Maternal and Child Health Bureau

Child Health USA 2006

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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 2006,* the 17th annual report on the health status and service needs of America's children. The Bureau's vision is that of a future nation in which the right to grow to one's full potential is universally assured through attention to the comprehensive physical, psychological, and social needs of the maternal and child population. To assess the Bureau's progress toward achieving this vision, MCHB has compiled this book of secondary data for more than 50 health status and health care indicators. It provides both graphical and textual summaries of relevant data, and addresses long-term trends where applicable and feasible.

All of the data discussed within the text of these pages is from the same sources as the information in the corresponding graphs (unless otherwise noted). 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. *Child Health USA 2006* addresses health status and health services utilization, as well as insight into the nation's progress toward the goals set out in the MCHB's strategic plan—to assure quality of care, eliminate barriers and health disparities, and improve the health infrastructure and systems of care.

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.

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

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Introduction

The health of the current child population has important implications for the future health of the overall United States population as today's children grow into adults. A number of childhood health issues—including weight, smoking, oral health, and vaccination coverage—can affect health throughout the lifespan. In 2005, approximately 25 percent of the United States population was under 18 years of age. The health and well-being of these children, as well as that of our country, depend on preventive services such as prenatal care and immunization, as well as the promotion of healthy life choices. These measures help assure that children are born healthy and maintain good health as they grow up.

Good health begins even before birth. Timely prenatal care is an important preventive strategy that can help protect the health of both mother and child. Entry into prenatal care during the first trimester has been improving, reaching 83.9 percent of pregnant women in 2004. A small proportion of women (3.6 percent) goes without prenatal care until the third trimester, or forgoes it entirely. This is more common among Black and Hispanic women, as well as those who are younger, unmarried, and less educated.

Several other indicators of maternal health are presented in *Child Health USA*. One of these is maternal age, which can affect the health of both infant and mother. In 2004, births to 15- to 19-year old women reached a record low, while births to older women (35 years and older) increased. Parental employment and child care can also affect the health and well-being of a family. In 2005, 70.5 percent of women with children under 18 years of age were in the labor force (either employed or looking for work). Of mothers with preschool-aged children (younger than 6 years), 62.8 percent were in the labor force and 58.5 percent were employed. In the same year, 60 percent of children under 6 years of age required at least one weekly nonparental child care arrangement.

After the health of the mother and the family, *Child Health USA* presents data regarding the health of infants and young children. Healthy birth weight is an important indicator of infant health, and evidence is currently emerging that birth weight affects children into adulthood, as well. Despite high rates of prenatal care utilization, preliminary data in 2004 indicate that 8.1 percent of infants were born at low birth weight (less than 2,500 grams, or 5 pounds 8 ounces) that year, which is the highest rate recorded in the last 3 decades. Although the increase in multiple births, which are more likely to result in low birth weight, are on the rise, the low birth weight rate among singleton births is rising as well. Very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces) is also on the rise, representing 1.5 percent of live births in 2004. This has increased from a rate of approximately 1 percent in 1980. Children born at very low birth weight are significantly more likely to die in the first year of life than babies of normal birth weight, and those who survive are at particularly high risk for severe physical, developmental, and cognitive problems. Although rates of maternal and infant mortality have dropped dramatically in the past century, the United States still has one of the highest rates of infant death in the industrialized world (6.9 deaths per 1,000 live births in 2004).

Breastfeeding can also support the health of infants and mothers. Breastfeeding rates have increased steadily since the beginning of the last

decade. In 2004, 70.3 percent of mothers reported ever breastfeeding their infant. However, the rate declined dramatically as infant age increased: 36.2 percent of mothers reported breastfeeding their infant at 6 months of age. The rate of exclusive breastfeeding at 6 months was even lower (14.1 percent).

Vaccination is a preventive health measure that protects the health of children into adulthood. Vaccines are available for a number of public health threats, including measles, mumps, rubella (German measles), polio, diphtheria, tetanus, pertussis (whooping cough), and *H. Influenzae* type b (a meningitis bacterium). In 2004, 80.9 percent of children aged 19 to 35 months had received the recommended series of vaccines; 76.0 percent of children in this age group received the recommended series plus the varicella (chicken pox) vaccine.

Oral health becomes an important factor in overall child health status as soon as the first tooth appears. In 2003, the parents of 68.4 percent of children reported that their children's teeth were in excellent or very good condition. Non-Hispanic White children were most likely to have teeth in excellent or very good condition, while Hispanic children were least likely. In 2004, 72.3 percent of children had seen a dentist in the past year.

Physical activity and healthy weight are other important factors in overall health that begin in early childhood. In 2003, 14.8 percent of children aged 10 to 17 years were classified as overweight. Results from the 2005 National Youth Risk Behavior Surveillance show that 35.8 percent of high school students met the currently recommended levels of physical activity, and 54.2 percent of students were enrolled in a physical education class on one or more days a week. Enrollment in weekly physical activity classes was higher in the younger grades (71.5 percent of 9th graders) than in the older grades (38.8 percent of 12th graders).

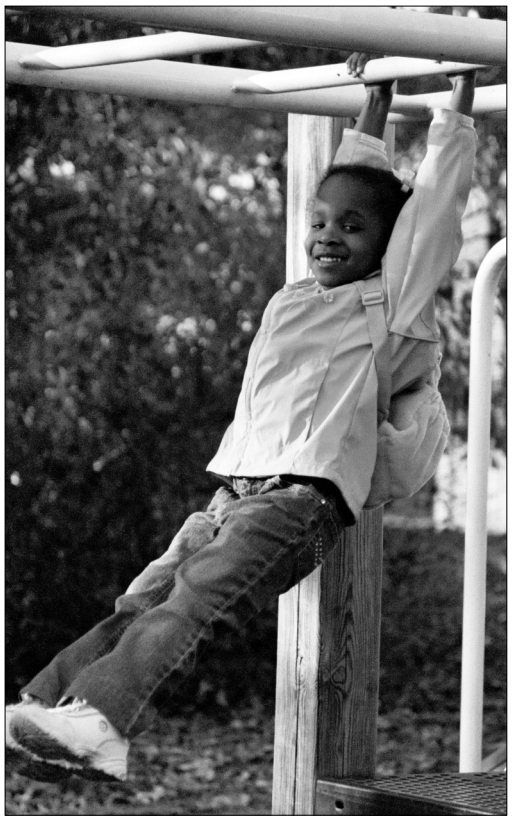
The period of adolescence introduces additional health issues that need to be monitored and addressed. In 2005, 46.8 percent of high school students reported ever having sexual intercourse. Among 9th grade students, more males were currently sexually active (24.5 percent) than females (19.5 percent). However, by 12th grade, females were more likely to be currently sexually active (51.7 percent) than males (47.0 percent). With sexual activity comes the risk of sexually transmitted infections (STIs). Adolescents (ages 15 to 19 years) and young adults (ages 20 to 24 years) are at much higher risk of contracting STIs than are older adults. Chlamydia continues to be the most common STI in adolescents and young adults, with rates of 1,579 and 1,660 cases per 100,000, respectively, in 2004. Gonorrhea followed in

prevalence with overall rates of 427 and 498 per 100,000 adolescents and young adults, respectively. Although specific statistics are yet unavailable, genital human papillomavirus (HPV) is believed to be the most common STI in the United States. A vaccine for HPV was recently approved by the Food and Drug Administration (FDA) for use in females aged 9 to 26 years.

Mental health is another issue that increasingly affects children as they grow older. In 2004, 22.5 percent of youth aged 12 to 17 years received mental health treatment or counseling in the past year, which includes treatment or counseling for emotional or behavioral problems not caused by drug or alcohol use. The rate in 2004 represented a significant increase over the previous year (20.6 percent). Depression was the leading reason reported for mental health treatment among this age group.

A number of other issues are interconnected with mental health, including violence and substance abuse. Results from the 2005 Youth Risk Behavior Surveillance indicate that 18.5 percent of high school students had carried a weapon (such as a gun, knife, or club) at some point during preceding 30 days. Among males, non-Hispanic Whites and Hispanics were more likely than non-Hispanic Blacks to carry a weapon. Among females, non-Hispanic Blacks were more likely to carry a weapon than their non-Hispanic White and Hispanic counterparts. With regard to substance abuse, 10.6 percent of adolescents aged 12 to 17 years reported using illicit drugs in the past month in 2004. Alcohol was the most commonly used drug among adolescents, with 17.6 percent reporting past-month use in 2004, while marijuana was the most commonly used illicit drug (7.6 percent).

The health status and health services utilization indicators reported in *Child Health USA* can help policymakers and public health officials analyze the current health climate and determine what programs might be needed to further improve the public's health. These indicators can also help identify positive health outcomes, which may allow lessons to be learned from the experiences of programs that have achieved success. The health of our children and adolescents relies on effective public health efforts that include providing access to knowledge, skills, and tools; providing drug-free alternative activities; identifying risk factors and linking people to appropriate services; building community supports; and supporting approaches that promote policy change. Such preventive efforts and health promotion activities are vital to the continued improvement of the health and well-being of America's children and families.



Population Characteristics

The population of the United States is becoming increasingly diverse, which is reflected by the socio-demographic characteristics of children and their families. The percentage of children who are Hispanic or Asian/Pacific Islander has more than doubled since 1980, while the percentage who are non-Hispanic White has declined. The percentage of children who are Black has remained relatively stable. This largely demonstrates the changes in the racial and ethnic makeup of the population as a whole.

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

This section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. Included are data on the age and racial and ethnic distribution of the U.S. population, as well as data displaying poverty status, child care arrangements, and school dropout rates.

POPULATION OF CHILDREN

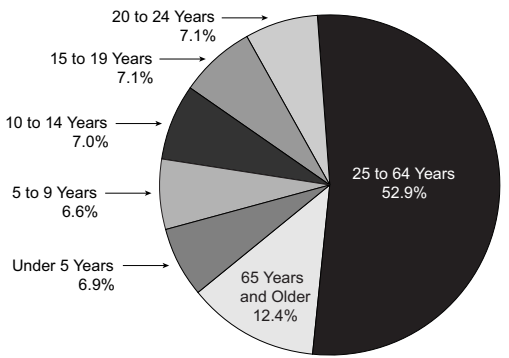
In 2005, there were an estimated 73.4 million children under 18 years of age in the United States, representing approximately 25 percent of the population. Young adults aged 20 to 24 years composed just over 7 percent of the population, while adults aged 25 to 64 years composed nearly 53 percent of the population and adults aged 65 years and older composed more than 12 percent.

Since the 2000 Census, the number of children under 5 years of age has risen 5.8 percent, and the number of children aged 5 to 19 years has risen just over 2 percent. The number of adults aged 65 years and older has risen over 5 percent in the same period.

The population of children reflects the increase in the diversity of the population over the past several decades. Hispanic children represented 9 percent of all children in 1980, compared to over 19 percent in 2005; Asian/Pacific Islander children represented 2 percent of all children in 1980 and over 4 percent in 2005. While the percentage of children who are Hispanic or Asian/Pacific Islander has more than doubled since 1980, the percentage who are non-Hispanic White has declined. The percentage of children who are Black has remained relatively stable.

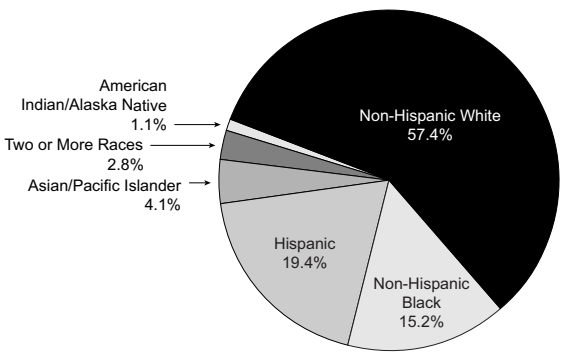
U.S. Resident Population, by Age Group: 2005

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



Population of Children Under Age 18, by Race/Ethnicity: 2005

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



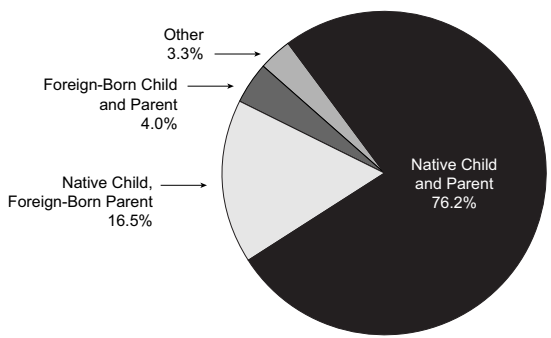
CHILDREN OF FOREIGN-BORN PARENTS

The foreign-born population in the United States has increased substantially since the 1970s, largely due to immigration from Asia and Latin America. In 2003, over 20 percent of children living in the United States had at least one foreign-born parent. Of all children, 16.5 percent were born in the United States to atleast one foreign-born parent and 4 percent were themselves foreign-born. Most children (76.2 percent) were native-born and lived in households with native-born parents.

Children with foreign-born parents were more likely than children with native-born parents to have family incomes below 100 percent of the Federal poverty level. Health insurance coverage also varies by nativity: native-born children with foreign-born parents were the most likely to have public insurance, while foreign-born children with foreign-born parents were the most likely to be uninsured. Native-born children with native-born parents were most likely to have private insurance.

Children Under Age 18, by Nativity of Child and Parent(s):* 2003

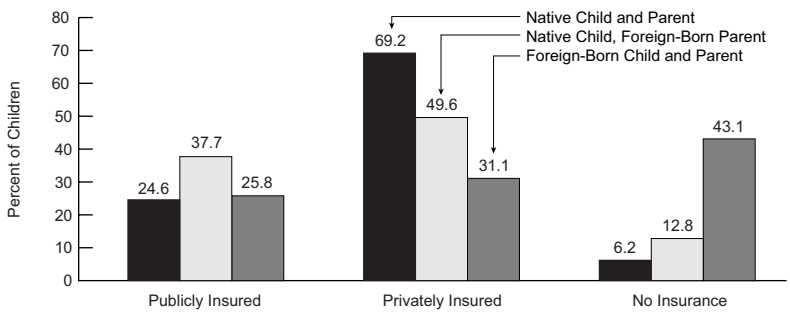
Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



**The term "native parent" indicates that both parents who live with the child were born in the U.S., while "foreign-born parent" indicates that one or both parents were born outside of the U.S.; "other" includes children with parents whose nativity status is unknown and foreign-born children with native parents.*

Children Under Age 18, by Health Insurance Status and Nativity of Child and Parent(s):* 2003

Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



**The term "native parent" indicates that both parents who live with the child were born in the U.S., while "foreign-born parent" indicates that one or both parents were born outside of the U.S.; "other" includes children with parents whose nativity status is unknown and foreign-born children with native parents.*

CHILDREN IN POVERTY

In 2004, just over 13 million children under 18 years of age lived in households with incomes below the Federal poverty threshold ($19,307 for a family of four);[1] this represents 17.8 percent of all children in the United States. Children represented over one-third of people in poverty, but only one-quarter of the population.

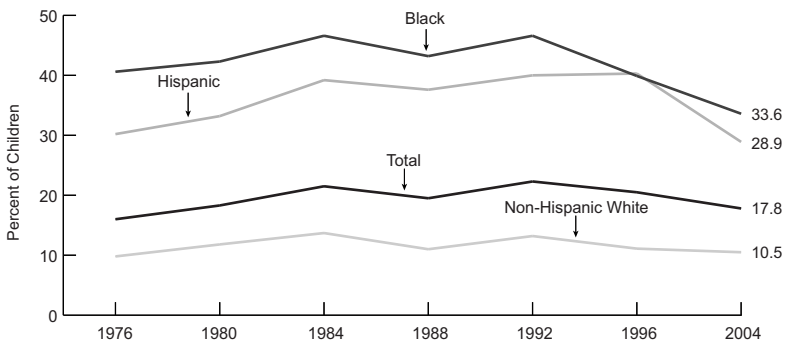
Poverty affects many aspects of a child's life, including living conditions, access to health care, and adequate nutrition, all of which contribute to health status. Black and Hispanic children are particularly vulnerable to poverty. A much higher proportion of Black (33.6 percent) and Hispanic (28.9 percent) children under age 18 were poor than were their non-Hispanic White counterparts (10.5 percent).

Children in single-parent families are particularly likely to be poor: of children under age 6 living with a single mother, 52.6 percent lived in poverty, approximately five times the rate of their counterparts in married-couple families. Although they compose only 18 percent of all families in the United States, female-headed households represent about half of all families in poverty.

1 *Following the Office of Management and Budget's Statistical Policy Directive 14, the Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty.*

Children Under Age 18 Living in Households with Incomes Below 100 Percent of Poverty Level, by Race/Ethnicity:* 1976-2004

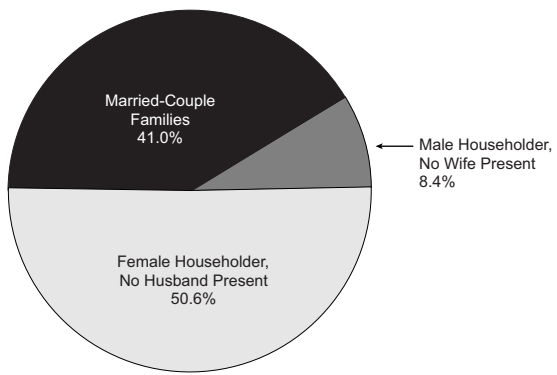
Source (I.3): U.S. Census Bureau, Current Population Survey



**The Current Population Survey currently allows respondents to choose more than one race; however, prior to 2002, only one race was reported. Figures reported here are for respondents who chose one race; however, Hispanics may be of any race.*

Families Below 100 Percent of Poverty Level, by Family Type: 2004

Source (I.3): U.S. Census Bureau, Current Population Survey



SCHOOL DROPOUTS

As of October 2004, there were approximately 3,766,000 high school dropouts* in the United States. This represents a dropout rate of 10.3 percent. The rate has generally declined over the past several decades; however, 2004 saw the first increase since 1998.

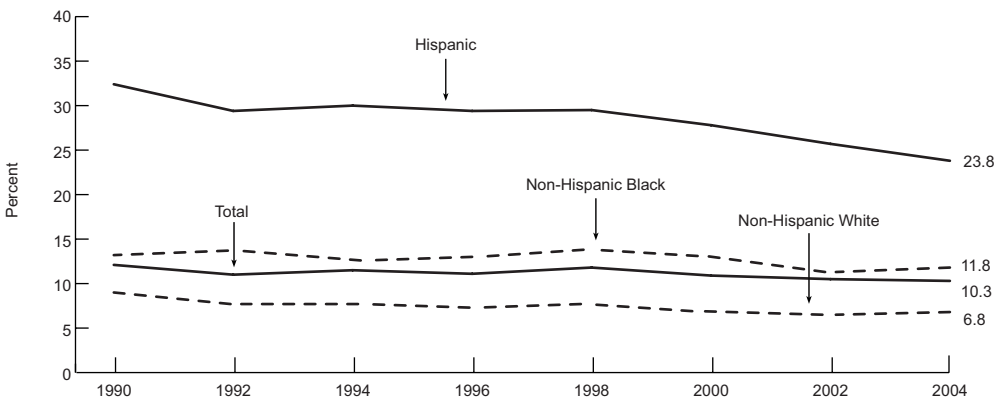
Since 1970, Hispanic students have had the highest dropout rates; the dropout rate among this group was 23.8 percent in 2004. The high Hispanic dropout rate is partly due to the high dropout rate among Hispanics born outside of the United States (38.4 percent). First generation Hispanics, those who were born in the United States but have at least one parent born outside of the country, have a much lower dropout rate (14.7 percent), and the rate among second-generation or more Hispanics, those who were born in the United States to American-born parents, is comparable to that of other racial/ethnic groups (13.7 percent). The dropout rates among non-Hispanic Whites and non-Hispanic Blacks were 6.8 and 11.8 percent, respectively, in 2004.

According to the U.S. Department of Commerce, high school dropouts are more likely to be unemployed and, when they are employed, earn less than those who completed high school. According to the National Center for Health Statistics, those who did not complete high school report worse health than their peers who did complete high school, regardless of income.

