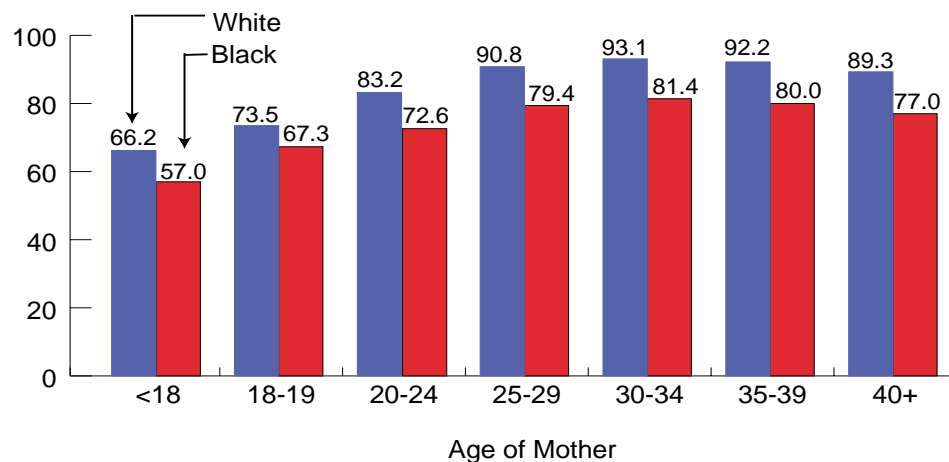
increased slightly from 3.8 percent in 1999 to 3.9 percent in 2000. However, the percent of women receiving late or no prenatal care has decreased from 6.1 percent in 1990.

Regardless of age, black and Hispanic 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 20 years old, being unmarried, having low educational attainment, and being a member of a racial or ethnic minority.

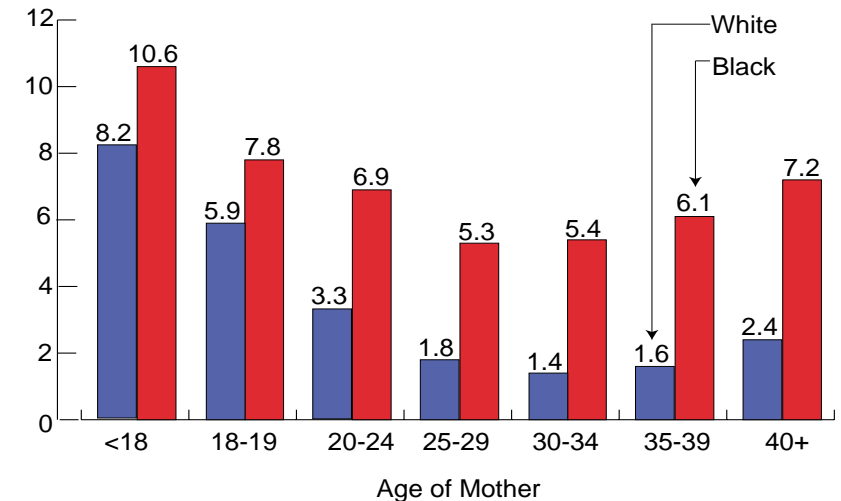
### PERCENTAGE OF MOTHERS BEGINNING PRENATAL CARE IN THE FIRST TRIMESTER, BY AGE AND RACE: 2000

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



### PERCENTAGE OF MOTHERS RECEIVING LATE OR NO PRENATAL CARE, BY AGE AND RACE: 2000

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. had continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) and the State Children's Health Insurance Program (SCHIP) helps to assure that children living in low-income families receive adequate health care services. In 2000, Vermont had the greatest proportion of children with Medicaid/SCHIP coverage (37 percent), while Virginia had the smallest proportion (8.7 percent). The national average was 20.6 percent. Texas led the states with the highest proportion of uninsured children at 21.5 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: 2000**

