

Child Health USA 2007



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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 2007*, the 18th annual report on the health status and service needs of America's children. The Bureau's vision is that of a Nation in which the right to grow to one's full potential is universally assured through attention to the comprehensive physical, psychological, and social needs of the maternal and child population. To assess the 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 are from the same sources as the information in the corresponding graphs (unless otherwise noted). Data are presented for the target populations of Title V Maternal and Child Health Block Grant funding: infants, children, adolescents, children with special health care needs, and women of childbearing age. *Child Health USA 2007* addresses health status and health services

utilization and offers 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.

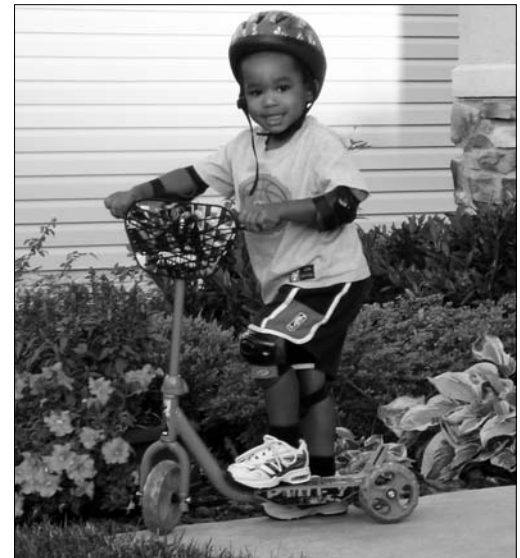
Child Health USA is published to provide the most current data available for public health professionals and other individuals in the private and public sectors. The book's succinct format is intended to facilitate the use of the information as a snapshot of measures of children's health in the United 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 utilization of selected health services. The final sections, **State Data** and **City Data** contain information on selected indicators at those levels.

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Introduction

The health of the current child population has important implications for the future health of the United States population. Many childhood health issues—including weight, smoking, oral health, and vaccination coverage—can affect health throughout the lifespan. In 2007, nearly 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 ensure 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 2005. A small proportion of women (3.5 percent) did not receive prenatal care until the third trimester or did not receive care at all. This was 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 also included in *Child Health USA*. For instance, data are presented on maternal age, which can affect the health of both infant and mother. In 2005, births to women aged 15–19 years reached another record low, while births to older women (35 years and older) increased slightly from the previous year.

Parental employment and child care can also affect the health and well-being of a family. In 2006, 70.9 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), 63.5 percent were in the labor force and 59.7 percent were employed. In 2005, 60 percent of children under 6 years of age required care from someone other than a parent at least once a week.

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 emerging evidence indicates that birth weight may affect children into adulthood

as well. 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. Despite high rates of prenatal care utilization, 2005 data indicate that 8.2 percent of infants were born at low birth weight (less than 2,500 grams, or 5 pounds 8 ounces), which is the highest rate recorded in the last 3 decades. Although the number of multiple births, which are more likely to result in low birth weight, is 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) represented 1.5 percent of live births in 2005. This represents an increase since 1980 when approximately 1 percent of infants were born at a very low birth weight. 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 (6.8 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 2005, 72.9 percent of mothers reported ever breastfeeding their infants. However, breastfeeding declined dramatically as infant age increased: 39.1 percent of mothers reported breastfeeding their infants at 6 months of age. The rate of exclusive breastfeeding at 6 months was even lower (13.9 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 2005, 80.8 percent of children aged 19–35 months had received the recommended series of vaccines; 76.1 percent of children in this age group received the recommended series plus the varicella (chicken pox) vaccine.

Physical activity is another important protective factor in lifelong health that begins in early childhood. Results from the 2005 Youth Risk Behavior Surveillance System 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 per 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 had 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 (aged 15–19 years) and young adults (aged 20–24 years) are at much higher risk of contracting STIs than are older adults. Chlamydia continues to be fairly common among adolescents and young adults, with rates of 1,621 and 1,719 cases per 100,000, respectively, in 2005. Gonorrhea followed in prevalence with overall rates of 438 and 507 per 100,000 adolescents and young adults, respectively. Genital human papillomavirus (HPV) is believed to be the most common STI in

the United States. It is estimated that 24.5 percent of females aged 14–19 years and 44.8 percent aged 20–24 years had an HPV infection in 2003–2004. In 2006, a vaccine for HPV was approved by the Food and Drug Administration (FDA) for use in females aged 9–26 years.

Mental health is another issue that increasingly affects children as they grow older. In 2005, 21.8 percent of youth aged 12–17 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 proportion of youth receiving treatment in 2005 represented a slight decrease from the previous year (22.5 percent). Depression was the leading reason reported for mental health treatment among this age group.