**Status dropouts refers to 16- to 24-year-olds who are not enrolled in school and have not earned high school credentials (diploma or equivalent).*

Status School Dropout Rates* for Children Aged 16-24, by Race/Ethnicity: 1990-2004

Source (I.4): U.S Department of Education, National Center for Education Statistics



**Status dropouts refers to 16- to 24-year-olds who are not enrolled in school and have not earned high school credentials (diploma or equivalent.)*

MATERNAL AGE

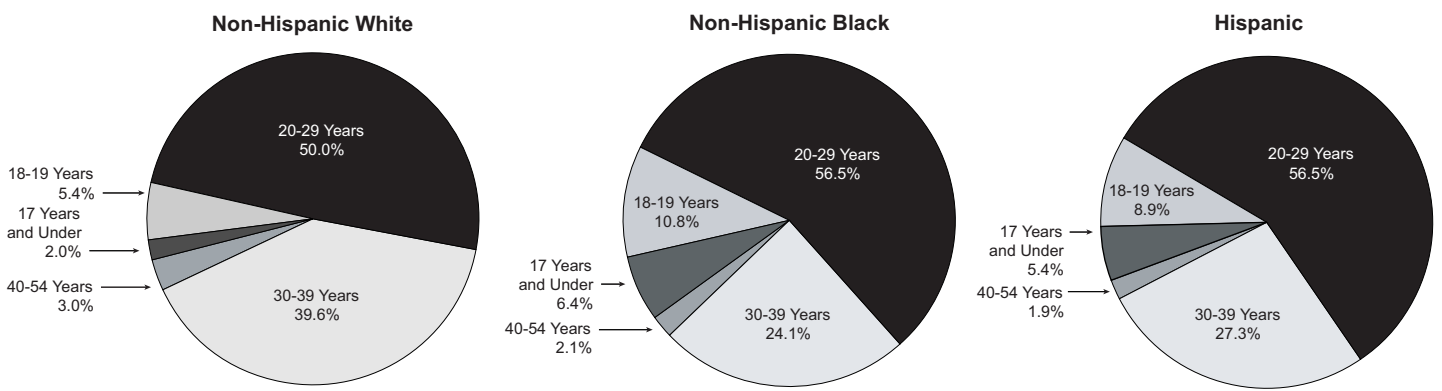
In 2004, the general fertility rate rose to 66.3 births per 1,000 women aged 15 to 44 years. The birth rate among teenagers 15 to 19 years continued to decline, reaching another record low. This rate was 33 percent lower than the recent peak of 41.2 births per 1,000 women in this age group reported in 1991. The rate among women aged 20 to 24 years also reached a record low (101.7 per 1,000). Conversely, the birth rate among women aged 30 to 34 years rose slightly (less than 1 percent), while the rates among women aged 35 to 39 and 40 to 44 years rose more notably (4 and 3 percent, respectively).

In 2004, just over 10 percent of births were to women aged 19 years and younger and 52 percent were to women in their twenties; just over one-third of births were to women in their thirties, and 2.7 percent were to women in their forties and early fifties.

Among non-Hispanic Black and Hispanic women, over half of births were to women in their twenties; exactly half of births to non-Hispanic White women occurred in the same age group. The proportion of births that were to teenagers was higher among non-Hispanic Black and Hispanic women (17.2 and 14.3 percent, respectively) than to non-Hispanic White women (7.4 percent). Non-Hispanic White women were more likely than non-Hispanic Black and Hispanic women to give birth in their thirties, forties, and early fifties.

Distribution of Births, by Maternal Age and Race/Ethnicity: 2004

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



WORKING MOTHERS AND CHILD CARE

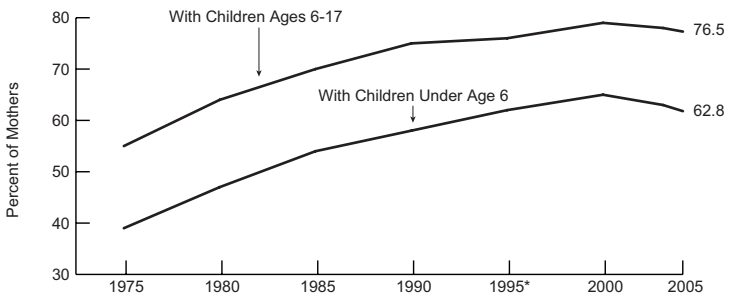
In 2005, 70.5 percent of women with children under 18 years of age were in the labor force (employed or looking for work). Of mothers with children younger than 6 years, 62.8 percent were in the labor force and 58.5 percent were employed. Of women with children aged 6 to 17 years, 76.5 percent were in the labor force and over 73 percent were employed.

Employed mothers with children aged 6 to 17 years were more likely than women with younger children to be employed full-time (77.0 versus 70.9 percent). Married mothers with a spouse present were less likely than never-married, divorced, separated, and widowed women to be in the labor force (68.2 versus 76.1 percent); however, married mothers in the labor force were more likely to be employed than women in other marital situations. The unemployment rate among married mothers was only 3.6 percent, compared to a rate of 9.2 percent among mothers in other marital situations.

In 2005, 40 percent of children under 6 years did not require nonparental child care, while 60 percent required at least one child care arrangement. Overall, 60 percent of children with at least one child care arrangement received center-based care, 22 percent received care from a nonrelative, and 35 percent received care from a relative other than a parent. Nonparental child care was more common among older than younger children. Among children who received child care, older children were more likely than young children to receive center-based care.

Mothers in the Work Force: 1975-2005

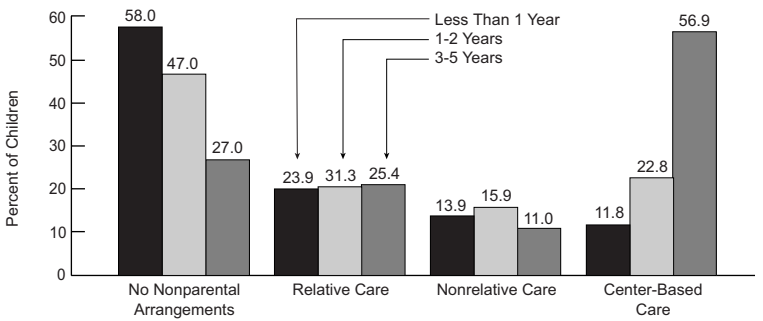
Source (I.6): U.S. Department of Labor, Bureau of Labor Statistics



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

Weekly Child Care Arrangements* for Children Aged 5 Years and Younger,** by Age: 2005

Source (I.7): Department of Education, National Center for Education Statistics



**Percents may equal more than 100 because children may have more than one type of nonparental care arrangement.*
***Includes only children not yet enrolled in kindergarten.*

Health Status

Assessing the health status of infants, children, and adolescents allows health professionals, program planners, and policymakers to assess the impact of past and current health intervention and prevention programs and identify areas of need within the child population. Although indicators of child health and well-being are often assessed on an annual basis, some surveillance systems collect data at intervals, such as every 2, 3, or 5 years. Trends can be identified by examining and comparing data from one year to the next wherever multiple years of data are available.

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

Health Status - Infants

BREASTFEEDING

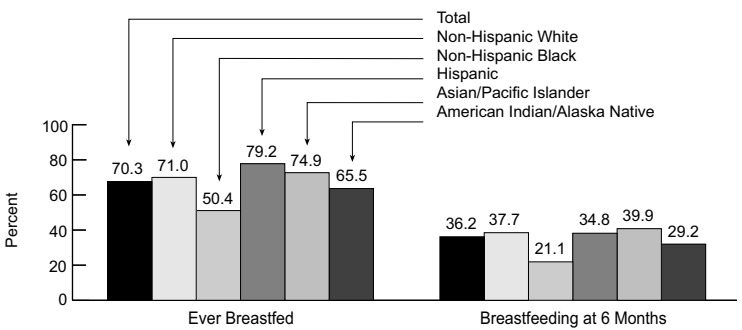
Breastfeeding has been shown to promote the health and development of infants, as well as their immunity to disease; it has also been shown to have a number of benefits to maternal health. For this reason, the American Academy of Pediatrics recommends exclusive breastfeeding—without supplemental foods or liquids—through the first 6 months of age, and continued supplemental breastfeeding through at least the first year.

Breastfeeding initiation rates in the United States have fluctuated over the past several decades, but have increased steadily since the early 1990s. In 2004, 70.3 percent of mothers ever breastfed their infants. Hispanic women were most likely to breastfeed their infants (79.2 percent), followed by Asian/Pacific Islander and non-Hispanic White women (74.9 and 71.0 percent, respectively). Breastfeeding rates increased with maternal age, higher educational achievement, and higher income.

Breastfeeding rates decrease as infant age increases. In 2004, 36.2 percent of mothers breastfed their infants at 6 months, and 17.8 percent breastfed at 12 months. Exclusive breastfeeding rates have not shown the same improvement over time as breastfeeding initiation. In 2004, only 14.1 percent of women practiced exclusive breastfeeding at 6 months. As with breastfeeding initiation, exclusive breastfeeding rates were higher among Hispanic, Asian/Pacific Islander, and non-Hispanic White women, as well as women who were older, educated, and had higher incomes.

Breastfeeding* Rates, by Race/Ethnicity: 2004

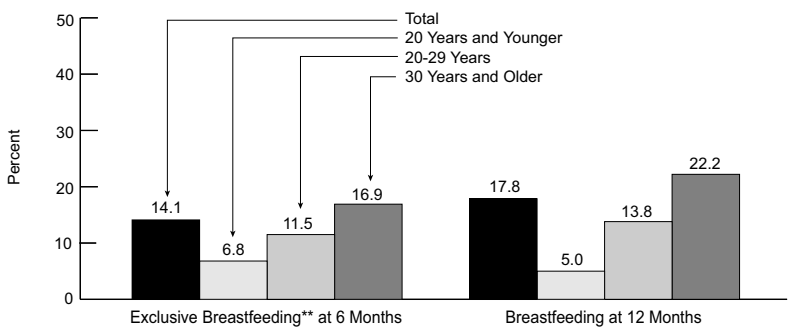
Source (II.1): Centers for Disease Control and Prevention, National Immunization Survey



*Includes exclusive and supplemental breastfeeding.

Breastfeeding Rates, by Recommended Duration* and Maternal Age: 2004

Source (II.1): Centers for Disease Control and Prevention, National Immunization Survey



*The American Academy of Pediatrics recommends exclusive breastfeeding through 6 months of age, and continued supplemental breastfeeding through 1 year.
**Defined as breast milk only—no solids, water or other liquids.

LOW BIRTH WEIGHT

In 2004, 8.1 percent of infants were born at low birth weight (less than 2,500 grams, or 5 pounds 8 ounces); this represents an increase from the rate recorded the previous year (7.9 percent). The percentage of infants born at low birth weight has risen steadily from a low of 6.7 percent in 1984 and is currently at the highest level recorded in the past three decades.

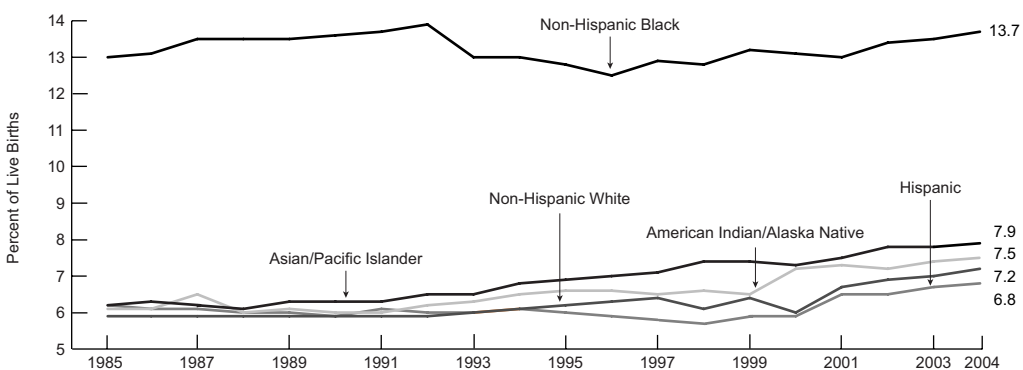
The increase in multiple births, which are at high risk of being born preterm and of low weight, has strongly influenced the increase in low birth weight; however, rates are also on the rise for singleton births.

In 2004, the low birth weight rate was much higher among non-Hispanic Black infants (13.7 percent) than among infants of other racial/ethnic groups. The next highest rate, which occurred among Asian/Pacific Islander infants, was 7.9 percent, followed by a rate of 7.5 percent among American Indian/Alaska Native infants. Low birth weight occurred among 7.2 percent of non-Hispanic White infants, and Hispanic infants experienced the lowest rate (6.8 percent). Although low birth weight rates were lowest among non-Hispanic White and Hispanic infants, these were also the only two racial/ethnic groups to experience a significant increase over the previous year.

Low birth weight is one of the leading causes of 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.

Low Birth Weight Among Infants, by Race/Ethnicity: 1985-2004*

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



*1985-88 data are based on the race of the infant; data from following years are based on the race of the mother.

VERY LOW BIRTH WEIGHT

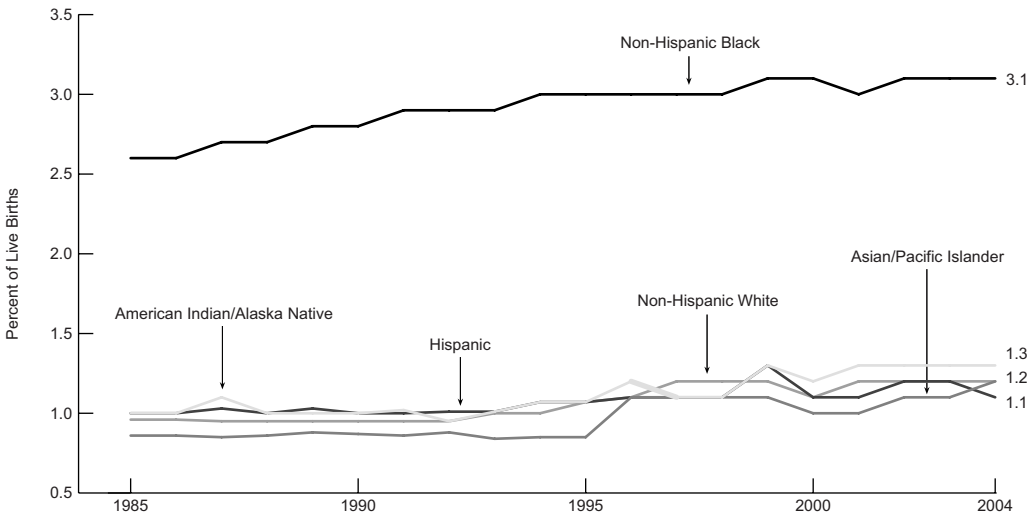
In 2004, 1.5 percent of live births were infants of very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces). This has slowly climbed from a rate of just over one percent in 1980.

Because the chance of survival increases as birth weight increases, very low birth weight infants have the lowest survival rates. Infants born at such low birth weights are approximately 100 times more likely to die in the first year of life than are infants of normal birth weight. Very low birth weight infants who survive are at a 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 non-Hispanic Black newborns (3.1 percent) is over two and a half times greater than the rate among most other racial and ethnic groups, including non-Hispanic Whites (1.2 percent), Hispanics (1.2 percent), and Asian/Pacific Islanders (1.1 percent). This difference is a major contributor to the disparity in infant mortality rates between non-Hispanic Black infants and infants of other racial/ethnic groups.

Very Low Birth Weight Among Infants, by Race/Ethnicity: 1985-2004*

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



*1985-88 data are based on the race of the infant; data from following years are based on the race of the mother.

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal. In 2004, 18,593 infants died before reaching 28 days of age, representing a neonatal mortality rate of 4.5 deaths per 1,000 live births. This rate is unchanged from the previous year.

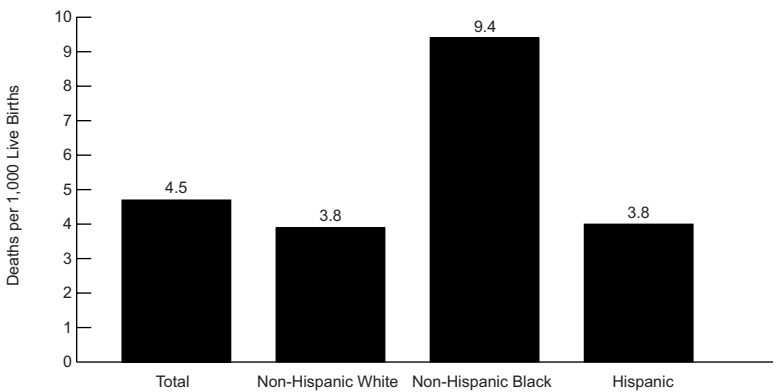
Neonatal mortality is generally related to short gestation and low birth weight, congenital malformations, and conditions occurring in the perinatal period.

Postneonatal. In 2004, 9,343 infants died between the ages of 28 days and 1 year, representing a postneonatal mortality rate of 2.3 deaths per 1,000 live births. This rate is unchanged from the previous year.

Postneonatal mortality is generally related to Sudden Infant Death Syndrome (SIDS), congenital malformations, and unintentional injuries.

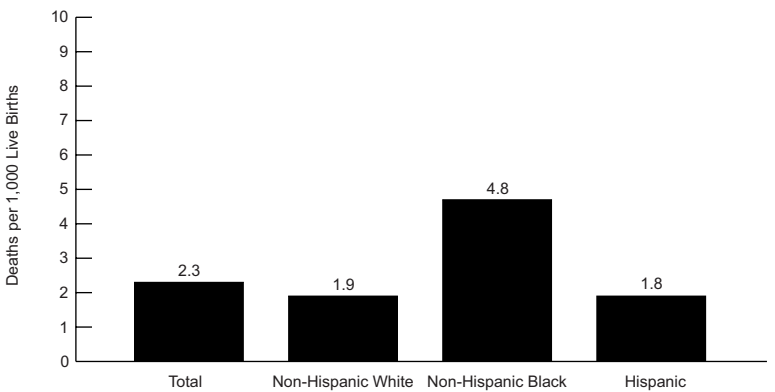
Neonatal Mortality Rates, by Maternal Race/Ethnicity: 2004

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



Postneonatal Mortality Rates, by Maternal Race/Ethnicity: 2004

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



MATERNAL MORTALITY

During the past several decades, the rate of maternal mortality in the United States has declined dramatically. However, the rate in 2004 (13.1 per 100,000 live births) was significantly different from the rate reported in 2002 (8.9 per 100,000). This may partly be due to a change in how pregnancy is recorded on death certificates.

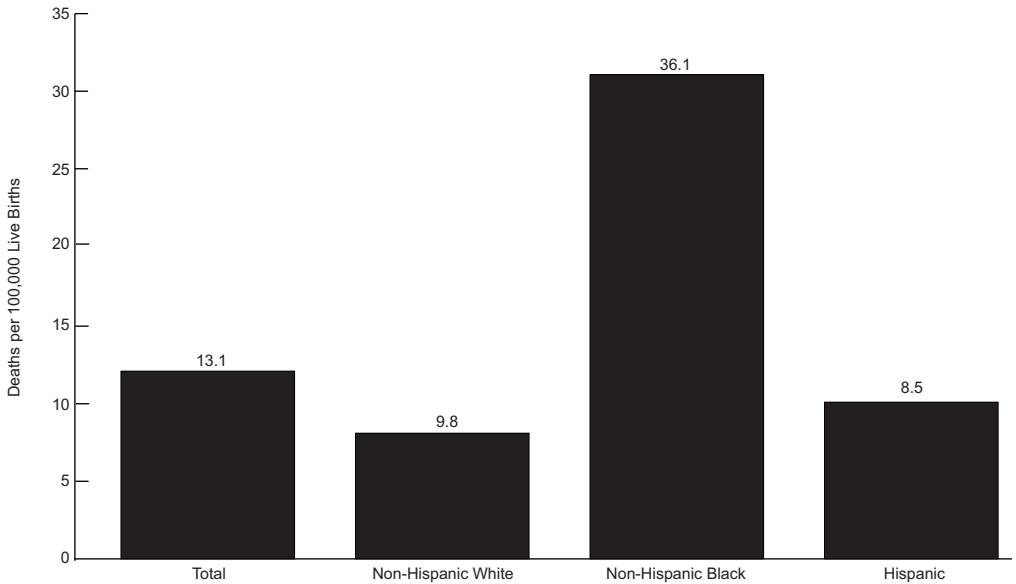
Overall, there were 540 maternal deaths resulting from complications during pregnancy, childbirth, or up to 42 days postpartum in 2004. The maternal mortality rate among non-Hispanic Black women (36.1 per 100,000 live births) is about four times the rate among non-Hispanic White women (9.8 per 100,000 live births). This disparity has widened since 2000.

According to the National Center for Health Statistics, the risk of maternal death increases for women over age 30, regardless of race. Women aged 35 to 39 years have over three times the risk of maternal death as women aged 20 to 24 years.[1]

1 *National Center for Health Statistics. Health, United States, 2004. Hyattsville, Maryland: 2004.*

Maternal Mortality Rates, by Race/Ethnicity: 2004

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



INFANT MORTALITY

In 2004, 27,936 infants died before their first birthday, representing an infant mortality rate of 6.8 deaths per 1,000 live births. The leading cause of infant mortality was congenital malformations, deformations and chromosomal abnormalities, which accounted for 20 percent of infant deaths.

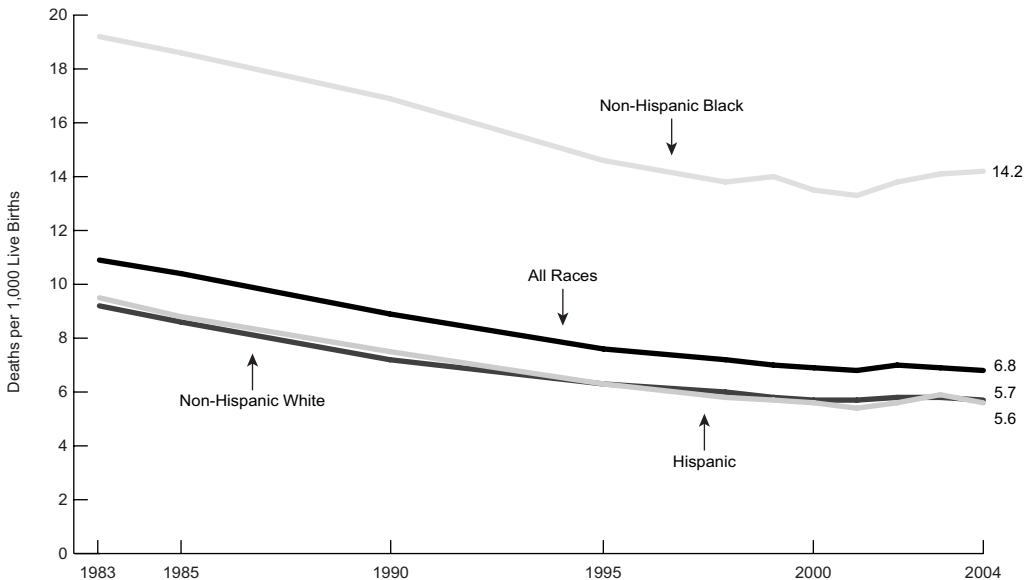
The infant mortality rate declined from the 1960s into this century, but increased slightly between 2001 and 2002. This was largely due to an increase in the percentage of infants born weighing less than 750 grams, reasons for which include a rise in both preterm and multiple births. The rapid decline in infant mortality that began in the mid-1960s slowed among 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 contributed to a renewed decline during the 1990s.