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				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		All***	White	Black	All***	White	Black	All***	White	Black	Hispanic
<b>UNITED STATES†</b>	<b>7.6</b>	<b>6.5</b>	<b>13.0</b>	<b>83.2</b>	<b>85.0</b>	<b>74.3</b>	<b>4.1</b>	<b>3.5</b>	<b>7.8</b>	<b>6.3</b>	NEVADA	7.2	6.7	12.9	74.4	75.0	65.9	4.4	4.2	7.8	6.4
ALABAMA	9.7	7.7	14.0	82.8	88.1	72.0	5.7	4.2	8.8	6.8	NEW HAMPSHIRE	6.3	6.3	*	91.1	91.4	76.7	1.8	1.8	3.8	3.8
ALASKA	5.6	4.9	11.7	80.1	84.2	81.8	4.0	2.4	8.2	5.2	NEW JERSEY	7.7	6.5	12.8	80.6	84.5	64.0	2.4	1.8	6.0	4.9
ARIZONA	7.0	6.8	12.8	76.5	77.0	74.1	5.3	5.1	7.5	8.0	NEW MEXICO	8.0	8.2	13.1	68.6	70.1	65.8	6.5	6.5	8.4	8.6
ARKANSAS	8.6	7.2	13.7	79.7	82.6	69.1	5.7	4.5	10.4	5.0	NEW YORK	7.7	6.7	11.4	80.9	84.3	71.4	2.8	2.4	5.2	5.2
CALIFORNIA	6.2	5.6	11.6	84.5	84.5	81.9	3.7	3.9	5.3	5.5	NORTH CAROLINA	8.8	7.1	13.6	84.6	87.7	75.9	4.5	3.4	7.9	5.6
COLORADO	8.4	8.0	14.8	80.7	81.0	75.2	4.2	4.1	7.1	8.2	NORTH DAKOTA	6.4	6.5	*	86.3	88.8	78.0	2.5	1.8*		4.5
CONNECTICUT	7.4	6.8	12.0	89.4	90.6	81.8	2.7	2.2	6.2	7.8	OHIO	7.9	7.0	13.1	86.4	88.4	75.3	3.9	3.1	8.9	6.5
DELAWARE	8.6	7.1	13.2	85.3	87.8	77.4	4.4	2.8	9.7	5.7	OKLAHOMA	7.5	6.9	13.1	79.1	81.3	70.7	5.3	4.6	8.6	8.5
DC	11.9	7.4	14.0	75.3	85.5	70.2	5.7	2.3	7.5	6.2	OREGON	5.6	5.4	11.0	81.3	81.6	76.2	3.8	3.7	7.3	6.9
FLORIDA	8.0	6.6	12.3	83.7	86.8	73.6	4.5	3.5	8.1	4.7	PENNSYLVANIA	7.7	6.7	13.5	85.4	87.6	72.6	3.5	2.6	9.0	9.1
GEORGIA	8.6	6.6	12.7	86.9	89.8	81.1	4.9	3.7	7.5	5.5	RHODE ISLAND	7.2	6.5	13.1	90.8	91.7	85.9	3.5	3.2	6.0	6.6
HAWAII	7.5	5.3	10.4	85.5	89.5	89.3	3.2	1.0	2.5	6.1	SOUTH CAROLINA	9.7	7.2	14.2	79.4	84.2	70.9	5.6	3.8	8.9	6.2
IDAHO	6.7	6.7	*	80.9	81.2	74.0	3.4	3.3	9.3	9.0	SOUTH DAKOTA	6.2	5.9	*	78.7	82.6	70.5	3.6	2.4	5.7	6.3
ILLINOIS	7.9	6.4	14.1	82.4	84.9	71.3	4.1	2.9	9.7	5.3	TENNESSEE	9.2	7.8	14.6	83.1	86.0	72.2	5.0	4.0	8.9	6.2
INDIANA	7.4	6.7	12.6	80.8	82.3	68.5	4.0	3.5	8.3	5.2	TEXAS	7.4	6.7	12.7	78.8	78.8	76.3	5.7	5.6	7.9	7.7
IOWA	6.1	5.9	11.7	88.2	88.7	77.4	3.1	2.9	9.5	6.5	UTAH	6.6	6.5	12.5	79.4	80.4	56.6	2.8	2.7	5.8	6.5
KANSAS	6.9	6.5	12.2	86.9	87.6	79.1	3.6	3.3	8.2	7.1	VERMONT	6.1	6.0	*	88.5	88.6	74.2	2.2	2.2	3.1	9.1
KENTUCKY	8.2	7.7	13.7	86.8	87.6	78.6	4.5	4.2	8.2	5.1	VIRGINIA	7.9	6.5	12.6	85.2	88.2	76.0	3.2	2.2	6.7	3.9
LOUISIANA	10.3	7.4	14.3	83.3	90.5	73.6	6.0	3.4	9.7	3.6	WASHINGTON	5.6	5.2	10.6	82.6	83.4	74.8	3.3	3.2	5.6	7.0
MAINE	6.0	6.0	*	88.7	89.0	75.9	2.7	2.7	6.3	2.1	WEST VIRGINIA	8.3	8.1	15.4	86.1	86.7	70.2	4.1	3.9	8.7	4.0
MARYLAND	8.6	6.4	12.8	86.4	90.8	77.7	3.6	2.2	6.6	3.7	WISCONSIN	6.5	5.8	13.3	84.2	86.5	69.9	3.3	2.3	11.2	7.1
MASSACHUSETTS	7.1	6.7	10.7	89.3	90.9	79.4	2.2	2.0	4.4	7.9	WYOMING	8.3	8.3	*	82.7	83.4	73.7	3.8	3.6	8.8	7.0
MICHIGAN	7.9	6.4	14.5	84.2	87.2	70.1	3.6	2.7	7.6	6.3											
MINNESOTA	6.1	5.7	11.0	84.8	87.3	67.5	2.7	2.0	7.5	6.5											
MISSISSIPPI	10.7	7.9	14.0	81.3	88.8	72.4	7.2	4.5	10.5	5.9											
MISSOURI	7.6	6.6	13.2	87.8	89.4	79.0	4.4	3.5	9.2	5.5											
MONTANA	6.2	6.1	*	83.3	86.1	86.4	3.8	2.9	4.4	7.0											
NEBRASKA	6.8	6.4	13.0	83.2	84.5	68.0	3.2	2.7	9.4	5.3											