A number of other issues are interrelated with mental health, including violence and substance abuse. Results from the 2005 Youth Risk Behavior Surveillance System 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. 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, 9.9 percent of adolescents aged 12–17 years reported using illicit drugs in the past month in 2005. Alcohol was the most commonly used drug among adolescents, with 16.5 percent reporting past-month use in 2005, while marijuana was the most commonly used illicit drug (6.8 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 public health professionals to draw upon the experiences of programs that have achieved success. The health of our children and adolescents relies on effective public health efforts that include providing access to knowledge, skills, and tools; providing drug-free alternative activities; identifying risk factors and linking people to appropriate services; building community supports; and supporting approaches that promote policy change. 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 in 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 reflects the changes in the racial and ethnic makeup of the population as a whole.

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

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



POPULATION OF CHILDREN

In 2006, there were an estimated 73.7 million children under 18 years of age in the United States, representing nearly 25 percent of the population. Young adults aged 20–24 years composed slightly more than 7 percent of the population, while adults aged 25–64 years composed over 53 percent of the population and adults aged 65 years and older accounted for more than 12 percent.

Since the 2000 Census, the number of children under 5 years of age is estimated to have

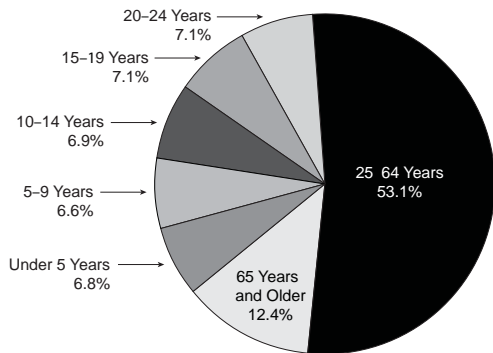
risen 6.4 percent, while the number of children aged 5–19 years has risen nearly 2 percent. The number of adults aged 65 years and older, however, has risen more than 8 percent in the same period.

The ethnic makeup of the child population reflects the increasing diversity of the population over the past several decades. Hispanic children represented 9 percent of all children in 1980, compared to more than 20 percent in 2006; Asian/Pacific Islander children represented 2 percent of all children in 1980 and more than 4 per-

cent in 2006. 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.

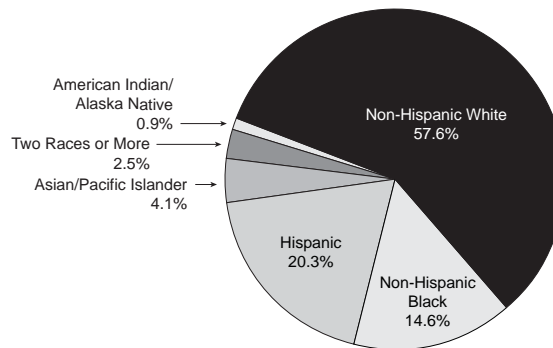
U.S. Resident Population, by Age Group, 2006

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



Population of Children Under Age 18, by Race/Ethnicity, 2006

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 2006, more than 21 percent of children living in the United States had at least one foreign-born parent. Of all children, 17.2 percent were born in the United States to foreign-born parents and nearly 4 percent were foreign-born. Most children were native-born and lived

in households with one or both native parents (74.4 percent).

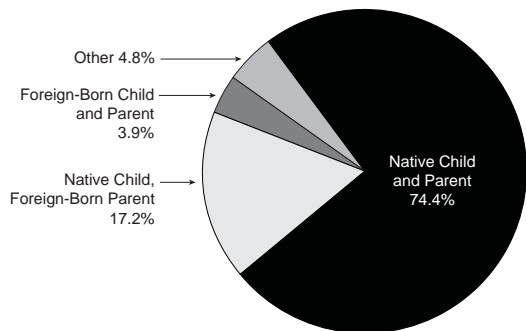
Children's poverty status varies with nativity. In 2006, foreign-born children of foreign-born parents were most likely to live in households with incomes below 100 percent of the poverty level (30.4 percent) and 100–199 percent of the poverty level (30.8 percent). Only 15.4 percent of native-born children of native parents lived below 100 percent of the poverty level, as did 20.2 percent of native children of foreign-born parents.¹

Children's health insurance coverage also varied by nativity in 2006. Native-born children with native parents were the most likely to be insured (92.1 percent), while foreign-born children of foreign-born parents were the least likely to be insured (66.0 percent). Just over 84 percent of native-born children of foreign-born parents had health insurance coverage (data not shown).