In 2004, the mortality rate among non-Hispanic Black infants was 14.2 deaths per 1,000 live births. This is more than twice the rate among non-Hispanic White infants (5.7 per 1,000 live births). Although the trend in infant mortality rates among both Blacks and non-Hispanic Whites has generally been one of decline throughout the last century, the proportional discrepancy in rates between the two races remains largely unchanged.

The Maternal and Child Health Block Grant and the MCHB's Healthy Start Program provide health and support services to pregnancy women and infants with the goal of improving pregnancy outcomes.

U.S. Mortality Rates Among Infants,* by Maternal Race/Ethnicity: 1983-2004

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



*Under 1 year of age.

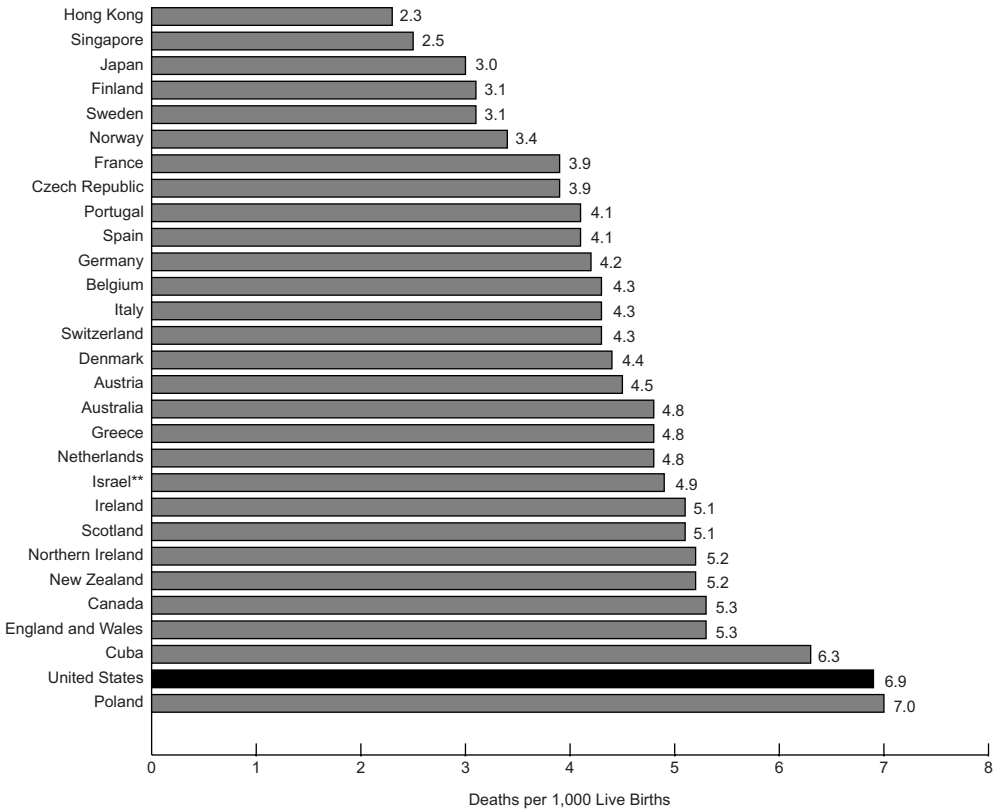
INTERNATIONAL INFANT MORTALITY

Although the infant mortality rate in the United States has declined significantly in recent decades, it was still ranked below many other industrialized nations in 2003 with a rate of 6.9 deaths per 1,000 live births. This represents a slight decline from the rate of 7.0 in 2002, and is equal to the rate from 2001; however, it is considerably below the rate of 26.0 per 1,000 reported in 1960. Differences in infant mortality rates among industrialized nations may reflect disparities in the health status of women before and during pregnancy, as well as the quality and accessibility of primary care for pregnant women and infants. However, some of these differences may be due, in part, to the international variation in the definition, reporting, and measurement of infant mortality.

According to data reported by individual countries, six countries or territories had infant mortality rates that were half the rate of the United States or less. Hong Kong had the lowest rate (2.3 per 1,000), followed by Singapore (2.5 per 1,000). Overall, the United States was ranked 28th.

International Infant Mortality Rates:* 2003

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



*Includes countries, territories, cities, or geographic areas with at least 1 million population and with complete counts of live births and infant deaths according to the United Nations Demographic Yearbook.

**Includes data for East Jerusalem and Israeli residents in certain other territories under occupation by Israeli military forces since June 1967.

Health Status - Children

ORAL HEALTH

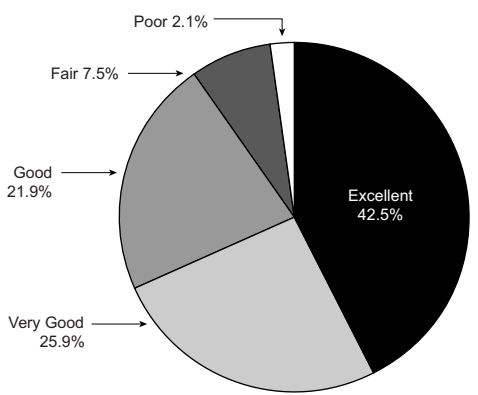
For the National Survey of Children's Health, parents were asked to rate the condition of their children's teeth as excellent, very good, good, fair, or poor. Overall, the parents of 68.4 percent of children reported that their children's teeth were in excellent or very good condition.

The condition of children's teeth varies by a number of factors, including race and ethnicity. In 2003, 76.4 percent of non-Hispanic White children had teeth that were in excellent or very good condition, as reported by their parents, as did 69.9 percent of multiracial children. The parents of non-Hispanic Black and Hispanic children were less likely to report that their children's teeth were in excellent or very good condition: 61.1 percent of non-Hispanic Black children and only 46.7 percent of Hispanic children had teeth that were in excellent or very good condition, as did 67.2 percent of children of other races.

Parents who reported that their child's teeth were in fair or poor condition were asked to identify the specific dental health issues experienced by their child. More than half of children whose teeth were in fair or poor condition (54.6 percent) were reported to have cavities. Other commonly reported problems included crooked teeth, or teeth that need braces (33.5 percent); broken front tooth or teeth that need repair (11.8 percent); teeth problems such as grinding, soft teeth, or teeth falling out (6.1 percent); and pain (4.6 percent).

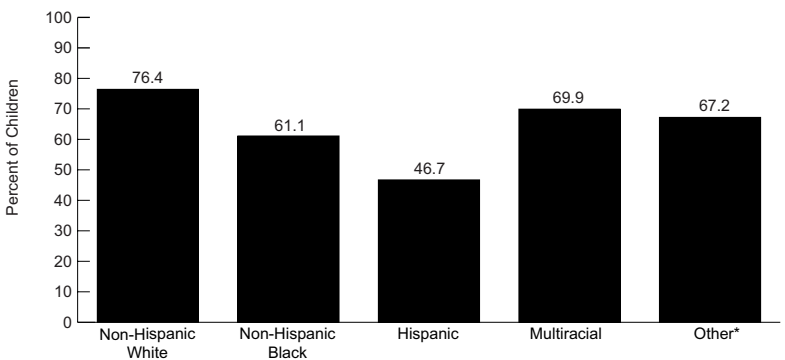
Condition of Children's Teeth: 2003

Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



Children Whose Teeth Are in Excellent or Very Good Condition, by Race/Ethnicity: 2003

Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



**Includes Asian/Pacific Islander and American Indian/Alaska Native children.*

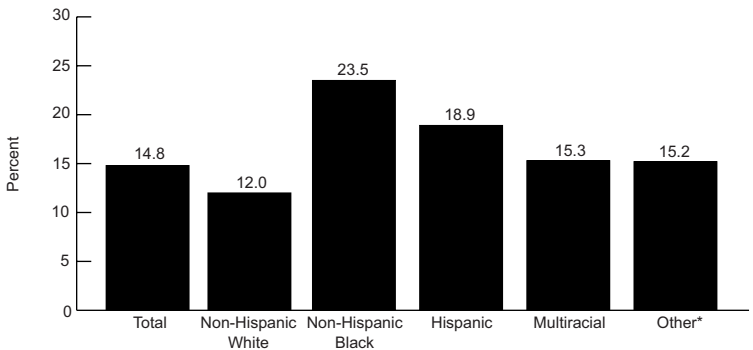
OVERWEIGHT

The National Survey of Children's Health asked parents to give the height and weight of their children in order to determine their Body Mass Index (BMI). Overweight means that the child's BMI, calculated from the parent-reported height and weight, is at or above the 95th percentile for sex and age. Overall, 14.8 percent of children aged 10 to 17 years were classified as overweight in 2003.

The prevalence of overweight varies by a number of factors, including race and ethnicity, age, and family income. Of children with family incomes below 100 percent of the Federal poverty level (FPL), almost one-quarter (22.4 percent) were overweight, compared to 19.0 percent of children with family incomes between 100 and 199 percent FPL, 13.7 percent of children with family incomes between 200 and 399 percent FPL, and 9.1 percent of children with family incomes of 400 percent FPL or more. With regard to race and ethnicity, Non-Hispanic Black children were most likely to be overweight (23.5 percent) based on parent-reported height and weight, followed by Hispanic children (18.9 percent); White children were least likely to be overweight (12.0 percent). Multiracial children and children of other races have rates of overweight that are approximately equal (15.3 and 15.2 percent, respectively).

Children Aged 10-17 Years Who Are Overweight, by Race/Ethnicity: 2003

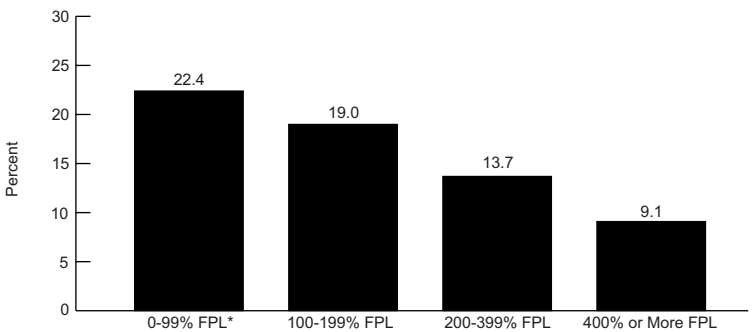
Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Includes Asian/Pacific Islander and American Indian/Alaska Native children.

Children Aged 10-17 Years Who Are Overweight, by Family Income: 2003

Source (I.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Federal poverty level, equal to $18,400 for a family of four in 2003.

PEDIATRIC AIDS

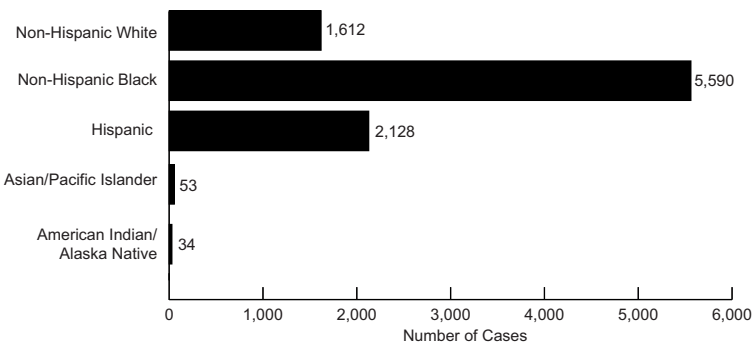
Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which damages or kills the cells that are responsible for fighting infection. An AIDS diagnosis is received when an HIV infection becomes advanced and meets certain criteria determined by the Centers for Disease Control and Prevention (CDC). By 2004, 9,443 cases of AIDS in children younger than 13 had ever been reported in the United States. Pediatric AIDS represents approximately one percent of all cases ever reported.

In 2004, an estimated 48 new AIDS cases were diagnosed among children, all of which were attributed to transmission through the mother before or during birth (perinatal transmission). The number of new cases of pediatric AIDS has declined substantially since 1992, when 945 cases were reported. A major factor in this decline is the increasing use of antiretroviral therapy before, during, and after pregnancy to reduce perinatal transmission of HIV, the virus that causes AIDS. 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 treatments and obstetric procedures.

Racial and ethnic minorities are disproportionately represented among pediatric AIDS cases. Non-Hispanic Blacks compose approximately 15 percent of the child population but represent almost 60 percent of all pediatric AIDS cases.

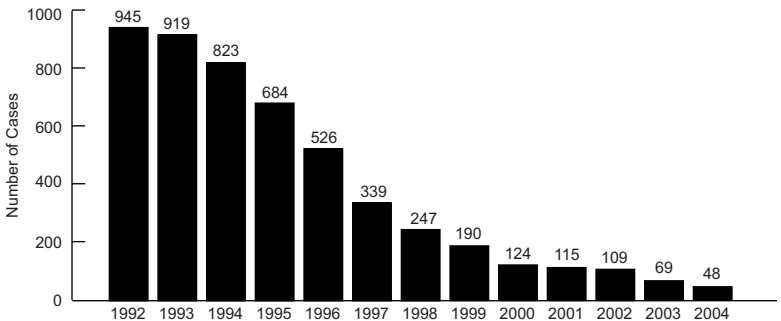
Estimated Numbers of AIDS Cases in Children Under Age 13, by Race/Ethnicity: Through 2004*

Source (II.4): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



Estimated Numbers of AIDS Cases in Children Under Age 13, by Year of Diagnosis: 1992-2004

Source (II.4): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



Includes children with a diagnosis of AIDS, from the beginning of the epidemic through 2004.

VACCINE-PREVENTABLE DISEASES

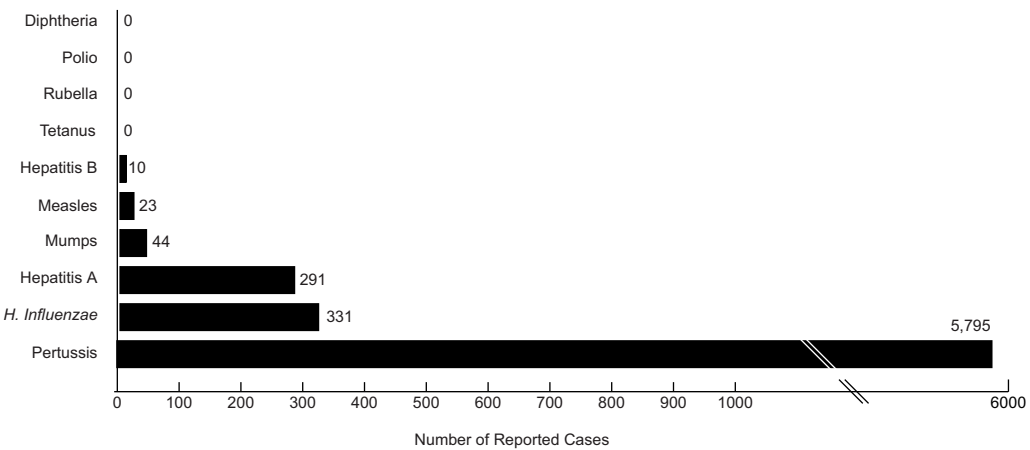
The number of reported cases of vaccine-preventable diseases has generally decreased over the past several decades. In 2004, there were no reported cases of diphtheria, rubella, or polio in the entire U.S. population and no cases of tetanus among children under 5 years of age.

From 2003 to 2004, the number of reported cases of *H. Influenzae* and hepatitis B decreased among children under 5 years of age. Rates of hepatitis B infection have steadily declined with the implementation of a national strategy to eliminate the disease. This strategy includes routine screening of pregnant women for the hepatitis B virus, and routine vaccination of infants and children. It is important to note that since most hepatitis B infections among infants and young children are asymptomatic, the reported number of cases likely underestimates the incidence in these age groups.

While the number of reported cases of several vaccine-preventable diseases decreased from 2003 to 2004, the number of reported cases of measles, mumps, hepatitis A, and pertussis increased over the same period. In 2004, the incidence of reported pertussis among the entire U.S. population increased for the third year in a row, and the number of cases was the highest reported since 1959. Of cases for which age was reported, 10 percent occurred among children under 6 months of age who were too young to have received the full schedule of acellular pertussis vaccine. The highest reported rate of the disease (136.5 per 100,000) occurred among this age group. With regard to hepatitis A, although the number of cases among children under 5 years increased from 2003 to 2004, the overall incidence of the disease has dropped dramatically since routine vaccination for children living in high-risk areas was recommended starting in 1996.

Incidence of Select Vaccine-Preventable Diseases Among Children Under Age 5: 2004

Source (II.5): Centers for Disease Control and Prevention



HOSPITALIZATION

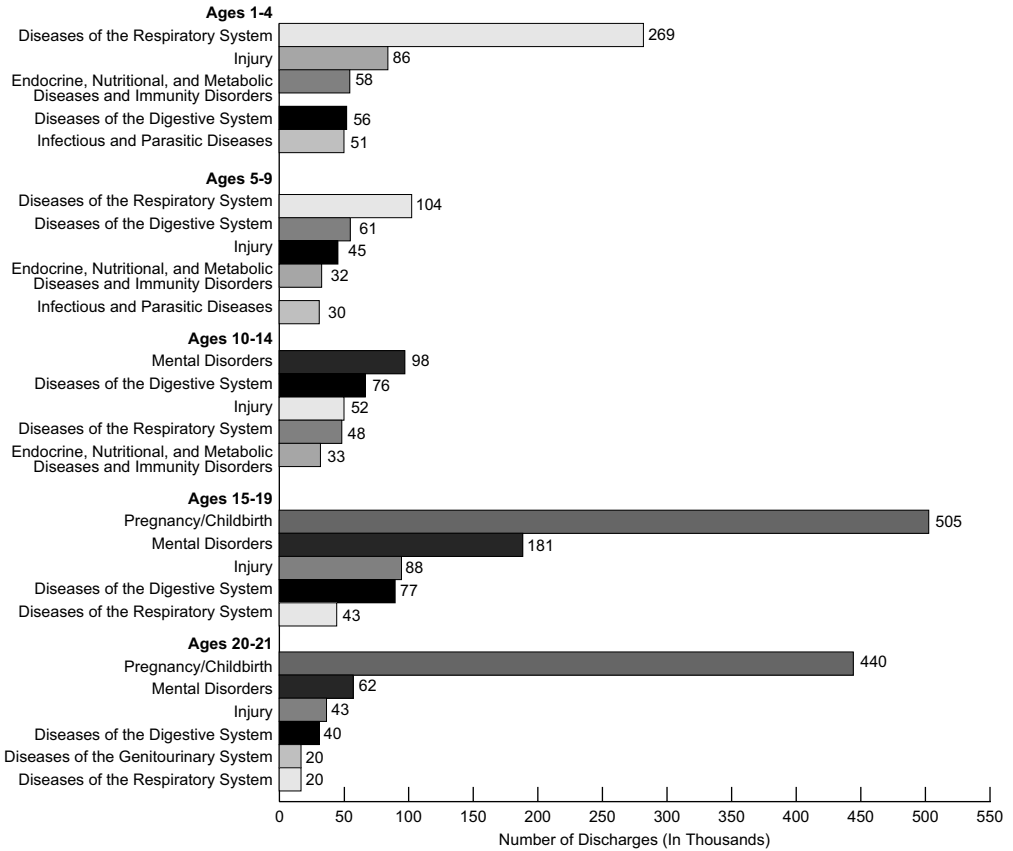
In 2004, there were 3.6 million hospital discharges among children aged 1 through 21, or 4.2 discharges per 100 children that year. This represents little change from 2003. Hospital discharge rates generally decrease with age until about age 9 and then increase during later adolescence.

While injuries are the leading cause of death among children older than 1 year, this category accounted for only 9 percent of hospital discharges of children 1 to 14 years old in 2004. Diseases of the respiratory system were the major cause of hospitalization for children 1 to 9 years of age, accounting for 31 percent of discharges. Pregnancy and childbirth accounted for 67 percent of discharges of young women aged 15 to 21. Mental disorders were the second leading cause of hospitalization for 15- to 21-year-olds.

Overall, there has been a significant decrease in hospital discharge rates among children over the past 20 years. From 1985 to 2004, there was a 33 percent decrease in discharge rates for children aged 1 to 14 years. During this period, hospital discharge rates for diseases of the respiratory systems declined 44 percent for children in this age group.