\* figure does not meet standards of reliability or precision

† excludes data for the territories

\*\*\* includes races other than white and black

## STATE-SPECIFIC DATA

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

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

State	Medicaid Enrollees*	Per Enrollee Expenditures**	Participant Ratio ***	State	Medicaid Enrollees*	Per Enrollee Expenditures**	Participant Ratio***
ALABAMA	364,832	\$740	.40	NEW HAMPSHIRE	58,861	\$1,963	.73
ALASKA	52,428	\$2,456	.49	NEW JERSEY	460,440	\$1,789	.31
ARIZONA	412,367	\$1,779	.60	NEW MEXICO	231,378	\$1,702	.49
ARKANSAS	236,727	\$1,734	.21	NEW YORK	1,621,869	\$2,854	.91
CALIFORNIA	3,438,056	\$1,177	.66	NORTH CAROLINA	674,006	\$1,570	.67
COLORADO	200,408	\$2,038	.44	NORTH DAKOTA	32,657	\$1,794	.40
CONNECTICUT	213,695	\$1,661	.51	OHIO	796,056	\$1,424	.33
DELAWARE	58,513	\$2,334	.67	OKLAHOMA	327,768	\$1,205	.35
DC	81,278	\$2,297	.52	OREGON	255,894	\$1,791	.45
FLORIDA	1,137,381	\$1,380	.45	PENNSYLVANIA	882,877	\$1,793	.50
GEORGIA	746,845	\$1,233	.44	RHODE ISLAND	77,751	\$2,049	.77
HAWAII	87,249	N/A	.64	SOUTH CAROLINA	369,983	\$1,369	.35
IDAHO	74,589	\$1,762	.42	SOUTH DAKOTA	52,925	\$1,647	.36
ILLINOIS	1,045,873	\$1,447	.69	TENNESSEE	669,063	\$1,178	.27
INDIANA	371,973	\$1,461	.48	TEXAS	N/A	\$1,448	N/A
IOWA	172,238	\$1,930	.91	UTAH	126,290	\$1,410	.53
KANSAS	N/A	\$1,407	N/A	VERMONT	62,282	\$1,717	.56
KENTUCKY	335,619	\$1,975	.41	VIRGINIA	412,235	\$1,235	.50
LOUISIANA	430,065	\$1,186	.61	WASHINGTON	N/A	\$1,082	N/A
MAINE	N/A	\$3,566	N/A	WEST VIRGINIA	209,341	\$1,251	.40
MARYLAND	338,566	\$2,352	.40	WISCONSIN	299,364	\$1,510	.52
MASSACHUSETTS	564,560	\$1,741	.46	WYOMING	31,697	\$1,527	.40
MICHIGAN	781,009	\$983	.40				
MINNESOTA	333,186	\$2,070	.47				
MISSISSIPPI	298,274	\$1,297	.42				
MISSOURI	467,499	\$1,172	.45				
MONTANA	51,466	\$1,615	.41				
NEBRASKA	132,063	\$1,533	.66				
NEVADA	80,747	\$1,540	.88				

\*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 1999 MSIS)

\*\*\*This ratio indicates the extent to which Medicaid eligibles receive any initial and periodic screening services during the year (FY 1999 416 Report)

N/A data not available

## STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AGGREGATE ENROLLMENT STATISTICS: FY 2001

Source (IV.3): Centers for Medicare and Medicaid Services

State	Type of SCHIP Program*	Date Implemented	Upper** Eligibility	Total SCHIP Enrollment	State	Type of SCHIP Program*	Date Implemented	Upper** Eligibility	Total SCHIP Enrollment
ALABAMA	COMBO	02/01/98	200%	68,179	NEW HAMPSHIRE	COMBO	05/01/98	300%	5,982
ALASKA	MEDICAID	03/01/99	200%	21,831	NEW JERSEY	COMBO	03/01/98	350%	99,847
ARIZONA	SEPARATE	11/01/98	200%	86,863	NEW MEXICO	MEDICAID	03/31/99	235%	10,347
ARKANSAS	MEDICAID	10/01/98	100%	2,884	NEW YORK	COMBO	04/15/98	250%	872,949
CALIFORNIA	COMBO	03/01/98	250%	693,048	NORTH CAROLINA	SEPARATE	10/01/98	200%	98,650
COLORADO	SEPARATE	04/22/98	185%	45,773	NORTH DAKOTA	COMBO	10/01/98	140%	3,404
CONNECTICUT	COMBO	07/01/98	300%	18,720	OHIO	MEDICAID	01/01/98	200%	158,265
DELAWARE	SEPARATE	02/01/99	200%	5,567	OKLAHOMA	MEDICAID	12/01/97	185%	38,858
DC	MEDICAID	10/01/98	200%	2,807	OREGON	SEPARATE	07/01/98	170%	41,468
FLORIDA	COMBO	04/01/98	200%	298,705	PENNSYLVANIA	SEPARATE	05/28/98	200%	141,163
GEORGIA	SEPARATE	11/01/98	235%	182,762	RHODE ISLAND	MEDICAID	10/01/97	250%	17,398
HAWAII	MEDICAID	07/01/00	200%	7,137	SOUTH CAROLINA	MEDICAID	10/01/97	150%	66,183
IDAHO	MEDICAID	10/01/97	150%	13,276	SOUTH DAKOTA	COMBO	07/01/98	200%	8,937
ILLINOIS	COMBO	01/05/98	185%	83,510	TENNESSEE	MEDICAID	10/01/97	100%	8,615
INDIANA	COMBO	10/01/97	200%	56,986	TEXAS	COMBO	07/01/98	200%	500,950
IOWA	COMBO	07/01/98	200%	23,270	UTAH	SEPARATE	08/03/98	200%	34,655
KANSAS	SEPARATE	01/01/99	200%	34,241	VERMONT	SEPARATE	10/01/98	300%	2,996
KENTUCKY	COMBO	07/01/98	200%	66,796	VIRGINIA	SEPARATE	10/22/98	200%	73,102
LOUISIANA	MEDICAID	11/01/98	150%	69,579	WASHINGTON	SEPARATE	02/01/00	250%	7,621
MAINE	COMBO	07/01/98	200%	27,003	WEST VIRGINIA	COMBO	07/01/98	200%	33,144
MARYLAND†	COMBO	07/01/98	300%	109,983	WISCONSIN	MEDICAID	04/01/99	185%	57,183
MASSACHUSETTS	COMBO	10/01/97	200%	105,072	WYOMING	SEPARATE	12/01/99	133%	4,652
MICHIGAN	COMBO	05/01/98	200%	76,181					
MINNESOTA	MEDICAID	10/01/98	280%	49					
MISSISSIPPI	COMBO	07/01/98	200%	52,436					
MISSOURI	MEDICAID	09/01/98	300%	106,594					
MONTANA	SEPARATE	01/01/99	150%	13,518					
NEBRASKA	MEDICAID	05/01/98	185%	13,933					
NEVADA	SEPARATE	10/01/98	200%	28,026					

\*Program type as of September 30, 2001.

\*\*Reflects upper eligibility level approved and in effect as of September 30, 2001.

†Implemented a separate child health program on July 1, 2001.



## STATE-SPECIFIC DATA

**HEALTH INSURANCE STATUS OF CHILDREN THROUGH AGE 18: 2000**

Source (IV.4): American Academy of Pediatrics' Analysis of 2001 Current Population Survey

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid/SCHIP	Percent Uninsured*	State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid/SCHIP	Percent Uninsured*
<b>UNITED STATES</b>	<b>67.6</b>	<b>20.6</b>	<b>11.8</b>	NEVADA	67.9	17.7	14.4
ALABAMA	65.5	26.0	8.6	NEW HAMPSHIRE	75.1	17.6	7.3**
ALASKA	52.4	34.6	13.0	NEW JERSEY	74.9	15.8	9.4
ARIZONA	64.1	23.8	12.1	NEW MEXICO	46.4	34.5	19.1
ARKANSAS	62.4	26.3	11.3	NEW YORK	63.4	25.9	10.7
CALIFORNIA	60.4	24.2	15.4	NORTH CAROLINA	68.9	20.9	10.2
COLORADO	74.1	11.2	14.6	NORTH DAKOTA	70.0	21.8	8.2
CONNECTICUT	84.7	11.9	3.4**	OHIO	73.2	17.2	9.6
DELAWARE	70.9	21.5	7.6	OKLAHOMA	55.6	31.5	12.9
DC	59.1	30.5	10.4	OREGON	68.0	19.0	13.0
FLORIDA	62.8	20.3	17.0	PENNSYLVANIA	78.0	17.0	5.0
GEORGIA	74.0	17.3	8.7	RHODE ISLAND	80.0	17.1	2.9**
HAWAII	69.6	19.6	10.8	SOUTH CAROLINA	70.6	20.4	9.0
IDAHO	64.0	22.2	13.7	SOUTH DAKOTA	73.5	17.4	9.0
ILLINOIS	70.5	18.8	10.7	TENNESSEE	64.4	30.2	5.4
INDIANA	74.2	12.3	13.4	TEXAS	61.3	17.2	21.5
IOWA	83.6	9.7	6.7	UTAH	73.2	16.4	10.4
KANSAS	77.2	11.7	11.1	VERMONT	54.0	37.0	9.0
KENTUCKY	72.7	19.2	8.1	VIRGINIA	78.7	8.7	12.6
LOUISIANA	54.5	29.0	16.4	WASHINGTON	67.2	24.0	8.8
MAINE	70.5	20.4	9.1**	WEST VIRGINIA	57.9	31.0	11.1
MARYLAND	82.3	9.9	7.8**	WISCONSIN	79.3	17.3	3.5**
MASSACHUSETTS	64.8	26.9	8.3	WYOMING	69.5	18.4	12.1
MICHIGAN	72.7	20.6	6.7				
MINNESOTA	78.0	13.5	8.5				
MISSISSIPPI	61.0	29.2	9.8				
MISSOURI	71.5	19.3	9.2				
MONTANA	57.2	29.2	13.6				
NEBRASKA	73.9	17.9	8.2				