Major Causes of Hospitalization, by Age: 2004

Source (II.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



HOSPITAL DISCHARGE TRENDS

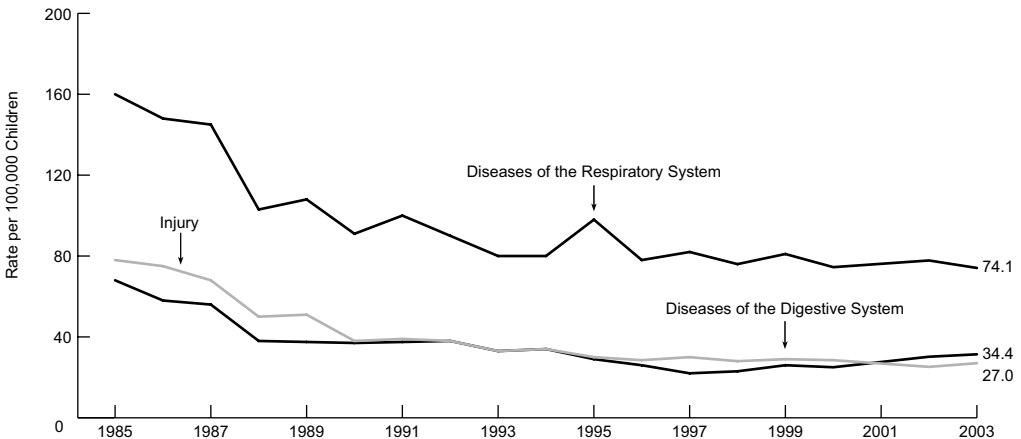
Since 1985, overall hospital discharge rates for children aged 1 to 14 have declined by 33 percent.

Between 1985 and 2004, hospital discharge rates for diseases of the respiratory system declined 44 percent for children in this age group.

Three diagnostic categories (respiratory diseases, digestive diseases, and injury) accounted for 44 percent of discharges among children aged 1 to 14 years in 2004.

Discharge Rates Among Children Aged 1-14, by Selected Diagnoses: 1985-2003

Source (II.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



CHILD ABUSE AND NEGLECT

State child protective services (CPS) agencies received approximately 3 million referrals, involving an estimated 5.5 million children, alleging abuse or neglect in 2004. Over half of these reports were made by community professionals, such as teachers and other educational personnel, medical personnel, and daycare providers.

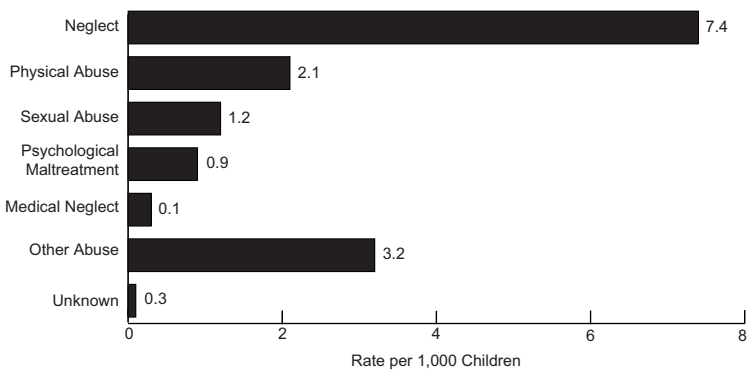
Investigations determined that an estimated 872,000 children were victims of abuse or neglect in 2004; this is equivalent to a rate of about 11.9 per 1,000 children under 18 years of age. Neglect was the most common type of maltreatment (7.4 per 1,000 children), followed by physical abuse (2.1 per 1,000). Other types of abuse included sexual abuse, psychological maltreatment, medical neglect, and categories of abuse based on specific State laws and policies. Some children suffer multiple types of maltreatment.

Victimization rates were highest among young children. In 2004, the rate of victimization among children from birth to age 3 was 16.1 per 1,000 children of the same age; the rate declined steadily as age increased. A majority of perpetrators of abuse and neglect, almost 80 percent, were parents. Remaining types of perpetrators included other relatives (6.5 percent), unmarried partners of parents (4.1 percent), and professionals such as daycare workers and residential facility staff (1.1 percent). Foster parents account for 0.4 percent of perpetrators, while friends and neighbors account for 0.3 percent.

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 CPS agencies.

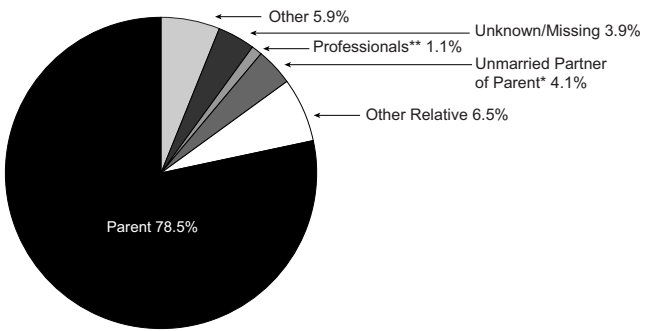
Child Abuse and Neglect Among Children Under Age 18, by Type of Maltreatment: 2004

Source (II.7): Administration on Children, Youth, and Families, National Child Abuse and Neglect Data System



Perpetrators of Child Abuse and Neglect, by Relationship to Victim: 2004

Source (II.7): Administration on Children, Youth, and Families, National Child Abuse and Neglect Data System



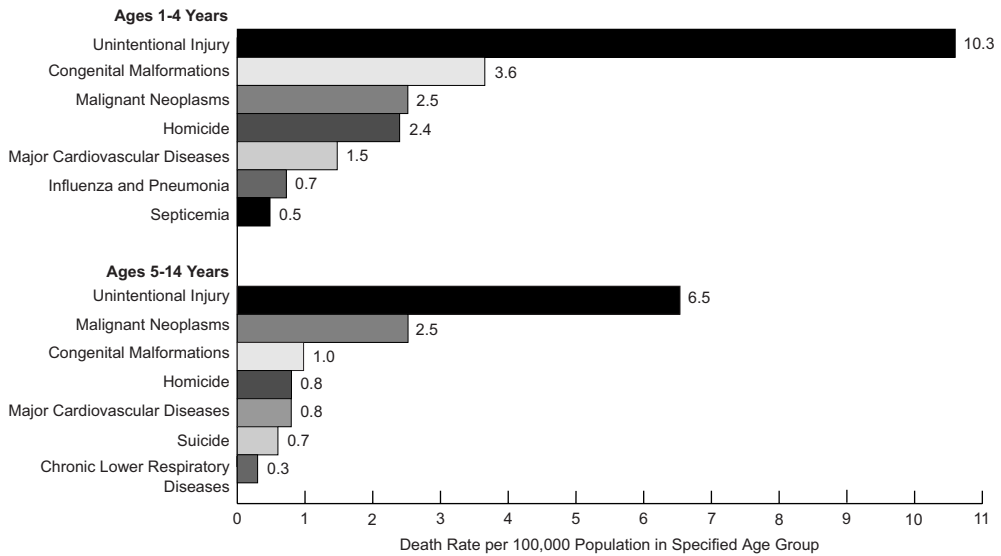
**Someone who has a relationship with the parent and lives in the household with the parent and maltreated child.*
***Includes residential facility staff, child daycare providers, and other professionals.*

CHILD MORTALITY

In 2004, 11,619 children between the ages of 1 and 14 years died of various causes; this was 222 fewer than the previous year. The overall death rate among 1- to 4-year-olds was 29.9 per 100,000, and the rate among 5- to 14-year-olds was 16.8 per 100,000. The leading cause of death among the younger age group continues to be unintentional injury, which accounted for 34.3 percent of all deaths in this age group in 2004. The next most common cause of death was congenital malformations (birth defects), followed by malignant neoplasms (cancer), homicide, and major cardiovascular diseases. Unintentional injury was also the leading cause of death among older children, accounting for 39.0 percent of deaths among 5- to 14-year-olds. This was followed by malignant neoplasms, congenital malformations, homicide, major cardiovascular diseases, and suicide.

Leading Causes of Death Among Children Aged 1-14: 2004

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



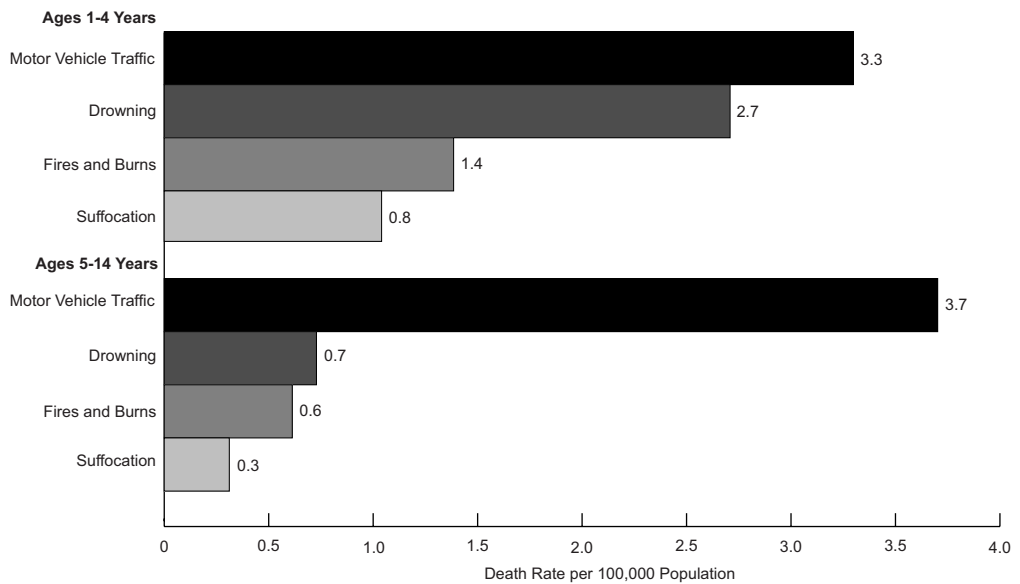
CHILDHOOD DEATHS DUE TO INJURY

In 2004, unintentional injuries caused the deaths of 1,641 children aged 1 to 4 years and 2,666 children aged 5 to 14 years. In 2004, motor vehicle crashes, drowning, and fires and burns were the most common causes of unintentional injury death among children aged 1 to 4 years. Motor vehicle crashes were the most common cause of unintentional injury death among children aged 5 to 14 years, followed by deaths due to drowning, fires and burns, and suffocation.

In addition, 377 children aged 1 to 4 years were the victims of homicide in 2004, and 614 children aged 5 to 14 years were the victims of homicide or suicide (data not shown).

Deaths Due to Unintentional Injury Among Children Aged 1-14: 2004

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



Health Status - Adolescents

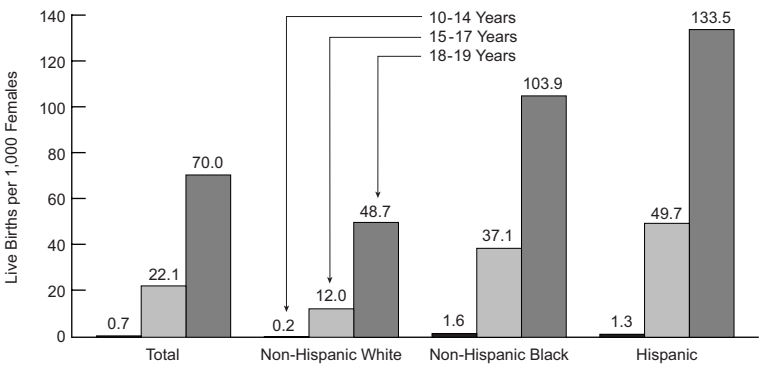
ADOLESCENT CHILDBEARING

The birth rate among adolescents aged 15 to 19 years decreased to 41.1 births per 1,000 females in 2004. This is 1 percent below the rate in the previous year, and represents a 33 percent decrease since the most recent peak in 1991. The birth rate among the youngest adolescents, aged 10 to 14 years, increased slightly to 0.7 per 1,000. Teenage birth rates were highest among the oldest adolescents, aged 18 to 19 years, at 70.0 per 1,000.

Teenage birth rates have historically varied considerably by race and ethnicity. Among adolescents aged 15 to 19 years, Asian/Pacific Islanders had the lowest birth rate in 2004 (17.3 per 1,000), followed by non-Hispanic Whites (26.7 per 1,000). Although non-Hispanic Black teens had one of the highest birth rates for this age group (63.1 per 1,000), they have also experienced the largest percentage drop since 1991 (47 percent). Hispanic females had the highest birth rate among teens aged 15 to 19 years (82.6 per 1,000) and the lowest percentage drop since 1991 (21 percent). Among the youngest teens, aged 10 to 14 years, non-Hispanic Black females had the highest birth rate (1.6 per 1,000), followed by Hispanic females (1.3 per 1,000); the lowest birth rates were again found among Asian/Pacific Islanders and non-Hispanic Whites (0.2 per 1,000 for both groups).

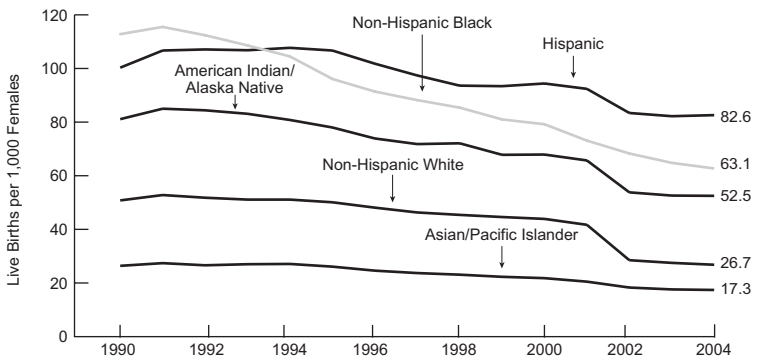
Birth Rates Among Adolescent Females, by Age and Maternal Race/Ethnicity: 2004

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



Birth Rates Among Females Aged 15-19, by Maternal Race/Ethnicity: 1990-2004

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



SEXUAL ACTIVITY

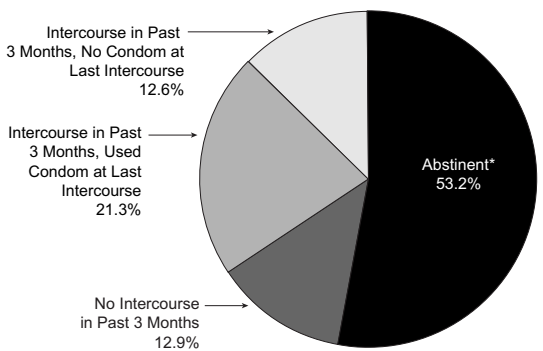
In 2005, 46.8 percent of high school students reported ever having had sexual intercourse, representing a slight increase since 2003. Although non-Hispanic Black students were most likely to report ever having sexual intercourse (67.6 percent), they were also most likely to report condom use during their last sexual encounter (68.9 percent of sexually active students). Hispanic students were second most likely to report ever having had sexual intercourse (51.0 percent), followed by non-Hispanic White students (41.8 percent), and non-Hispanic students of other races (36.4 percent).

Almost half of all 12th grade students reported having sexual intercourse in the 3 months preceding the survey. Among 9th grade students, more males were currently sexually active than females (24.5 percent versus 19.5 percent). However, by 12th grade, females were more likely to be currently sexually active than males (51.7 percent versus 47.0 percent). More than half of all high school students reported that they had never had sexual intercourse.

In 2005, 62.8 percent of sexually active students reported using a condom during their last sexual encounter, representing a slight decrease since 2003. Males were more likely to report using condoms than females in every grade, and younger students were more likely than older students (74.5 and 65.3 percent of 9th and 10th graders, compared to 61.7 and 55.4 percent of 11th and 12th graders, respectively).

Sexual Activity Among High School Students: 2005

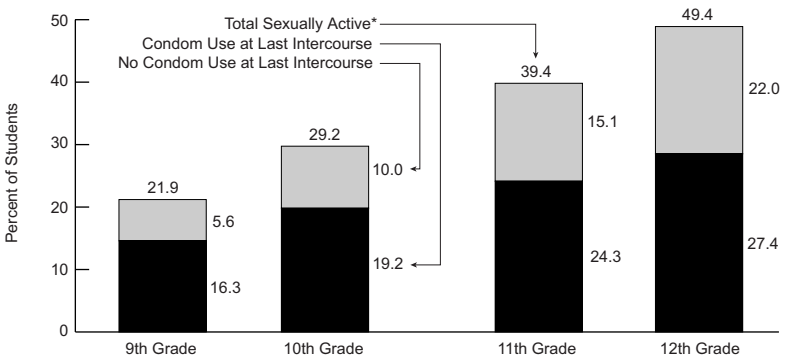
Source (II.8): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



*Have never had intercourse.

Condom Use Among Sexually Active High School Students, by Grade: 2005

Source (II.8): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



*Had sexual intercourse during the 3 months preceding the survey.

SEXUALLY TRANSMITTED INFECTIONS

Adolescents (ages 15 to 19 years) and young adults (ages 20 to 24 years) are at much higher risk of contracting sexually transmitted infections (STIs) than are older adults. Within each of these age groups, reported rates of chlamydia, gonorrhea, and syphilis infection are significantly higher among non-Hispanic Black youth than youth of all other reported racial and ethnic categories.

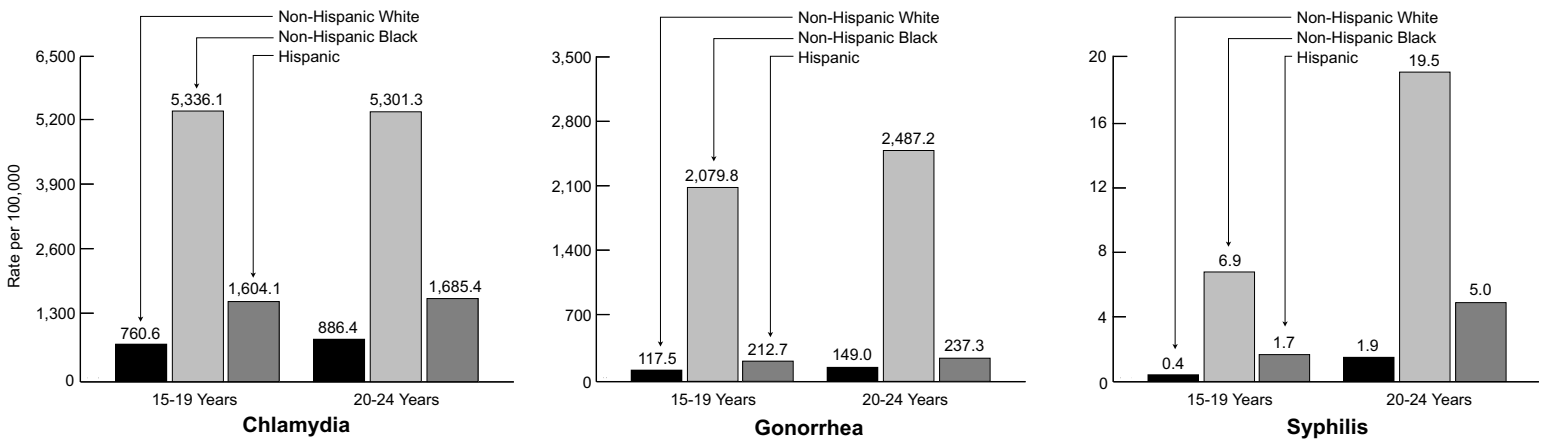
Chlamydia continues to be the most common STI in adolescents and young adults, with rates of 1,579 and 1,660 cases per 100,000, respectively, in 2004. Gonorrhea followed in prevalence with overall rates of 427 and 498 per 100,000 adolescents and young adults, respectively. Syphilis is far less common among young people and the population as a whole, with a rate of 1.7 per 100,000 adolescents and a rate of 5.0 per 100,000 young adults.

Another STI, genital human papillomavirus (HPV), is the most common STI in the United States. It is estimated that as many as half of those who are infected with HPV are adolescents and young adults. There are many different types of HPV, and some, which are referred to as "high-risk," can cause cancer. Although cervical cancer in women is the most serious health problem caused by HPV, it is highly preventable with regular Pap tests and follow-up care. A vaccine for HPV was recently approved by the Food and Drug Administration (FDA) for use in females aged 9 to 26 years.[1]

1 *Centers for Disease Control and Prevention, Division of STD Prevention. HPV and HPV vaccines: information for healthcare providers. June 2006. Available from: www.cdc.gov/std/hpv/STDFact-HPV-vaccine-hcp.htm*

Prevalence of Sexually Transmitted Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity: 2004

Source (II.9): Centers for Disease Control and Prevention, STD Surveillance System



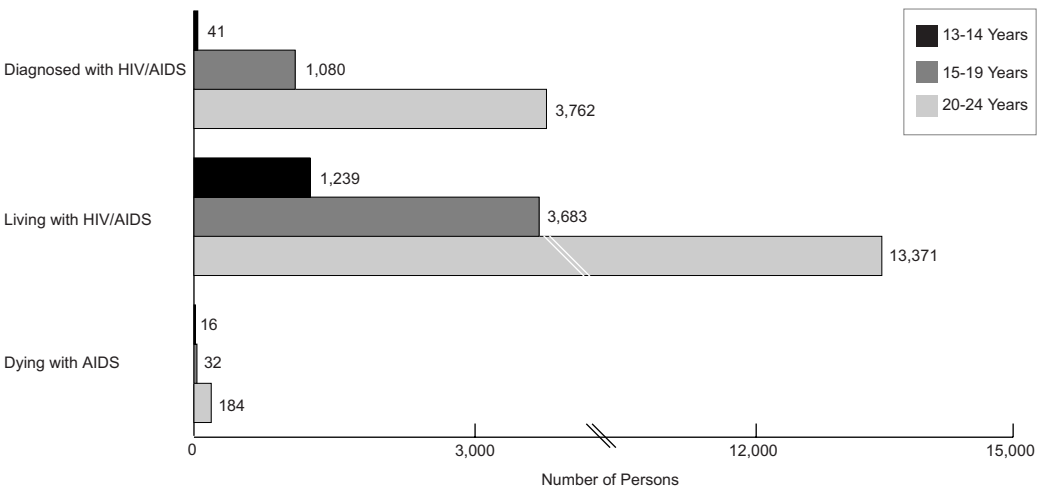
ADOLESCENT AND YOUNG ADULT HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which damages or kills the cells that are responsible for fighting infection. AIDS is diagnosed when an HIV infection becomes advanced and meets certain criteria determined by the Centers for Disease Control and Prevention (CDC). In 2004, 4,883 people aged 13 to 24 years were diagnosed with HIV/AIDS,* representing approximately 12.5 percent of all diagnoses. The number of AIDS cases diagnosed among this age group was 2,174 in 2004, and 40,059 since the epidemic began in the early 1980s.