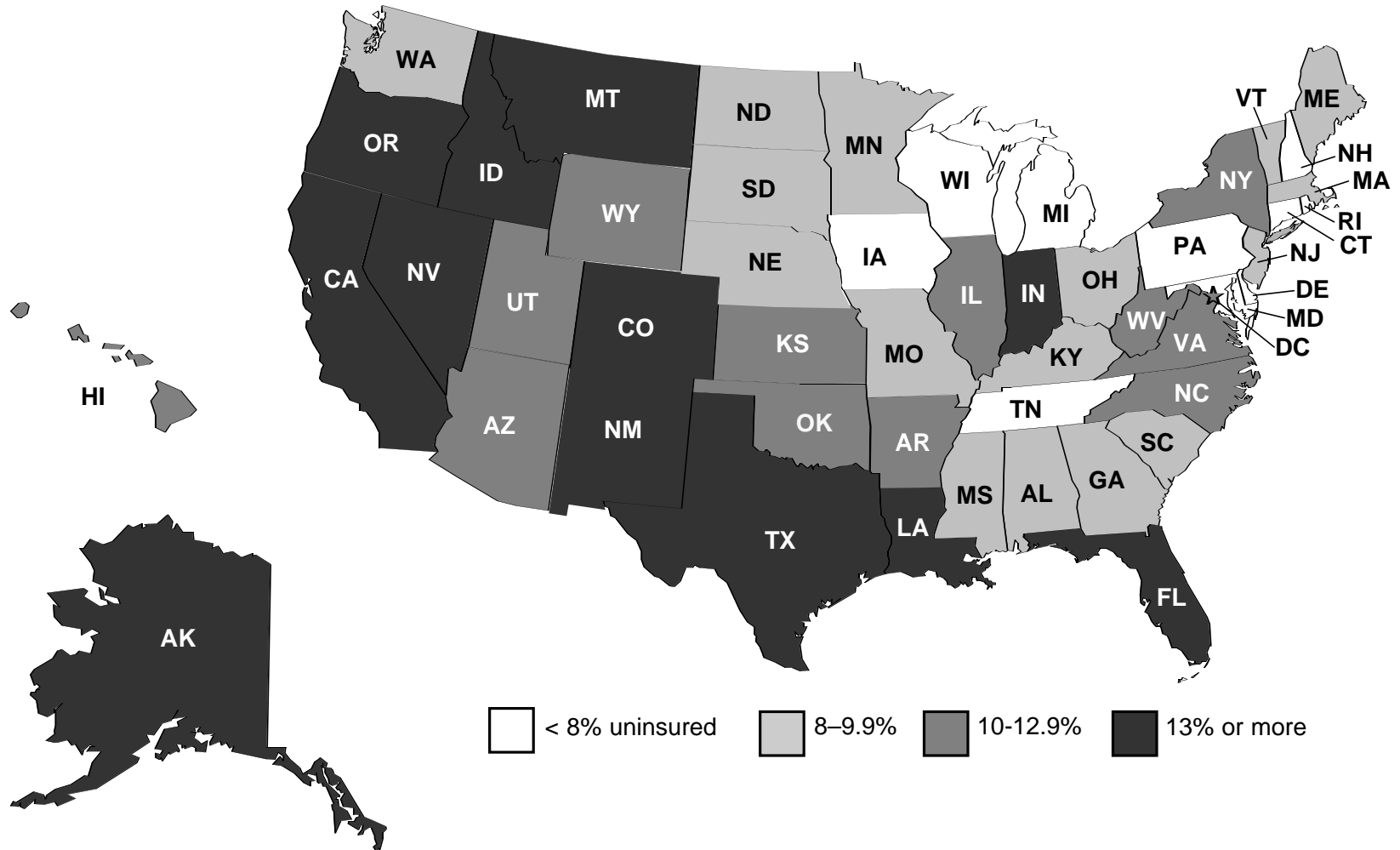
\*See map on facing page

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

Note: Estimates for 2000 should not be compared directly with estimates from previous years due to changes in survey design that decreased the uninsured estimate by about 8 percent.