There were 18,293 people aged 13 to 24 years living with HIV/AIDS in 2004, representing approximately 4 percent of all cases. Among people who died with AIDS in 2004, just over 1 percent (232 persons) were adolescents and young adults. Since the beginning of the epidemic, just over 10,000 people in this age group have died with the disease. While the number of people living with HIV/AIDS has increased in recent years, the number of deaths of people with the disease has decreased due in part to the availability of effective prescription drugs to combat the disease.

Number of Persons Aged 13-24 Diagnosed with and Living with HIV/AIDS,* and Dying with AIDS: 2004

Source (II.4): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



*This includes persons with a diagnosis of HIV infection only, a diagnosis of HIV infection and a later AIDS diagnosis, and concurrent diagnoses of HIV infection and AIDS.

PHYSICAL ACTIVITY

Results from the 2005 Youth Risk Behavior Survey show that 35.8 percent of high school students met the currently recommended levels of physical activity and 68.7 percent of students met the previously recommended standard for physical activity in the previous week. Current physical activity standards for this age group recommend 60 minutes of physical activity five days per week; previous standards recommended at least 20 minutes of vigorous activity or 30 minutes of moderate activity five days per week. Only 9.6 percent of students did not engage in any vigorous or moderate physical activity.

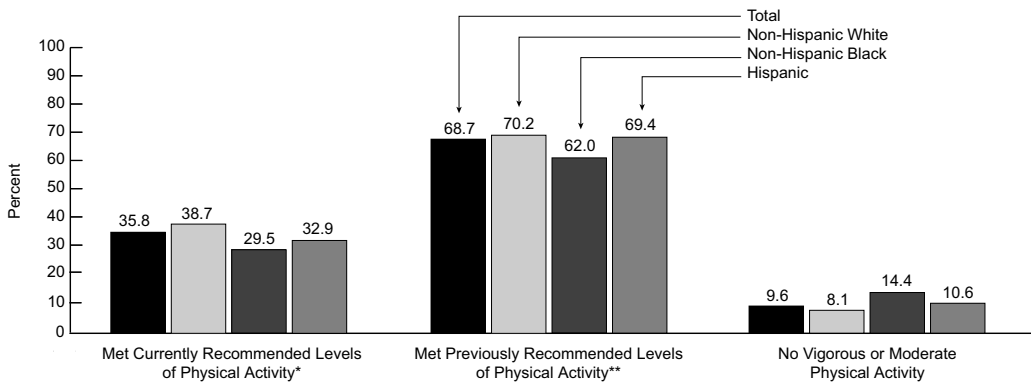
Nationwide, 54.2 percent of high school students were enrolled in a physical education class on one or more days a week, although the percentage is far higher in the younger grades (71.5 percent of 9th graders) than in the older grades (38.8 percent of 12th graders). The percentage of students attending daily physical education classes has dropped from 42 percent in 1991 to 33.0 percent in 2005. Among those students who attended physical education classes, 84.0 percent reported exercising or playing sports for more than 20 minutes during an average class.

In 2005, a total of 56.0 percent of high school students reported playing on one or more sports teams in the past year. This was more common among children in younger grades (60.4 percent of 9th graders) than in the older grades (49.2 percent of 12th graders). High school students also reported sedentary activities, such as using a computer or watching television. Over one-fifth (21.1 percent) of students reported using a computer (for something other than school work) for 3 or more hours per day on an average school day, while 37.2 percent of students reported watching television for 3 or more hours on an average school day.

The *HealthierUS* Initiative—available online at www.healthierus.gov—provides credible, accurate information about physical fitness, nutrition, and prevention to help Americans of all ages to make healthy decisions.

Physical Activity Among High School Students, by Race/Ethnicity: 2005

Source: (II.8): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



**Participation in physical activity for a total of 60 minutes or more per day on 5 or more of the past 7 days.*
***Participation in at least 20 minutes of vigorous physical activity on 3 or more of the past 7 days and/or at least 30 minutes of moderate physical activity on 5 or more of the past 7 days.*

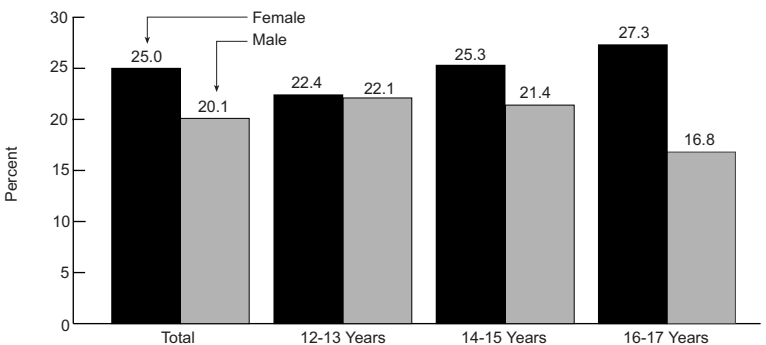
MENTAL HEALTH TREATMENT

In 2004, 22.5 percent of youth aged 12 to 17 years received mental health treatment or counseling in the past year, which includes treatment or counseling for emotional or behavioral problems not caused by drug or alcohol use. The rate in 2004 represented an increase over the previous year's rate of 20.6 percent. Overall, there was little difference by age group or race and ethnicity; however, females were more likely than males to receive treatment (25.0 versus 20.1 percent). The treatment rate among males declined with age, while the rate among females increased with age. Youth with lower family incomes were more likely to receive treatment that those with higher family incomes.

Among youth who received mental health treatment or counseling, 33.6 percent used illicit drugs in the past year. Illicit drug use among those receiving treatment was most common among 12- to 13-year-olds (38.5 percent), and least common among 16- to 17-year-olds (31.4 percent). Females receiving mental health treatment were far more likely than males to report past year illicit drug use (41.6 versus 25.6 percent).

Mental Health Treatment/Counseling* in the Past Year Among Children Aged 12-17, by Age and Sex: 2004

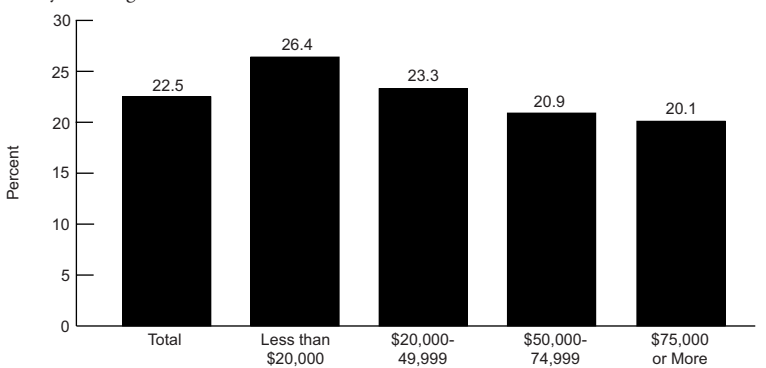
Source (II.10): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



Treatment or counseling from any of 10 specific sources for emotional or behavioral problems not caused by drug or alcohol use.

Mental Health Treatment/Counseling* in the Past Year Among Children Aged 12-17, by Family Income: 2004

Source (II.10): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



Treatment or counseling from any of 10 specific sources for emotional or behavioral problems not caused by drug or alcohol use.

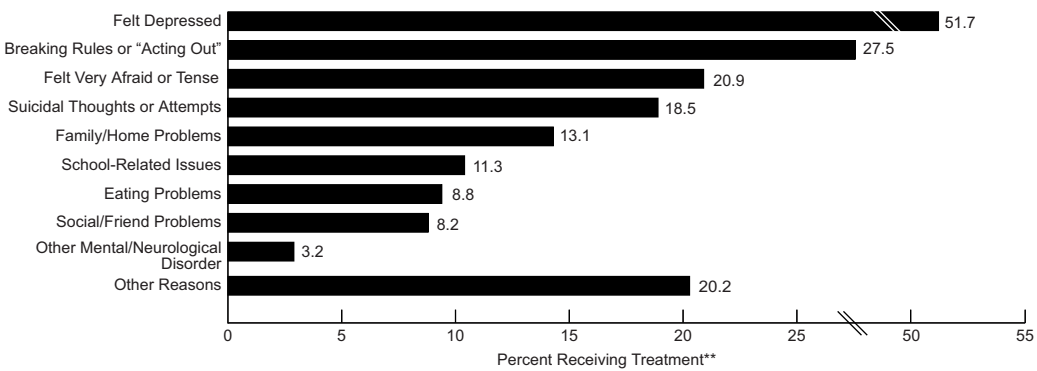
MENTAL HEALTH TREATMENT, CONTINUED

Depression was the leading reason reported for mental health treatment among 12- to 17-year-olds. Other common reasons for treatment included breaking rules or "acting out" (27.5 percent), feeling very afraid or tense (20.9 percent), and suicidal thoughts or attempts (18.5 percent). Survey respondents were able to report more than one reason for seeking treatment.

The most common source of mental health treatment among those youth receiving treatment was a school counselor or psychologist, or regular teacher meetings (46.7 percent). Also common was a private source, such as a therapist or psychologist (45.0 percent). Use of a partial day hospital or treatment program was reported by 7.8 percent of youth receiving treatment, and an overnight or longer stay in a residential treatment center was reported by 5.3 percent. Youth receiving treatment could indicate any number of 10 possible sources of care.

Reasons for Mental Health Treatment/Counseling* in the Past Year Among Children Aged 12-17 Who Received Treatment: 2004

Source (II.10): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



**Having received treatment or counseling from any of 10 specific sources for emotional or behavioral problems not caused by alcohol or drug use.*
***Respondents could indicate more than one reason for treatment.*

VIOLENCE

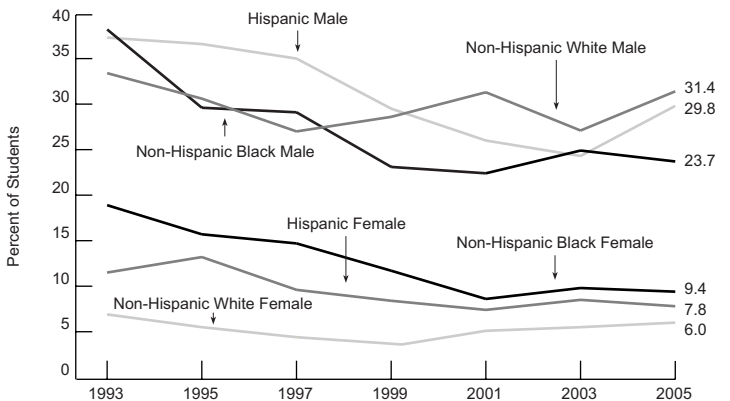
Violence among adolescents is a critical public health issue in the United States. In 2004, the latest year for which data are available, homicide was the second leading cause of death among persons aged 15 to 24 years.

Results from the 2005 Youth Risk Behavior Survey (YRBS) indicate that 18.5 percent of high school students had carried a weapon (such as a gun, knife, or club) at some point during the preceding 30 days. Males were more than four times as likely as females to carry a weapon (29.8 versus 7.1 percent). Non-Hispanic White and Hispanic males were more likely than non-Hispanic Black males to carry a weapon (31.4 and 29.8 versus 23.7 percent), and non-Hispanic Black females were more likely than non-Hispanic White and Hispanic females (9.4 versus 6.0 and 7.8 percent). Just over 5 percent of students reported carrying a gun in the preceding 30 days, and males were more than 11 times as likely as females to do so. Almost 36 percent of students had been in a physical fight at least once in the preceding 12 months.

In 2005, 6.5 percent of students carried a weapon on school property on at least one of the preceding 30 days, which did not vary significantly by grade Almost 8 percent of students were threatened or injured with a weapon on school property in the preceding 30 days; this was relatively consistent across grades. Almost 14 percent of high school students had been in a fight on school property in the preceding 12 months, and 6 percent of students missed school on at least one of the 30 preceding days because of safety concerns.

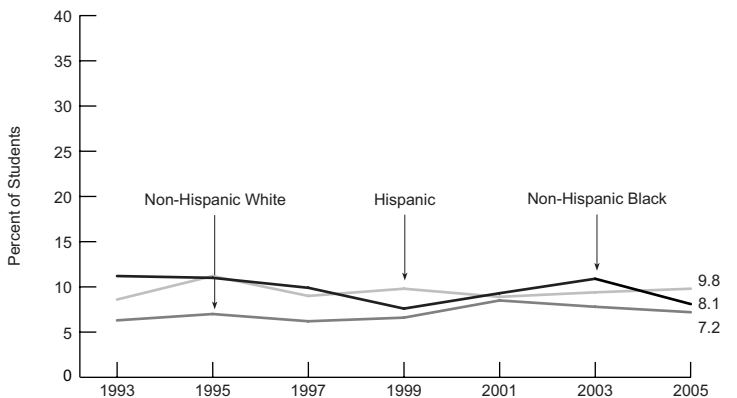
High School Students Who Carried a Weapon in the Past 30 Days, by Sex and Race/Ethnicity: 1993-2005

Source (II.8): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



High School Students Threatened or Injured with a Weapon on School Property in Past Year, by Race/Ethnicity: 1993-2005

Source (II.8): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



SUBSTANCE ABUSE

Prevalence. In 2004, 10.6 percent of adolescents aged 12 to 17 years reported using illicit drugs in the past month. The use of illicit drugs within the past month increased with age. Among those aged 12 to 13 years, 3.8 percent reported past-month use, compared to 10.9 percent of those aged 14 to 15 years and 17.3 percent of those aged 16 to 17 years. Rates of past-month illicit drug use were similar among non-Hispanic White, non-Hispanic Black, and Hispanic adolescents (ranging from 9.3 to 11.1 percent); American Indian/Alaska Native adolescents had the highest rate of past-month use (26.0 percent), while Asian adolescents had the lowest (6.0 percent).

Alcohol is the most commonly used drug among adolescents, with 17.6 percent reporting past-month use in 2004. Marijuana is the most commonly used illicit drug (7.6 percent), followed by the nonmedical use of psychotherapeutic drugs, such as pain relievers, tranquilizers, and stimulants (3.6 percent). Marijuana use is more common among male adolescents than their female counterparts (8.1 versus 7.1 percent), while prescription drug abuse is more common among females (4.1 versus 3.2 percent).

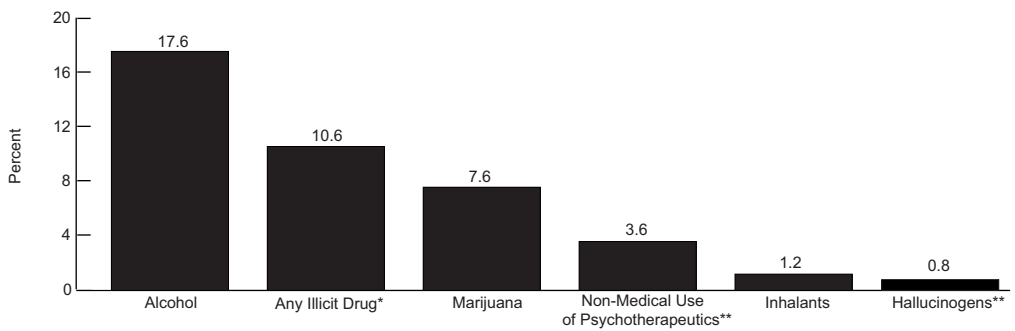
In 2004, 47.5 percent of adolescents who smoked cigarettes in the past month also used an illicit drug, compared to only 5.6 percent of those who didn't smoke. Among those adolescents who both smoked cigarettes and used alcohol, 58.8 percent also used an illicit drug.

Perception of Risk and Access to Drugs. In 2004, 35.0 percent of adolescents perceived smoking marijuana once a month to be a great risk, while 49.6 percent perceived the same risk regarding cocaine use. Smoking one or more packs of cigarettes a day was considered a great risk by 67.5 percent of adolescents, which represented a significant increase over the past year (from 64.2 percent). Drinking five or more drinks on one or two occasions per week was considered to be a great risk by 40.9 percent of adolescents.

In 2004, 52.2 percent of adolescents reported that marijuana would be fairly or very easy to obtain. The same was reported by 24.4 percent of teens regarding cocaine, 16.9 percent for LSD, and 14.0 percent for heroin. Just over 16 percent of adolescents reported being approached by someone selling drugs in the past month.

Past Month Drug Use Among Adolescents Aged 12-17: 2004

Source: (II.10): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Does not include alcohol.
**Psychotherapeutics include prescription-type pain relievers, tranquilizers, stimulants (including methamphetamine), and sedatives but do not include over-the-counter drugs; hallucinogens include LSD, PCP, and Ecstasy.

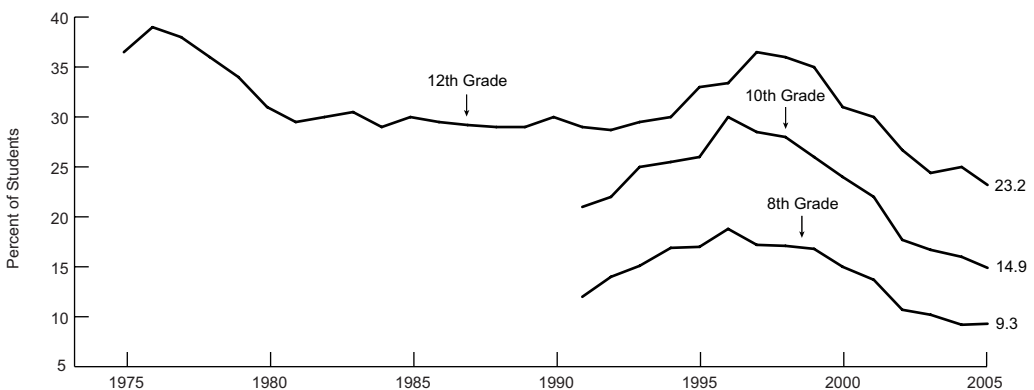
CIGARETTE SMOKING

As reported in the Monitoring the Future Study, cigarette smoking declined among 10th and 12th graders but remained stable for 8th graders between 2004 and 2005. Among 10th graders, 14.9 percent reported smoking at least once during the previous 30 days in 2005, compared to 16.0 percent the year before. The rate among 12th graders dropped from 25.0 to 23.2 percent over the same period. Overall, there has been a 56 percent decline among 8th graders and a 51 percent decline among 10th graders since use peaked among those grades in 1996. Among 12th graders, use peaked in 1997 and has seen a more modest decline of 36 percent. Factors that appear to have contributed to this decline include increases in perceived risk and disapproval of smoking, high cigarette prices, and anti-smoking advertising campaigns.

The teen smoking rate increased substantially between 1991 and 1996. Increases occurred in virtually every sociodemographic group: both sexes, those planning on attending college and not, those living in all four regions of the country, those living in rural and urban areas, and among Whites, Black, and Hispanics. Since 1996, rates have declined across all demographic groups consistently. Although absolute rates of smoking have declined among adolescents, certain subgroups are less likely to smoke than others. Students who are not college-bound are more likely to smoke than their college-bound peers, and Black adolescents are less likely to smoke cigarettes than White adolescents. The decline in rates of cigarette smoking since 1996 is likely to have important long-term health consequences for this generation of adolescents.

Any Cigarette Use Among High School Students in the Past 30 Days, by Grade: 1975-2005

Source (II.11): University of Michigan, Monitoring the Future Study



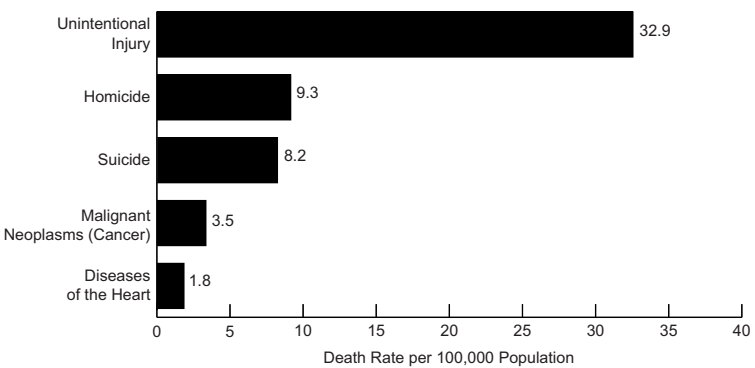
ADOLESCENT MORTALITY

In 2004, 13,706 deaths were reported of adolescents aged 15 to 19 years. After a moderate increase for this age group in the early 1980s, death rates have since gradually declined. Unintentional injury remains the leading cause of death among this age group and accounted for 49.8 percent of all deaths among adolescents in 2004. Homicide and suicide were the next leading causes of death, accounting for 14.1 and 12.4 percent, respectively, of all deaths within this age group.

Deaths Due to Injury. Within the classification of deaths due to injury or other external causes, motor vehicle crashes were the leading cause of mortality among 15- to 19-year-olds in 2004, and accounted for 48 percent of injury-related deaths among adolescents. Alcohol is a significant contributor to these deaths: recent data suggest that nearly one-third of adolescent drivers killed in crashes had been drinking. Firearms were the next leading cause of injury death, accounting for 23 percent of injury-related deaths in this age group. Adolescent death rates due to motor vehicle injuries and firearms were similar in the early 1990s until 1994, when they began to diverge. The rate of adolescent firearm deaths was recorded at 12.0 per 100,000 population in 2004, less than half the rate of motor vehicle injury deaths (24.7 per 100,000).

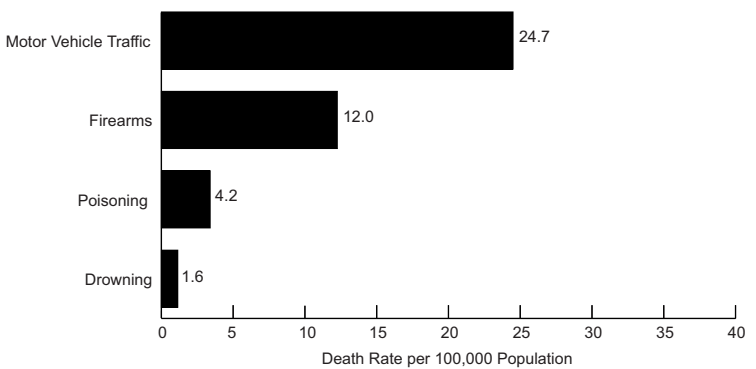
Leading Causes of Death Among Adolescents Aged 15-19: 2004

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



Deaths Due to Injury Among Adolescents Aged 15-19: 2004

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



ADOLESCENT MORTALITY FROM TRAFFIC AND FIREARM INJURIES

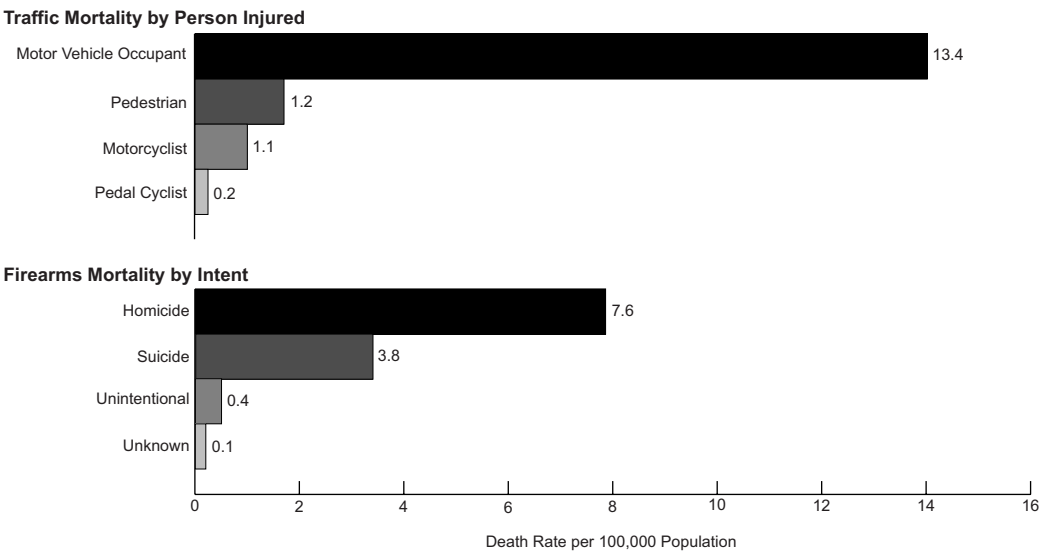
The two leading mechanisms of injury deaths among adolescents are motor vehicle crashes and firearms. In 2004, motor vehicle traffic caused the deaths of 5,113 adolescents 15 to 19 years of age. The vast majority of those killed were in motor vehicle accidents as either a passenger or driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among adolescents.

Results of the 2005 Youth Risk Behavior Survey revealed that 10.2 percent of high school students had rarely or never worn seat belts when riding in a car driven by someone else. Additionally, in the 30 days preceding the survey, 28.5 percent of students had ridden on one or more occasions with a driver who had been drinking alcohol.

In 2004, 2,494 adolescents aged 15 to 19 years were killed by firearms. Of these, homicide accounted for 65 percent of firearm deaths, suicide accounted for 32 percent, and 3 percent were considered unintentional.

Adolescent Mortality from Traffic and Firearm Injuries: 2004

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



Health Services Financing and Utilization

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

Children may receive health coverage through a number of sources, including private insurance, either employer-based or purchased directly, and public programs, such as Medicaid or the State Children's Health Insurance Program (SCHIP). Eligibility for public programs is based on a family's income compared to the Federal poverty level. Every State has SCHIP programs that help expand coverage to children who would otherwise be uninsured. Despite the progress achieved through public programs, approximately 8.3 million children remain uninsured in the United States.

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

HEALTH CARE FINANCING

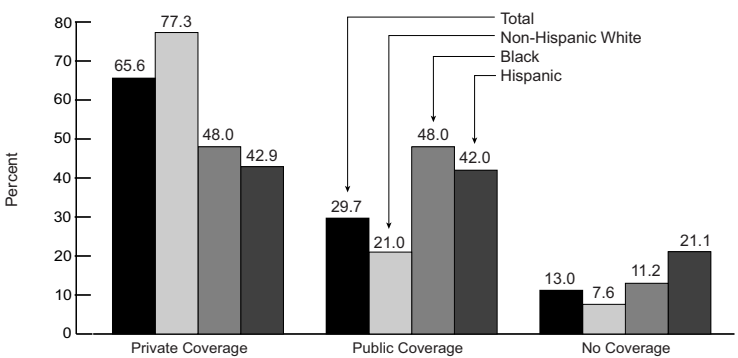
In 2004, 8.3 million children younger than 18 years of age had no health insurance coverage; this represents 11.2 percent of the child population. Almost 30 percent of children were publicly insured by sources such as Medicaid and the State Children's Health Insurance Program (SCHIP).

Children's insurance status varies by a number of factors, including family income and race and ethnicity. Non-Hispanic White children had high rates of private insurance coverage in 2004 (77.3 percent), while fewer than half of Black and Hispanic children had private coverage during the same period (48.0 and 42.9 percent, respectively). Black children were the most likely to have public coverage (48.0 percent), while Hispanic children were the most likely to be uninsured (21.1 percent). Rates of private coverage rise and rates of public coverage and no coverage fall with increasing family income. Children with family incomes below 100 percent of the poverty level were the most likely to have public coverage (66.8 percent) or be uninsured (19.4 percent), while they were the least likely to have private coverage (20.2 percent); the majority (85.7 percent) of children with family incomes of 200 percent of the poverty level or more were privately insured.

In 1997, SCHIP was created in response to the growing number of uninsured children in low-income working families. In 2004, over 6 million children were enrolled in SCHIP. Although designed to cover children with family incomes below 200 percent of the poverty level, many States have expanded eligibility to children with higher family incomes.

Health Insurance Coverage Among Children Under Age 18, by Race/Ethnicity and Type of Coverage:* 2004

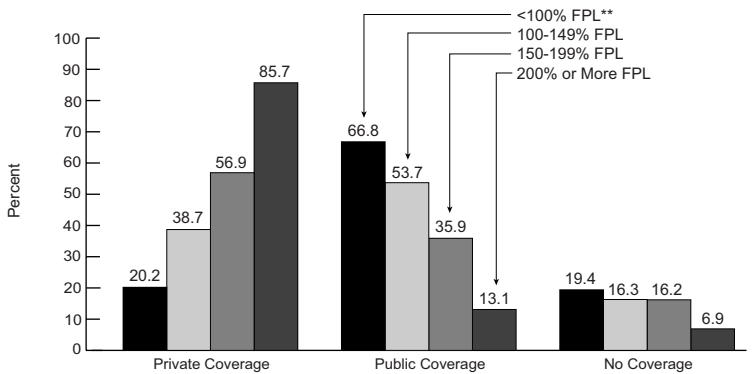
Source (III.1): U.S. Census Bureau, Current Population Survey



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

Health Insurance Coverage Among Children Under Age 18, by Poverty Level and Type of Coverage:* 2004

Source (III.2): Employee Benefit Research Institute, Analysis of Current Population Survey



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

VACCINATION COVERAGE

The Healthy People 2010 objective for the complete series of routinely recommended childhood vaccinations is immunization of at least 90 percent of 19- to 35-month-olds with the full series of vaccines. Data released from the CDC's 2004 National Immunization Survey show that 80.9 percent of children aged 19 to 35 months had received the recommended 4:3:1:3:3 series of vaccines. This series comprises 4 doses of diphtheria, tetanus, and pertussis vaccine, 3 doses of poliovirus vaccine, 1 dose of measles-mumps-rubella vaccine, and 3 doses of *Haemophilus influenzae* type b vaccine. Overall, 76.0 percent had received that series plus the varicella (chicken pox) vaccine.

Since 2000, the greatest increases in vaccination rates have occurred with the diphtheria, tetanus, and pertussis vaccine and the varicella vaccine (which was added to the schedule in 1996.) They have risen 4.7 and 29 percent, respectively. Vaccination rates for other vaccines have generally risen about 2 percent over the same period. Racial and ethnic disparities in vaccination rates persist, with non-Hispanic Black children and American Indian/Alaska Native children (data not shown) having the lowest rates for each of the major vaccines. Non-Hispanic White children experience the highest vaccination rates.

Each year, the CDC publishes an updated version of the recommended childhood immunization schedule (see facing page). The 2006 schedule continues to encourage the routine use of hepatitis B vaccines for all infants before hospital discharge and the use of annual influenza vaccines for all children starting at 6 months of age.

Estimated Vaccination Rates Among Children Aged 19-35 Months, by Race/Ethnicity: 2004

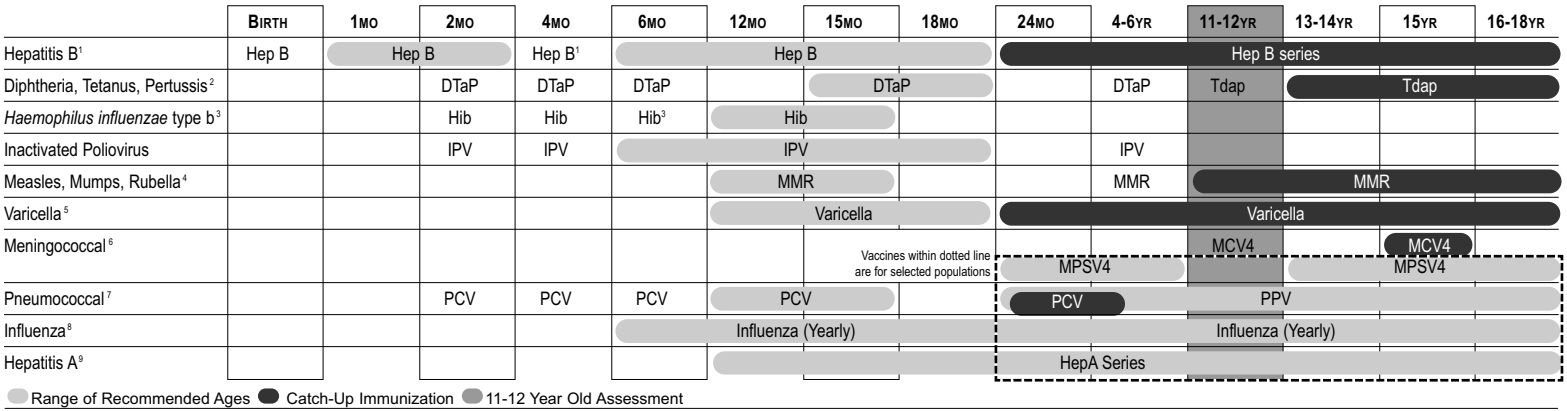
Source: (III.3): Centers for Disease Control and Prevention, National Immunization Survey

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic
Complete Series	76.0	77.2	70.9	75.9
4+ DTP	85.5	87.7	79.5	84.1
3+ Polio	91.6	92.1	90.4	91.2
1+ MMR*	93.0	93.5	90.7	93.2
3+ Hib	93.5	94.7	90.9	92.6
3+ HepB	92.4	93.0	90.8	91.9
1+ Varicella	87.5	86.5	86.3	89.1

**The immunization schedule calls for one dose of measles-containing vaccine (MCV), which can include the measles-mumps-rubella (MMR) vaccine shown above.*

Recommended Childhood and Adolescent Immunization Schedule, United States, 2006

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



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. The graphic indicates age groups that warrant special effort to administer those vaccines not previously administered. 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 other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that does of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). AT BIRTH: All newborns should receive monovalent HepB soon after birth and before hospital discharge. Infants born to mothers who are HBsAg-positive should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. Infants born to mothers whose HBsAg status is unknown should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). For infants born to HBsAg-negative mothers, the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. FOLLOWING THE BIRTHDOSE: The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1-2 months. The final dose should be administered at age 24 weeks or younger. It is permissible to administer 4 doses of HepB (e.g., when combination vaccines are given after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. Infants born to HBsAgpositive mothers should be tested for HBsAg and antibody to HBsAg after completion of the HepB series, at age 9-18 months (generally at the next well-child visit after completion of the vaccine series).

2. 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. The final dose in the series should be given at age 4 years or younger. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap - adolescent preparation) is recommended at age 11-12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. Adolescents 13-18 years who missed the 11-12-year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent tetanus and diphtheria toxoids (Td) are recommended every 10 years.

3. Haemophilus influenzae type b conjugate vaccine (Hib). 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 after any Hib vaccine. The final dose in the series should be administered at age 12 months or younger.

4. 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 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 age 11-12 years.

5. 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 or younger should receive 2 doses administered at least 4 weeks apart.

6. Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be given to all children at the 11-12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged 2 years or younger with terminal complement deficiencies or anatomic or functional asplenia and certain other high risk groups (see MMWR 2005;54 [RR-7]:1-21); use MPSV4 for children aged 2-10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices www.cdc.gov/nip/acip, American Academy of Pediatrics www.aap.org, and American Academy of Family Physicians www.aafp.org

7. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children aged 2-23 months and for certain children aged 24-59 months. The final dose in the series should be given at age 12 months or younger. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups. See MMWR 2000; 49(RR-9):1-35.

8. Influenza vaccine. Influenza vaccine is recommended annually for children aged 6 months or younger with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see MMWR 2005;54[RR-8]:1-55). In addition, healthy children aged 6-23 months and close contacts of healthy children aged 0-5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5-49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See MMWR 2005;54(RR-8):1-55. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if aged 6-35 months or 0.5 mL if aged 3 years or younger). Children aged 8 years or younger who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

9. Hepatitis A vaccine (HepA). HepA is recommended for all children at 1 year of age (i.e.,12-23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children 2-18 years of age are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of 1-year-old children should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups (see MMWR 1999; 48[RR-12]1-37).

DENTAL CARE

In a 2000 report on oral health, the Surgeon General identified dental caries (tooth decay) as the single most common chronic disease among children in the United States. This is a preventable health problem that can significantly affect children's health, ability to concentrate in school, and quality of life, and is more common in children of low-income families.

To promote good oral hygiene, the American Dental Association recommends that children have their first dental checkup within 6 months of the eruption of their first tooth and no later than 12 months of age. In Federal Fiscal Year 2004, only 26.5 percent of children eligible for services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program received a preventive dental service.

In 2004, 72.3 percent of children had seen a dentist in the past year. Frequency of dental visits among children varies by family income and race and ethnicity. Non-Hispanic White children between the ages of 1 and 18 years were most likely to have visited a dentist or other dental specialist within the past year (76.9 percent), while Hispanic children were least likely (62.3 percent). Children with family incomes at or above 200 percent of the poverty level were more likely (78.1 percent) to have seen a dentist in the past year than children living with family incomes below 200 percent of the poverty level (63.3 percent).

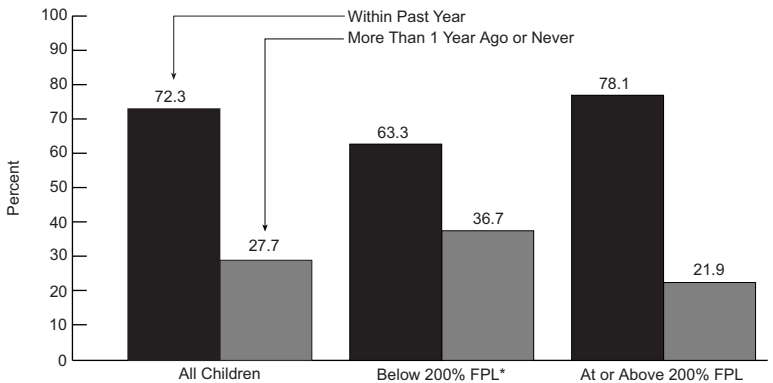
Children Receiving an EPSDT Preventive Dental Service: 1990-2004

Source (III.5): Centers for Medicare and Medicaid Services

*Includes data from 42 States.

Children's Receipt of Dental Care, by Family Income: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Federal poverty level.

TIMING OF PHYSICIAN VISITS

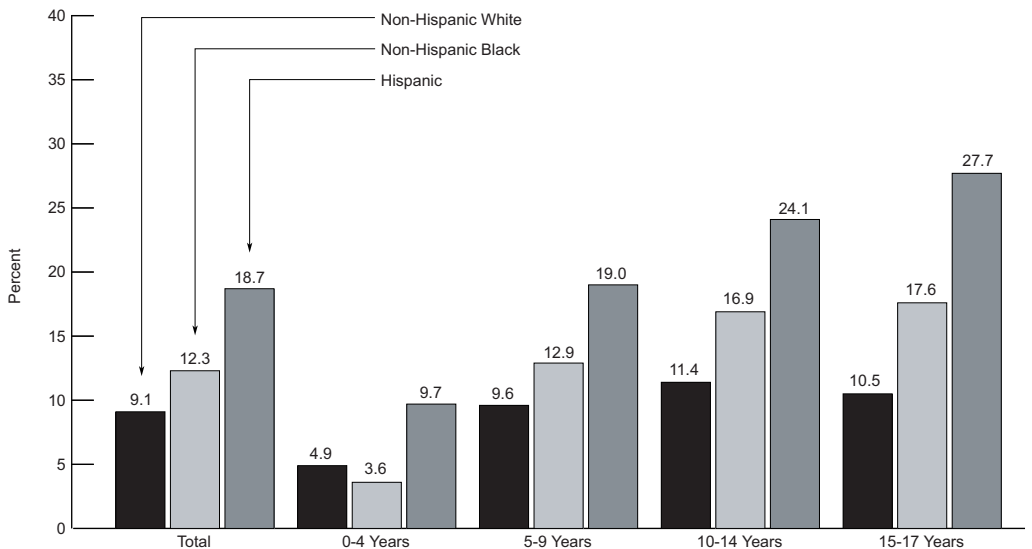
In 2004, 11.8 percent of children under 18 years of age had not seen a physician or other health care professional in the previous year (not including overnight hospitalization, trips to the emergency room, home visits, or dental visits). Older children were more likely than younger children to go without a physician visit. More than 15 percent of 15- to 17-year-olds had not had a physician visit in the previous year, compared to only 5.9 percent of children under 5 years of age.

Across all age groups, Hispanic children were the least likely to have seen a physician in the prior year; non-Hispanic White children were most likely to have seen a physician, except among children under 5 years of age, among whom non-Hispanic Black children were the most likely. At all ages, Hispanic children were approximately twice as likely as non-Hispanic White children to have had no physician visits.

The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence.

Children Reported Not to Have Seen a Physician or Other Health Professional in the Past Year, by Age and Race/Ethnicity: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



RECEIPT OF PREVENTIVE CARE

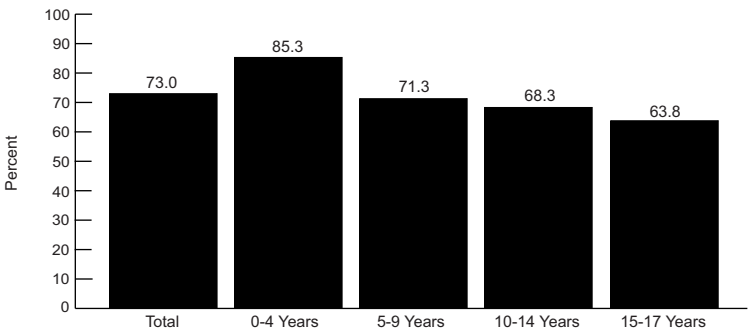
In 2004, 73 percent of children under 18 years of age were reported by parents to have had a preventive medical visit (or "well-child" visit) in the past year. The American Academy of Pediatrics (AAP) recommends that children have eight such visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence.

Despite the recommendation that older children should have one preventive visit per year, only 68.3 percent of children aged 10 to 14 years and 63.8 percent of children aged 15 to 17 years received a well-child visit in the past year. Younger children (ages birth to 4 years) were the most likely to have received a well-child visit in the past year (85.3 percent).

The rate of preventive visits for children also varied by racial and ethnic group. Non-Hispanic Black children were the most likely to have received a preventive visit in the past year (79.4 percent), followed by non-Hispanic White children (73.9 percent). Hispanic children were least likely to receive a preventive visit (64.9 percent). Children with family incomes above the Federal poverty level were more likely to receive a preventive visit than those children with family incomes below the poverty level (74.5 versus 68.9 percent; data not shown).