## PERCENTAGE OF CHILDREN UNDER THE AGE OF 19 WHO ARE UNINSURED: 2000

Source (IV.4): American Academy of Pediatrics' Analysis of 2001 Current Population Survey



## STATE-SPECIFIC DATA

## INFANT AND NEONATAL MORTALITY RATES, BY RACE OF MOTHER AND STATE: 1999

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

State	Infant Mortality <sup>1</sup>			Neonatal Mortality <sup>2</sup>			State	Infant Mortality <sup>1</sup>			Neonatal Mortality <sup>2</sup>		
	All**	White	Black	All**	White	Black		All**	White	Black	All**	White	Black
<b>UNITED STATES</b>	<b>7.1</b>	<b>5.8</b>	<b>14.6</b>	<b>4.7</b>	<b>3.9</b>	<b>9.8</b>	NEW JERSEY	6.7	5.2	14.1	4.9	3.9	9.9
ALABAMA	9.8	6.9	16.0	6.2	4.2	10.4	NEW MEXICO	6.9	6.5	*	3.9	3.8	*
ALASKA	5.7	4.7	*	2.6	*	*	NEW YORK	6.4	5.5	10.6	4.5	3.9	7.2
ARIZONA	6.8	6.2	19.1	4.5	4.2	11.4	NORTH CAROLINA	9.1	6.9	15.5	6.7	5.1	11.5
ARKANSAS	8.0	7.0	12.0	4.6	4.2	6.0	NORTH DAKOTA	6.8	5.8	*	4.3	3.9	*
CALIFORNIA	5.4	5.0	12.9	3.6	3.4	7.9	OHIO	8.2	6.6	17.6	5.5	4.5	11.8
COLORADO	6.7	6.3	16.2	4.3	4.1	10.7	OKLAHOMA	8.5	8.0	15.6	5.0	4.9	8.2
CONNECTICUT	6.1	5.7	10.6	4.7	4.4	8.4	OREGON	5.8	5.7	*	4.2	4.2	*
DELAWARE	7.4	3.9	18.0	5.2	2.6	13.1	PENNSYLVANIA	7.3	5.8	16.8	5.1	4.1	11.6
DC	15.0	*	19.0	11.7	*	14.9	RHODE ISLAND	5.7	5.0	*	4.3	3.9	*
FLORIDA	7.4	5.6	13.6	4.9	3.9	8.7	SOUTH CAROLINA	10.2	6.7	16.9	7.1	4.4	12.3
GEORGIA	8.2	5.4	13.8	5.5	3.5	9.5	SOUTH DAKOTA	8.9	7.7	*	5.4	5.1	*
HAWAII	7.0	*	*	4.9	*	*	TENNESSEE	7.7	5.7	15.2	5.0	3.6	9.9
IDAHO	6.7	6.6	*	4.6	4.5	*	TEXAS	6.2	5.5	12.5	3.9	3.5	7.8
ILLINOIS	8.5	6.3	18.4	5.9	4.4	12.6	UTAH	4.8	4.8	*	3.2	3.2	*
INDIANA	8.0	7.0	17.0	5.3	4.6	10.8	VERMONT	5.8	5.9	*	3.4	3.4	*
IOWA	5.7	5.3	20.6	3.4	3.2	*	VIRGINIA	7.3	5.6	13.0	5.1	3.7	9.6
KANSAS	7.3	6.8	14.4	4.9	4.7	8.1	WASHINGTON	5.0	4.7	15.0	3.2	3.0	9.3
KENTUCKY	7.6	7.1	12.7	4.8	4.5	8.0	WEST VIRGINIA	7.4	7.3	*	4.7	4.6	*
LOUISIANA	9.2	5.9	14.2	5.9	3.7	9.1	WISCONSIN	6.7	5.8	16.0	4.3	3.7	10.0
MAINE	4.8	4.7	*	3.7	3.5	*	WYOMING	6.9	6.8	*	4.1	3.8	*
MARYLAND	8.4	5.1	14.6	5.8	3.4	10.4							
MASSACHUSETTS	5.2	4.8	9.8	4.1	3.8	8.1							
MICHIGAN	8.1	6.0	17.9	5.5	4.0	12.4							
MINNESOTA	6.2	5.4	15.4	4.0	3.5	9.7							
MISSISSIPPI	10.1	6.8	14.2	6.2	4.1	8.8							
MISSOURI	7.8	5.8	18.9	5.1	3.8	12.9							
MONTANA	6.7	5.9	*	3.0	2.5	*							
NEBRASKA	6.8	5.9	18.9	4.5	3.9	*							
NEVADA	6.6	6.1	13.2	3.9	3.7	*							
NEW HAMPSHIRE	5.8	5.7	*	4.3	4.3	*							