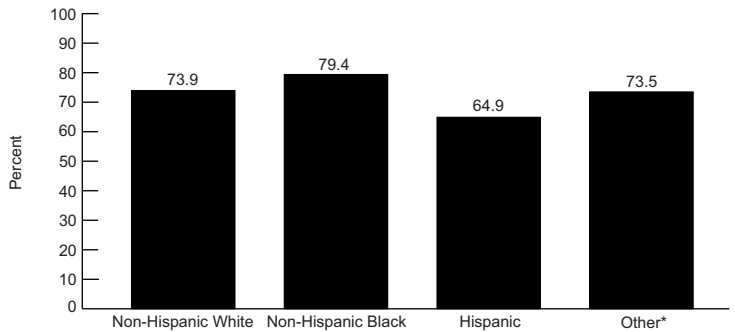
Children Under Age 18 Who Have Received Preventive Medical Care in the Past Year, by Age: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Children Under Age 18 Who Have Received Preventive Medical Care in the Past Year, by Race/Ethnicity: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Includes American Indian/Alaska Native and those of more than one race.*

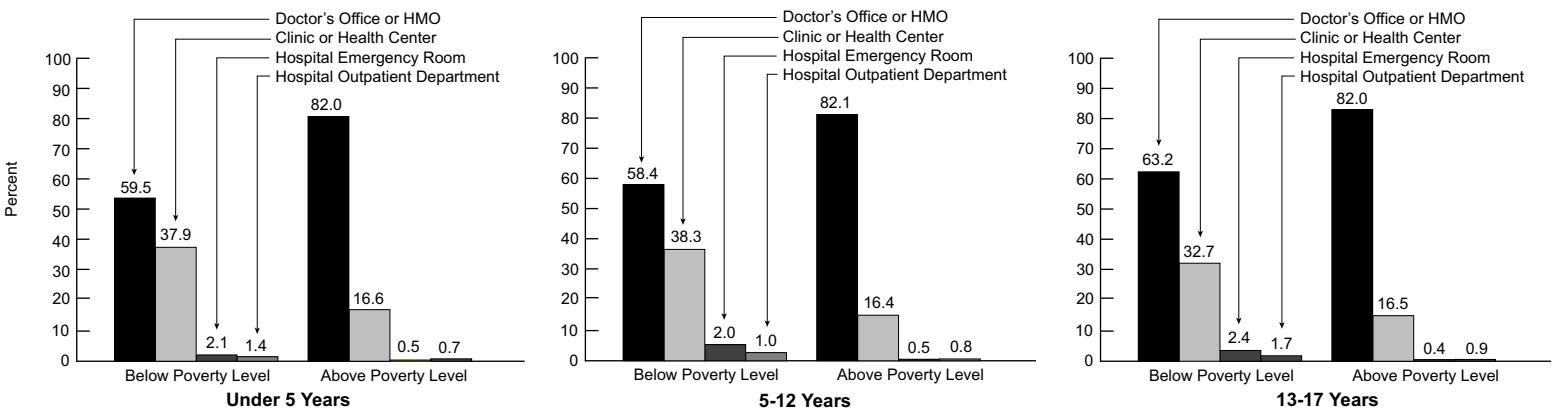
PLACE OF PHYSICIAN CONTACT

In 2004, a doctor's office or HMO was the usual place of sick care (not including routine or preventive care) for nearly 79 percent of children in the United States, a rate that varies by age and family income. Children with family incomes above the poverty level were more likely to visit a doctor's office or HMO for sick care than children with family incomes below the Federal poverty level. While this discrepancy was evident within all age groups, it was most pronounced among children aged 5 to 12 years. Within this age group, 82.1 percent of children with family incomes above the poverty level went to a doctor's office or HMO compared to 58.4 percent of children in poverty. Moreover, poor children were more likely to visit a clinic or health center for sick care (38.3 percent versus 16.4 percent of 5- to 12-year-olds). Only a small proportion of children used a hospital emergency room or outpatient department as a source of sick care, but children in all age groups with family incomes below the poverty level were more likely to do so than children with higher family incomes.

Younger children were more likely than older children to visit clinics or health centers, hospital emergency rooms, and hospital outpatient departments when sick. Use of a doctor's office or HMO as a source of sick care increased with age.

Place of Physician Contact,* by Age and Poverty Level: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The place where the child usually goes when sick; does not include routine or preventive care visits.

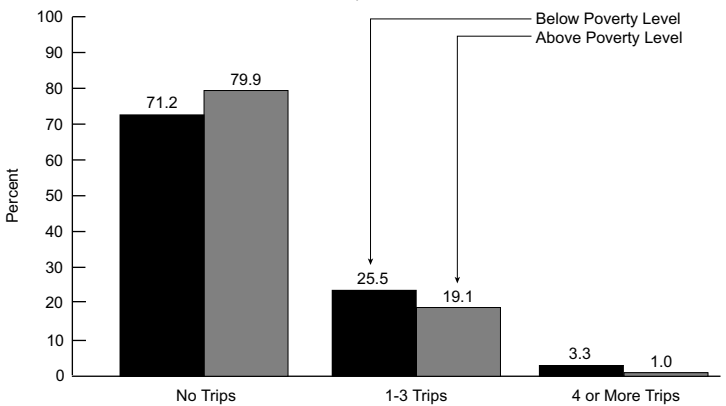
HOSPITAL UTILIZATION

In 2004, over 20 percent of children went to a hospital emergency room or emergency department (ER/ED) at least once. Children with family incomes above the Federal poverty level were less likely than children with family incomes below the Federal poverty level to have visited the ER/ED. Children in low-income families were more likely than their peers in higher-incomes families to have gone one to three times (25.5 versus 19.1 percent) and four or more times (3.3 versus 1.0 percent).

The rate of ER/ED visits varied by other factors, including age, race and ethnicity. Children under 5 years of age were more likely than children in other age groups to have visited the ER/ED at least once. The rate of visits among this group was 24.3 percent, compared to 18.4 percent among children aged 5 to 9 years, 16.5 percent among children aged 10 to 14 years, and 18.8 percent among children aged 15 to 17 years. Non-Hispanic Black children had the highest rate of ER/ED visits in 2004 (23.4 percent), followed by Hispanic children (20.8 percent), and non-Hispanic White children (20.6 percent); non-Hispanic children of other races (including Asian) had the lowest rate (16.7 percent).

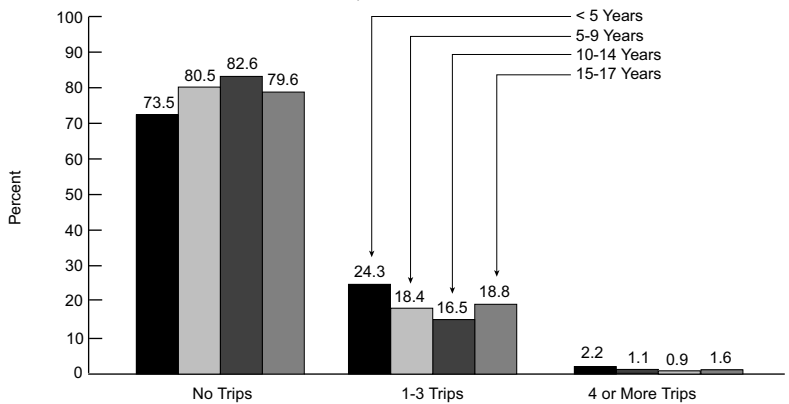
Children's Trips to the Emergency Room/Emergency Department, by Poverty Level: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Children's Trips to the Emergency Room/Emergency Department, by Age: 2004

Source (III.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



PRENATAL CARE

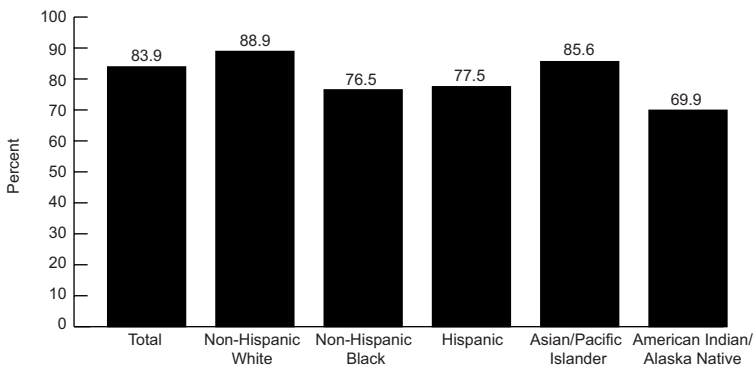
Timely Prenatal Care. Prenatal care—especially care beginning in the first trimester—improves pregnancy outcomes by identifying and managing chronic and pregnancy-related conditions and providing expectant parents with relevant health care advice. The rate of first trimester prenatal care utilization has been increasing fairly steadily since the early 1990s, and in 2004, 83.9 percent of women in 41 States, Washington DC, and New York City received prenatal care during the first trimester of pregnancy.

The increase in prenatal care utilization over the past 15 years has been especially remarkable among racial and ethnic groups with historically low rates of prenatal care. The proportion of non-Hispanic Black, Hispanic, and American Indian/Alaska Native women receiving early prenatal care increased by 20 percent or more since 1990; however, disparities still exist. In 2004, non-Hispanic White women had the highest rates of early prenatal care utilization (88.9 percent), followed by Asian/Pacific Islander women (85.6 percent), Hispanic women (77.5 percent), and non-Hispanic Black women (76.5 percent); American Indian women had the lowest rate (69.9 percent).

Late or No Prenatal Care. The percentage of women beginning prenatal care in the third trimester or going without prenatal remained steady in 2004 at 3.6 percent. Hispanic and non-Hispanic Black women are more than twice as likely as non-Hispanic White women to receive late or no prenatal care. Risk factors for late or no prenatal care include being younger than 20 years old, being unmarried, and having low educational attainment.

Mothers Beginning Prenatal Care in the First Trimester, by Race/Ethnicity: 2004*

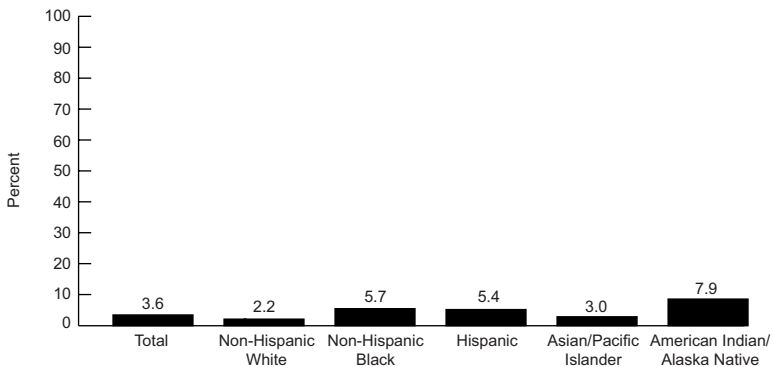
Source (I.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



2004 data includes 41 States, Washington DC and New York City.

Mothers Receiving Late or No Prenatal Care, by Race/Ethnicity: 2004*

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



2004 data includes 41 States, Washington DC and New York City.

State Data

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

The following pages reveal important disparities in these measures across States. For instance, the rates of low birth weight births (less than 2,500 grams or 5 pounds 8 ounces) were highest in the District of Columbia and several southern States, including Alabama, Louisiana, Mississippi, and South Carolina. These States, in addition to New Mexico and Texas, were also among those with the highest rates of births to women under 18 years of age.

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

State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics: FY 2005

Source (IV.1): Centers for Medicare and Medicaid Services

State	Type of SCHIP Program	Date Implemented	Upper Eligibility	Total SCHIP Enrollment
Alabama	Separate	02/01/98	200%	81,856
Alaska	Medicaid	03/01/99	175%	22,322
Arizona	Separate	11/01/98	200%	88,005
Arkansas	Combo	10/01/98	200%	1,214
California	Combo	03/01/98	250%	1,223,475
Colorado	Separate	04/22/98	185%	59,530
Connecticut	Separate	07/01/98	300%	22,289
Delaware	Combo	02/01/99	200%	10,354
District Of Columbia	Medicaid	10/01/98	200%	6,631
Florida	Combo	04/01/98	200%	384,801
Georgia	Separate	11/01/98	235%	306,733
Hawaii	Medicaid	07/01/00	200%	20,602
Idaho	Combo	10/01/97	185%	21,839
Illinois	Combo	01/05/98	200%	281,432
Indiana	Combo	10/01/97	200%	129,544
Iowa	Combo	07/01/98	200%	46,562
Kansas	Separate	01/01/99	200%	47,323
Kentucky	Combo	07/01/98	200%	63,728
Louisiana	Medicaid	11/01/98	200%	109,150
Maine	Combo	07/01/98	200%	30,654
Maryland	Combo	07/01/98	300%	120,316
Massachusetts	Combo	10/01/97	200%	162,679
Michigan	Combo	05/01/98	200%	89,257
Minnesota	Combo	10/01/98	280%	5,076
Mississippi	Separate	07/01/98	200%	79,352
Missouri	Medicaid	09/01/98	300%	115,355
Montana	Separate	01/01/99	150%	15,841
Nebraska	Medicaid	05/01/98	185%	44,706
Nevada	Separate	10/01/98	200%	39,316
New Hampshire	Combo	05/01/98	300%	11,892
New Jersey	Combo	03/01/98	350%	129,591
New Mexico	Medicaid	03/31/99	235%	24,310
New York	Separate	04/15/98	250%	618,973
North Carolina	Separate	10/01/98	200%	196,181
North Dakota	Combo	10/01/98	140%	5,725
Ohio	Medicaid	01/01/98	200%	216,495
Oklahoma	Medicaid	12/01/97	185%	108,100
Oregon	Separate	07/01/98	185%	52,722
Pennsylvania	Separate	05/28/98	200%	179,807
Rhode Island	Combo	10/01/97	250%	27,144
South Carolina	Medicaid	10/01/97	150%	80,646
South Dakota	Combo	07/01/98	200%	14,038
Tennessee*		10/01/97		
Texas	Separate	07/01/98	200%	526,406
Utah	Separate	08/03/98	200%	43,931
Vermont	Separate	10/01/98	300%	6,614
Virginia	Combo	10/22/98	200%	124,055
Washington	Separate	02/01/00	250%	15,547
West Virginia	Separate	07/01/98	200%	38,614
Wisconsin	Medicaid	04/01/99	185%	57,165
Wyoming	Separate	12/01/99	200%	6,120

**Tennessee does not currently cover any children in an SCHIP program.*

Medicaid Enrollees, Expenditures, and Reported EPDST Utilization for Children Under 21: FY 2003

Source (IV.2, IV.3): Centers for Medicare and Medicaid Services, Fiscal Year 2003 National MSIS Tables and Annual EPSDT Participation Report

State	Medicaid Enrollees*	Per Enrollee Expenditure**	Participation Ratio***
Alabama	481,845	$1,836.40	48%
Alaska	87,286	$4,110.60	50%
Arizona	579,640	$2,342.56	56%
Arkansas	346,665	$2,301.14	27%
California	3,558,434	$1,851.14	41%
Colorado	262,321	$2,221.69	50%
Connecticut	269,073	$1,927.66	56%
Delaware	75,829	$2,928.68	70%
D.C.	89,993	$3,379.62	69%
Florida	1,570,711	$1,745.87	55%
Georgia	1,022,908	$1,634.63	100%
Hawaii****	107,259	$1,699.68	70%
Idaho	145,333	$1,846.51	33%
Illinois	1,146,996	$1,611.20	73%
Indiana	572,672	$1,728.27	56%
Iowa	214,993	$2,277.59	98%
Kansas	202,917	$1,982.79	61%
Kentucky	340,350	$3,090.63	48%
Louisiana	694,224	$1,361.64	60%
Maine****	120,844	$5,087.43	59%
Maryland	482,276	$2,510.09	52%
Massachusetts	497,400	$2,189.83	92%
Michigan	958,135	$1,456.38	46%
Minnesota	391,447	$3,148.38	81%
Mississippi****	434,327	$1,564.49	29%
Missouri	654,873	$1,674.01	61%
Montana	62,629	$2,392.37	55%
Nebraska	166,725	$2,130.85	53%
Nevada	146,198	$1,844.22	99%
New Hampshire****	73,975	$2,639.16	54%
New Jersey	500,141	$2,418.08	51%
New Mexico****	303,439	$2,386.92	49%
New York	2,015,608	$2,775.83	89%
North Carolina	819,202	$2,180.26	69%
North Dakota	38,494	$1,960.10	49%
Ohio	1,103,858	$1,785.62	45%
Oklahoma****	420,165	$1,635.03	45%
Oregon	272,298	$2,073.06	51%
Pennsylvania	941,719	$2,720.48	57%
Rhode Island	109,989	$2,989.72	53%
South Carolina	641,797	$1,482.73	31%
South Dakota	80,188	$2,113.05	41%
Tennessee	782,057	$1,336.41	39%
Texas	2,445,943	$1,819.75	60%
Utah	163,122	$2,016.50	47%
Vermont	72,160	$2,798.91	88%
Virginia	466,705	$1,657.28	56%
Washington	659,843	$1,363.56	50%
West Virginia	216,516	$1,794.02	50%
Wisconsin	436,630	$1,642.08	55%
Wyoming	50,993	$1,866.49	38%

**Unduplicated number of individuals under age 21 determined to be eligible for EPSDT services.*
***Total Medicaid vendor payments divided by Medicaid eligibles under 21.*
****The percent of Medicaid eligibles under age 21 who received any initial and periodic screening services during FY 2003.*
*****Based on FY 2002 data.*

Health Insurance Status of Children Through Age 18: 2004*

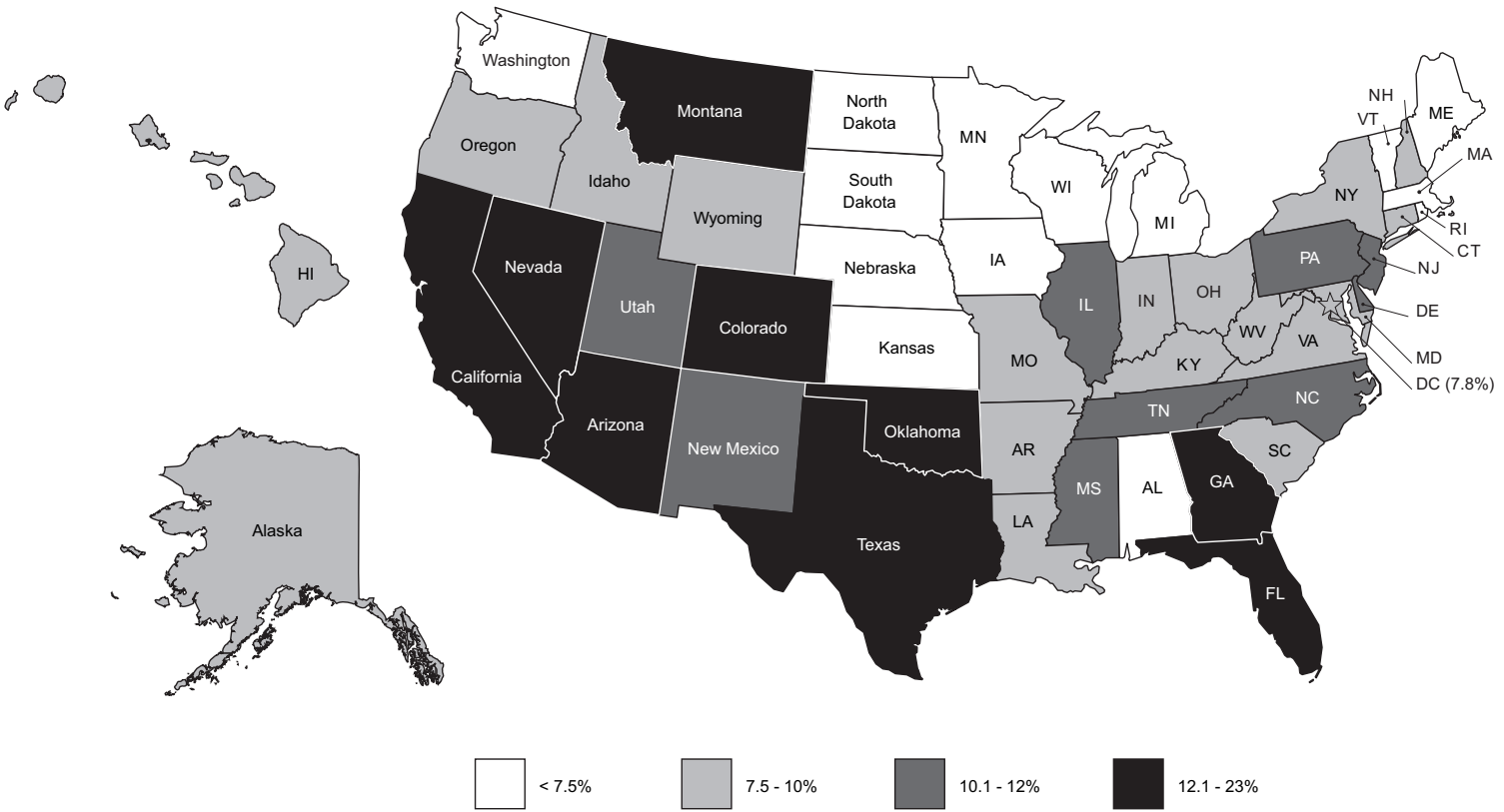
Source (IV.4): Analysis of 2005 Current Population Survey, American Academy of Pediatrics