\* Figure does not meet standards of reliability or precision

\*\* Includes races other than white or black

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



## CITY DATA

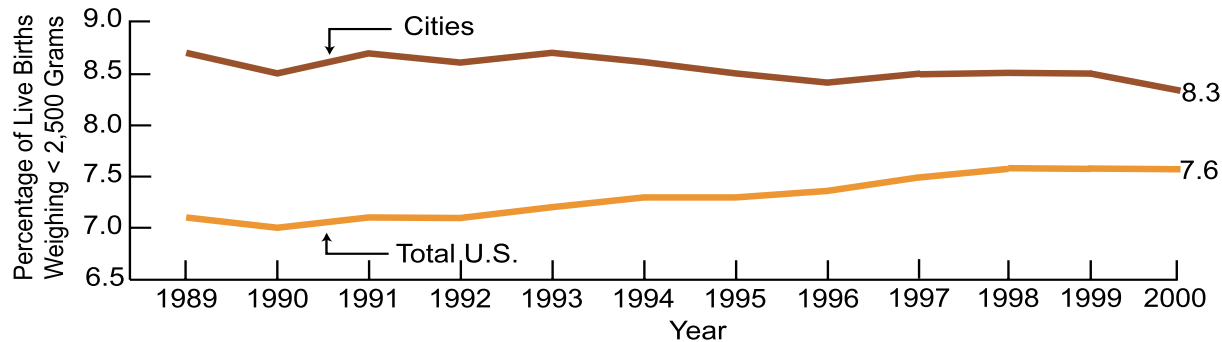
How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight, and prenatal care for women and children who reside in the nation's central cities with populations over 100,000.

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 1999 city infant mortality rate of 8.0 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 (84.9 percent). The percentage of women receiving late or no prenatal care is higher in cities than in the nation as a whole (5.0 percent versus 3.3 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.

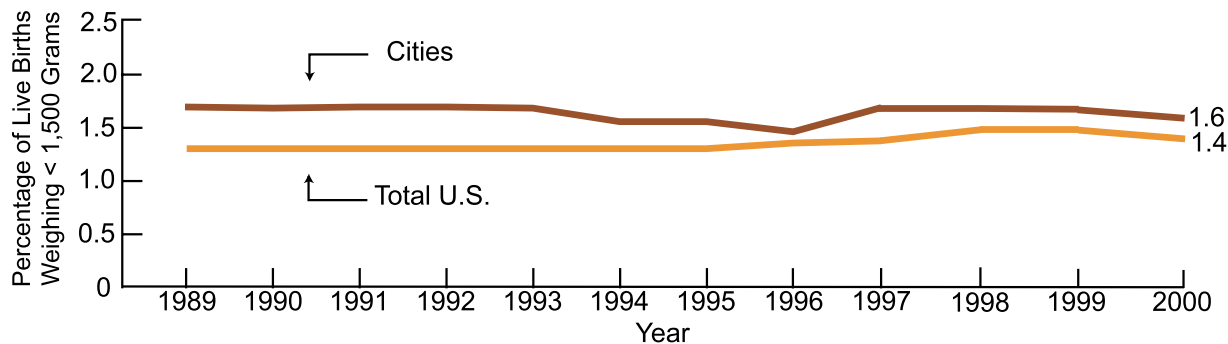
### PERCENTAGE OF INFANTS BORN AT LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1989-2000

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



### PERCENTAGE OF INFANTS BORN AT VERY LOW BIRTH WEIGHT IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1989-2000

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 2000, 103,407 babies (8.3 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 2000 percentage of urban infants born at low birth weight was 9 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 2000, 1.6 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 14 percent.

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

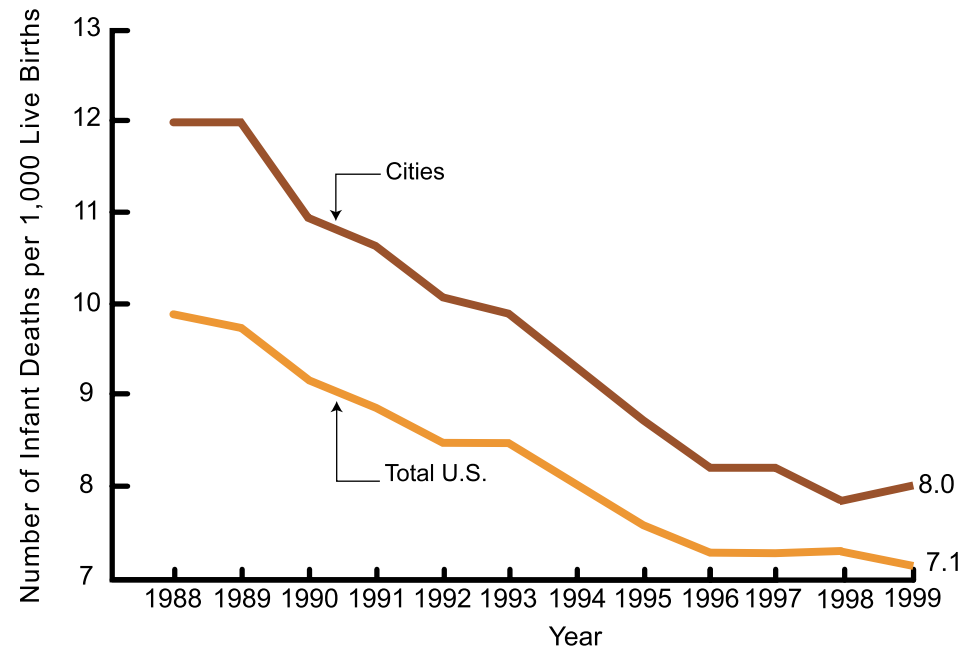
## INFANT MORTALITY

In 1999, 9,703 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 8.03 deaths per 1,000 live births, 13.7 percent higher than the rate of 7.06 for the nation as a whole. The 1999 rate of 8.03 represents an almost 8 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: 1988-1999

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.

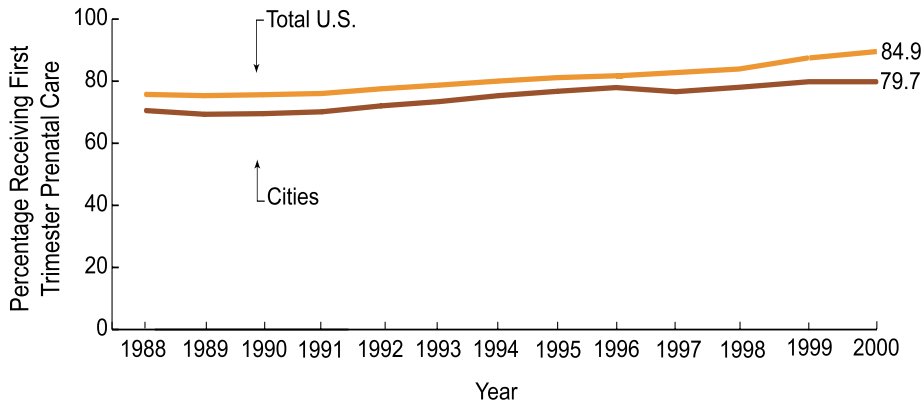
In 2000, 79.7 percent of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 84.9 percent nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The Healthy People 2010 Objective is to have 90 percent of pregnant women begin prenatal care in the first trimester.

### *Late or No Prenatal Care*

In 2002, 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 34 percent higher among women living in cities than among the overall U.S. population.

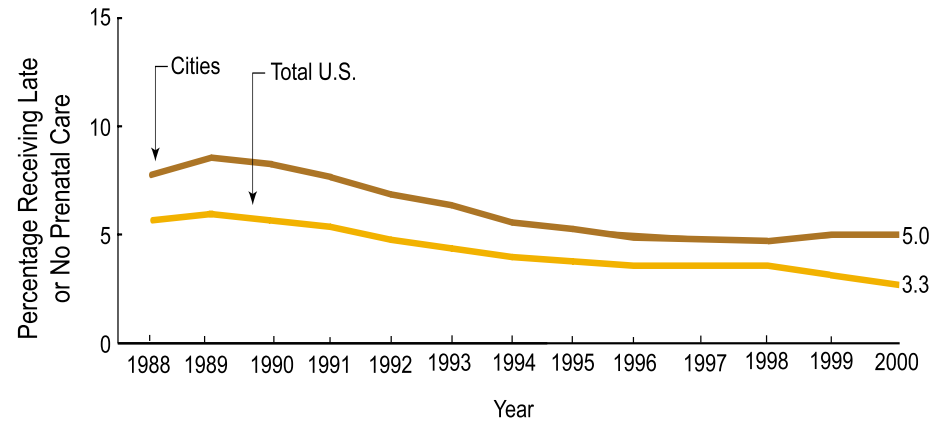
**PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1988-2000**

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: 1988-2000**

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



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## CONTRIBUTORS

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