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid/SCHIP**	Percent Uninsured***
Alabama	60.5	32.1	7.4
Alaska	52.6	38.9	8.5
Arizona	53.6	31.3	15.1
Arkansas	51.5	40.9	7.6
California	55.1	31.8	13.1
Colorado	70.7	14.2	15.1
Connecticut	70.8	20.1	9.0
Delaware	67.9	19.3	12.8
District of Columbia	49.6	42.6	7.8
Florida	57.7	26.3	15.9
Georgia	53.7	34.0	12.4
Hawaii	72.8	21.7	5.5
Idaho	63.6	27.1	9.3
Illinois	67.7	20.4	12.0
Indiana	63.5	27.3	9.3
Iowa	68.9	24.2	7.0
Kansas	71.3	21.6	7.2
Kentucky	61.6	30.0	8.4
Louisiana	52.5	39.3	8.2
Maine	60.3	33.7	6.0
Maryland	71.7	18.6	9.8
Massachusetts	71.2	22.2	6.7
Michigan	65.9	27.0	7.1
Minnesota	76.9	16.5	6.6
Mississippi	46.4	39.3	14.4
Missouri	62.8	28.5	8.7
Montana	54.2	33.2	12.6
Nebraska	67.7	26.1	6.1
Nevada	70.3	13.3	16.4
New Hampshire	77.0	15.2	7.8
New Jersey	72.4	15.9	11.7
New Mexico	42.5	43.5	14.0
New York	59.3	31.9	8.8
North Carolina	64.1	24.8	11.2
North Dakota	71.4	22.4	6.2
Ohio	68.6	23.7	7.7
Oklahoma	52.5	33.6	13.9
Oregon	66.4	23.6	10.0
Pennsylvania	67.2	22.0	10.8
Rhode Island	62.4	30.3	7.3
South Carolina	58.1	33.8	8.1
South Dakota	61.3	33.2	5.5
Tennessee	59.1	30.5	10.4
Texas	51.9	26.5	21.7
Utah	71.2	17.8	11.0
Vermont	56.2	38.3	5.5
Virginia	72.9	18.2	9.0
Washington	63.0	30.5	6.5
West Virginia	59.8	31.1	9.2
Wisconsin	68.2	26.0	5.8
Wyoming	65.3	25.0	9.7

**Estimates for 2004 should not be compared directly to estimates prior to 2000 due to changes in survey design.*
***Includes children covered by Medicare and the Indian Health Service.*
****See map on facing page.*

Percent of Children Through Age 18 Who Are Uninsured: 2004

Source (IV.4): American Academy of Pediatrics



Percent of Infants Born at Low Birth Weight, Women Receiving First Trimester Prenatal Care, and Births to Unmarried Women, by State and Race of Mother: 2004

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

	Low Birth Weight			Early Prenatal Care			Births to Unmarried Women			
State	Total*	Non-Hispanic White	Non-Hispanic Black	Total	Non-Hispanic White	Non-Hispanic Black	Total	White**	Black**	Hispanic
United States	8.1	7.2	13.7	83.9	88.9	76.5	35.8	24.5	69.3	46.4
Alabama	10.4	8.5	15.1	84.0	90.1	77.2	36.2	21.1	70.6	25.1
Alaska	6.0	5.1	9.3	80.7	85.4	85.2	34.6	22.4	39.3	34.9
Arizona	7.2	7.3	12.0	76.3	87.2	77.8	42.2	25.2	61.2	54.0
Arkansas	9.3	8.1	15.5	82.3	85.4	76.1	38.8	28.4	77.0	42.4
California	6.7	6.3	12.4	87.1	90.7	83.5	34.4	20.5	63.3	44.5
Colorado	9.0	8.7	14.6	80.2	86.2	72.0	27.5	18.9	52.8	41.6
Connecticut	7.8	6.7	12.7	87.2	92.3	77.4	30.6	17.0	66.7	62.2
Delaware	9.0	7.4	13.8	85.1	90.0	81.7	42.3	27.9	71.2	58.1
D.C.	11.1	5.6	14.1	77.8	91.8	72.8	55.9	6.3	77.5	62.9
Florida	8.5	7.3	13.1	N/A	N/A	N/A	41.4	30.4	67.4	43.1
Georgia	9.3	7.4	14.0	83.9	90.3	79.4	39.2	22.6	66.5	45.2
Hawaii	7.9	6.2	10.2	81.8	85.2	87.4	33.4	23.6	28.4	44.6
Idaho	6.8	6.6	N/A	N/A	N/A	N/A	22.6	19.2	37.8	37.2
Illinois	8.4	7.3	14.6	85.5	90.8	74.2	36.3	22.1	77.5	45.4
Indiana	8.1	7.5	13.6	80.8	84.3	68.5	38.8	32.5	77.9	52.7
Iowa	7.0	6.9	11.0	88.4	90.0	76.3	31.0	28.1	72.9	44.4
Kansas	7.3	7.0	13.7	86.5	89.8	78.3	33.0	27.8	71.2	45.3
Kentucky	8.8	8.4	13.3	N/A	N/A	N/A	35.0	30.7	75.7	48.9
Louisiana	10.9	8.0	15.2	85.5	91.5	77.4	49.1	29.7	76.7	40.7
Maine	6.4	6.4	N/A	88.5	88.9	80.2	34.1	34.0	35.5	31.7
Maryland	9.3	7.4	13.2	82.3	90.2	74.7	35.7	21.2	59.6	48.9
Massachusetts	7.8	7.2	11.8	89.6	92.2	80.4	28.5	20.4	57.1	63.1
Michigan	8.3	7.1	14.5	85.9	89.8	71.9	35.7	26.6	74.0	45.7
Minnesota	6.5	6.0	10.5	86.3	90.4	74.0	29.0	22.4	57.7	51.6
Mississippi	11.6	8.7	15.5	84.4	90.6	77.6	48.3	25.5	76.7	46.8
Missouri	8.3	7.3	14.0	88.2	90.2	80.4	37.0	29.4	77.0	47.5
Montana	7.6	7.6	N/A	83.2	86.4	93.6	34.3	27.8	51.1	40.8
Nebraska	7.0	7.0	11.8	82.9	86.0	72.5	30.2	24.2	69.5	43.9
Nevada	8.0	7.8	13.8	75.0	83.8	68.8	39.7	29.3	68.8	47.8
New Hampshire	6.8	6.9	N/A	N/A	N/A	N/A	26.4	25.9	40.0	40.4
New Jersey	8.3	7.2	13.7	79.1	88.4	63.3	30.1	13.6	64.8	54.4
New Mexico	8.1	8.0	14.7	69.4	76.5	66.9	48.8	28.3	54.3	55.8
New York	8.2	6.9	13.0	N/A	N/A	N/A	37.8	20.7	67.3	61.6
North Carolina	9.0	7.7	14.2	84.0	90.4	76.5	36.9	22.0	68.1	50.1
North Dakota	6.6	6.4	N/A	85.7	88.7	81.1	29.9	22.9	26.4	35.3
Ohio	8.5	7.5	14.0	87.8	89.9	78.6	37.4	29.8	76.0	52.4
Oklahoma	8.0	7.8	13.0	78.1	82.3	72.2	38.4	31.3	71.7	46.1
Oregon	6.0	6.0	10.6	80.5	84.0	73.6	32.5	28.8	65.4	44.5
Pennsylvania	8.2	7.1	13.5	N/A	N/A	N/A	35.2	26.0	74.8	61.0
Rhode Island	8.0	7.3	11.0	90.0	92.5	82.4	37.3	27.0	64.1	60.7
South Carolina	10.2	7.9	15.3	N/A	N/A	N/A	41.9	24.9	73.2	43.8
South Dakota	6.9	6.9	N/A	77.9	83.4	63.6	35.1	25.4	42.1	46.8
Tennessee	9.2	8.2	13.8	N/A	N/A	N/A	38.2	27.5	74.4	48.8
Texas	8.0	7.4	13.9	81.8	88.2	78.4	36.0	23.6	64.2	40.7
Utah	6.7	6.3	10.8	80.0	83.7	60.5	17.5	12.6	45.6	40.5
Vermont	6.4	6.3	N/A	90.0	90.4	71.7	32.3	32.5	49.1	34.7
Virginia	8.3	7.0	12.8	85.6	90.5	79.0	31.0	20.0	62.4	44.0
Washington	6.2	5.7	11.1	N/A	N/A	N/A	30.4	25.7	55.2	44.1
West Virginia	9.3	9.1	14.3	86.0	86.4	76.2	34.8	33.6	76.7	34.4
Wisconsin	7.0	6.2	13.6	85.3	88.7	76.9	31.3	23.5	81.9	47.8
Wyoming	8.6	8.5	N/A	85.2	87.0	83.3	31.7	27.9	46.3	49.0

N/A: Figure does not meet standards of reliability or precision or the State did not report this indicator.
**Includes races other than White and Black.*
***Includes Hispanics.*

Infant and Neonatal Mortality Rates, by State and Race of Mother: 2004

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

State	Infant Mortality			Neonatal Mortality		
	Total*	White	Black	Total*	White	Black
United States	6.79	5.66	13.79	4.52	3.78	9.13
Alabama	8.67	6.79	13.25	5.07	3.78	8.26
Alaska	6.67	5.47	N/A	3.48	3.04	N/A
Arizona	6.73	6.54	11.96	4.54	4.55	7.58
Arkansas	8.27	7.12	13.40	4.93	4.35	7.45
California	5.16	4.89	12.39	3.49	3.36	7.96
Colorado	6.34	5.98	14.68	4.47	4.22	9.22
Connecticut	5.54	4.50	12.88	4.11	3.37	10.04
Delaware	8.62	6.52	15.48	5.63	4.26	9.98
D.C.	11.98	N/A	14.65	8.70	N/A	10.20
Florida	7.05	5.60	11.81	4.54	3.60	7.62
Georgia	8.51	6.07	13.93	5.72	3.94	9.73
Hawaii	5.69	5.21	N/A	4.27	4.05	N/A
Idaho	6.17	6.13	N/A	3.91	3.96	N/A
Illinois	7.46	5.95	15.73	4.97	4.13	9.73
Indiana	8.03	6.96	16.92	5.45	4.77	11.00
Iowa	5.07	4.84	N/A	3.20	3.19	N/A
Kansas	7.16	6.48	16.54	4.46	4.21	8.09
Kentucky	6.78	6.26	12.59	3.91	3.57	7.72
Louisiana	10.46	7.65	14.78	6.29	4.20	9.43
Maine	5.67	5.46	N/A	4.23	4.11	N/A
Maryland	8.44	5.74	13.96	6.02	3.98	10.11
Massachusetts	4.84	4.44	9.18	3.76	3.49	6.77
Michigan	7.58	5.50	17.51	5.35	3.87	12.25
Minnesota	4.70	4.21	9.21	3.19	3.05	5.13
Mississippi	9.81	6.21	14.58	6.00	3.57	9.13
Missouri	7.51	6.38	14.66	4.81	4.15	8.99
Montana	4.51	4.17	N/A	2.60	2.24	N/A
Nebraska	6.57	5.91	16.53	4.22	3.88	N/A
Nevada	6.39	5.27	18.56	4.26	3.58	11.81
New Hampshire	5.56	5.30	N/A	4.46	4.21	N/A
New Jersey	5.65	4.75	10.66	3.99	3.33	7.78
New Mexico	6.31	5.79	N/A	3.77	3.56	N/A
New York	6.07	5.00	10.90	4.28	3.66	7.35
North Carolina	8.79	6.26	16.76	6.02	4.13	11.84
North Dakota	5.62	5.13	N/A	4.52	4.13	N/A
Ohio	7.67	6.09	16.34	5.02	3.96	10.72
Oklahoma	8.01	7.06	17.21	4.68	4.09	11.26
Oregon	5.49	5.34	N/A	3.87	3.78	N/A
Pennsylvania	7.25	6.16	13.47	4.90	4.12	9.26
Rhode Island	5.32	4.97	N/A	3.99	3.86	N/A
South Carolina	9.28	6.79	14.12	6.43	4.72	9.84
South Dakota	8.20	6.96	N/A	5.03	4.89	N/A
Tennessee	8.63	6.65	15.97	5.40	4.01	10.52
Texas	6.31	5.60	12.73	4.14	3.69	8.15
Utah	5.21	5.21	N/A	3.41	3.46	N/A
Vermont	4.55	4.68	N/A	3.03	3.12	N/A
Virginia	7.47	5.81	14.19	5.07	3.93	9.52
Washington	5.52	5.35	10.60	3.34	3.29	6.66
West Virginia	7.57	7.44	N/A	4.79	4.75	N/A
Wisconsin	5.99	4.57	19.39	3.99	3.13	12.27
Wyoming	8.81	8.34	N/A	5.88	5.98	N/A

N/A: Figure does not meet standards of reliability or precision.
**Includes races other than White or Black.*

City Data

The following section presents data on the health of infants and children living in cities compared to that of children nationwide. Included are data on infant mortality, low birth weight, and prenatal care for those women and children who reside in U.S. cities with over 100,000 residents.

The following measures indicate that the health status of children living in large U.S. cities is generally poorer than that of children in the nation as a whole. In 2004, the percentage of infants born at low birth weight was 8 percent higher in cities compared to the national average (8.6 versus 8.1 percent). Infant mortality was also higher in cities, likely due at least in part to the higher rate of low birth weight. In 2003, the city infant mortality rate was 7.5 per 1,000 live births, compared to a rate of 6.8 nationwide. The percentage of pregnant women receiving first trimester prenatal care was lower in cities (81.7 percent) than it was in the 42 jurisdictions that reported these data (83.4 percent).

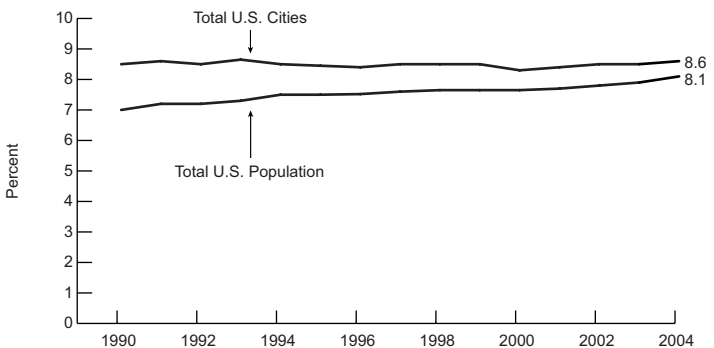
BIRTH WEIGHT

Low Birth Weight. Disorders related to short gestation and low birth weight are the second leading cause of neonatal mortality in the United States. In 2004, 116,651 babies 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 pounds 8 ounces); this represents a rate of 8.6 percent. The 2004 percentage of urban infants born at low birth weight was 6 percent higher than the national rate of 8.1 percent.

Very Low Birth Weight. Infants born at very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces) are at highest risk for poor health outcomes. In 2004, 1.63 percent of live births in cities with populations over 100,000 were of very low birth weight. This exceeded the national very low birth weight rate by 10 percent.

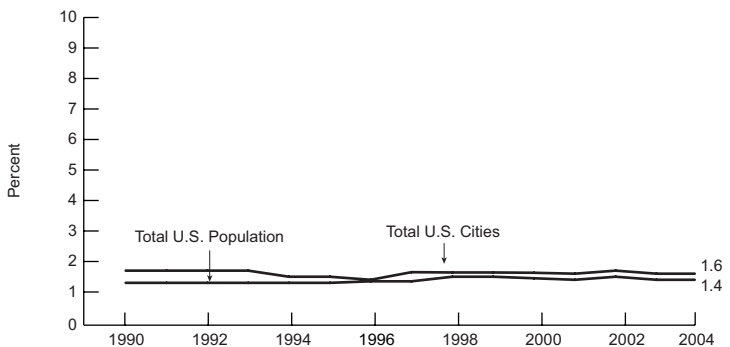
Infants Born at Low Birth Weight in U.S. Cities with Populations over 100,000: 1990-2004

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



Infants Born at Very Low Birth Weight in U.S. Cities with Populations over 100,000: 1990-2004

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

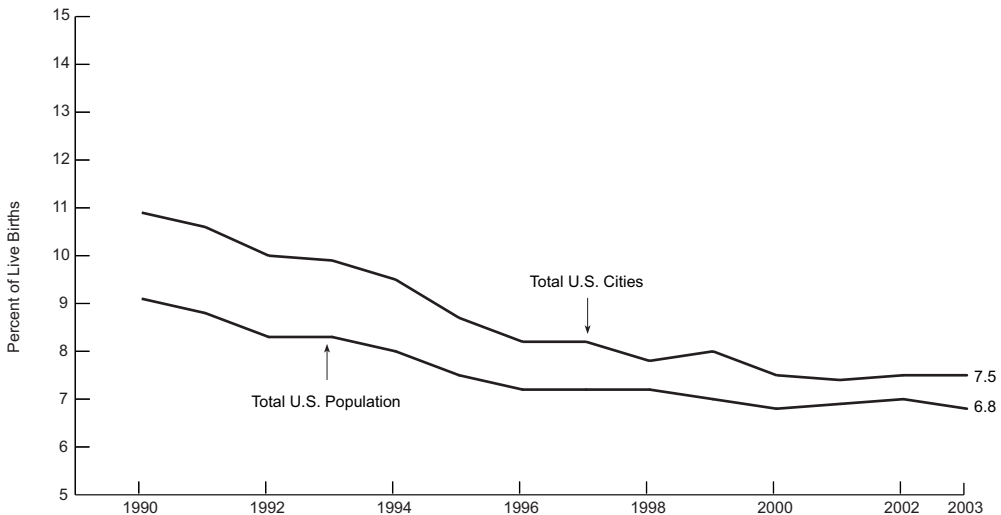


INFANT MORTALITY

In 2003, 6,620 infants born to residents of cities in the United States with populations over 250,000 died in the first year of life. The city infant mortality rate was 7.5 deaths per 1,000 live births, higher than the rate of 6.8 for the nation as a whole. Although the infant mortality rate in cities has routinely been higher than the rate nationwide, it has declined over the past decade. Between 1990 and 2000, infant mortality in cities declined by roughly one-third; the decline nationwide in the same period was 25 percent. Between 2001 and 2002 there was an increase of 0.1 and 0.2 deaths per 1,000 live births, respectively, in cities and nationwide.

Infant Mortality Rates in U.S. Cities:* 1990-2003

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



Data for 1990-2002 were for cities with populations over 100,000; data for 2003 were for cities with populations over 250,000.

PRENATAL CARE

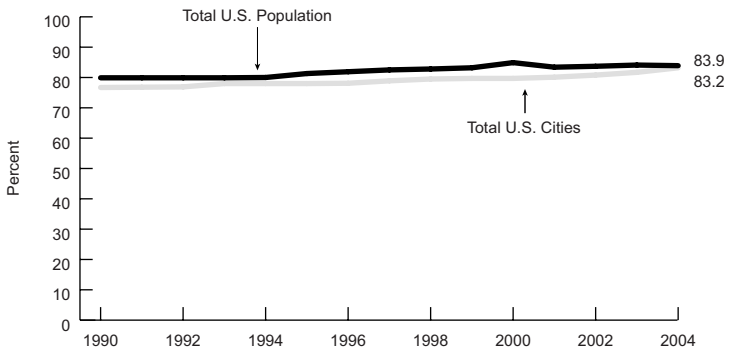
Early Prenatal Care. Women living in cities with a population of over 100,000 are less likely to begin prenatal care in the first 3 months of pregnancy than women nationwide. The gap in early entry into prenatal care between urban women and the Nation as a whole has narrowed since 1991.

In 2004, 83.2 percent of pregnant women living in cities in 41 States, Washington DC, and New York City began prenatal care in the first trimester of pregnancy, compared to 83.9 percent of the overall population in the reporting jurisdictions. The percentage of women receiving prenatal care has increased steadily in the past decade at both the city and nationwide levels. The Healthy People 2010 objective is for 90 percent of pregnant women to begin prenatal care in the first trimester.

Late or No Prenatal Care. In 2004, 3.8 percent of pregnant women living in U.S. cities with a population over 100,000 in 41 States, Washington DC, and New York City either began prenatal care in the third trimester or received no prenatal care. The percentage of women receiving late or no prenatal care is 6 percent higher among women living in cities than among the overall population in the 41 reporting jurisdictions.

Pregnant Women Receiving First Trimester Prenatal Care in U.S. Cities with Populations over 100,000: 1990-2004*

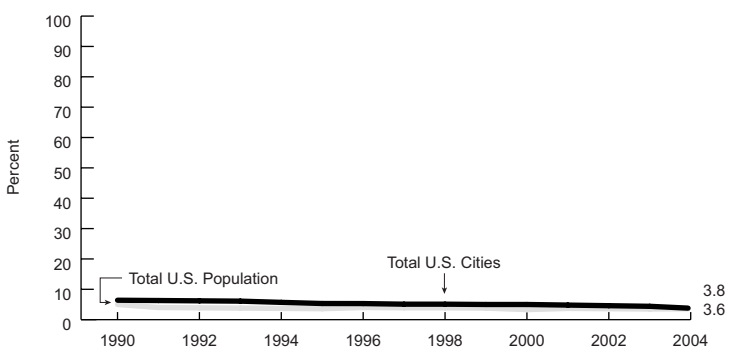
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*2004 data includes 41 States, Washington DC and New York City.

Pregnant Women Receiving Late or No Prenatal Care in U.S. Cities with Populations over 100,000: 1990-2004*

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



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Contributors

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