¹ The U.S. Census Bureau poverty threshold was \$20,444 for a family of four in 2006. 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, by Nativity of Child and Parent(s),* 2006

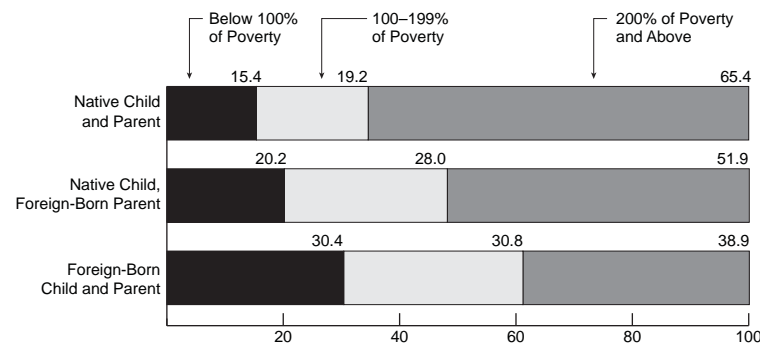
Source (1.2): U.S. Census Bureau, Current Population Survey



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

Children Under Age 18, by Poverty Level* and Nativity of Child and Parent(s),** 2006

Source (1.2): U.S. Census Bureau, Current Population Survey



*The U.S. Census Bureau poverty threshold for a family of four was \$20,444 in 2006. **"Native parent" indicates that both of the child's parents were U.S. citizens at birth, "foreign-born parent" indicates that one or both parents were born outside of the United States.

CHILDREN IN POVERTY

In 2005, nearly 13 million children under 18 years old lived in households with incomes below the poverty threshold (\$19,971 for a family of four in 2005);¹ this represents 17.6 percent of all children in the United States. Children represented more than one-third of people in poverty, but only about 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. In 2005, a much higher proportion of Black (34.5 percent) and Hispanic (28.3 percent) children under age 18 were poor than were their non-Hispanic White counterparts (10.0 percent).

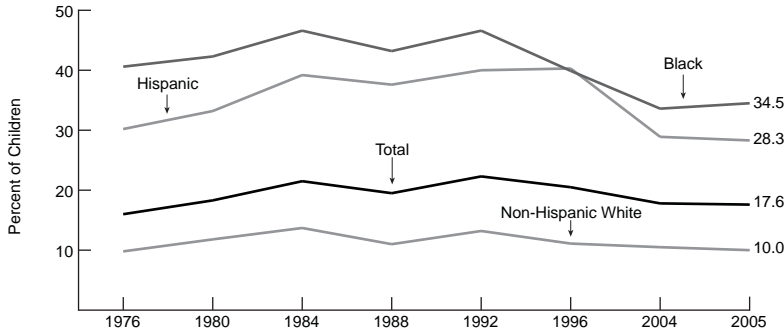
Children in single-parent families are particularly likely to be poor: of children under age 6 living with a single mother, 52.9 percent lived in poverty, which was more than five times the rate of their counterparts in married-couple families. Similarly, 42.8 percent of children under 18 living with a female head of household with no

husband present lived in poverty, compared to 8.5 percent of children in married-couple families (data not shown). Although they compose only 18.2 percent of all families in the United States, female-headed households represent 52.8 percent 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:* 1976–2005

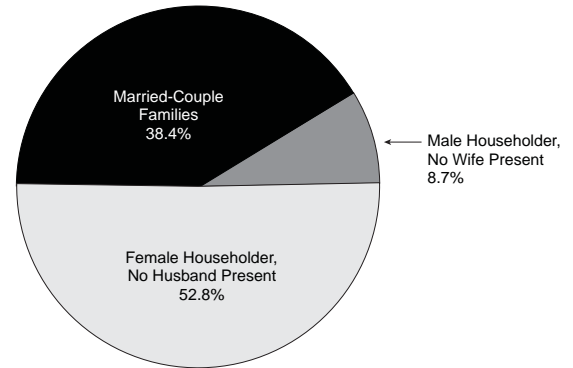
Source (I.3): U.S. Census Bureau, Current Population Survey



*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. Hispanics may be of any race. Data not reported for American Indian/Alaska Natives or children of multiple races.

Families Below 100 Percent of Poverty Level,* by Family Type, 2005**

Source (I.4): U.S. Census Bureau, Current Population Survey



*The U.S. Census Bureau poverty threshold for a family of four was \$19,971 in 2005. **Totals do not equal 100 percent due to rounding.

SCHOOL DROPOUTS

As of October 2005, there were nearly 3.5 million high school status dropouts¹ in the United States, representing 9.4 percent of the population aged 16–24 years. The dropout rate has generally declined over the past several decades and, after a slight increase in 2004, reached a new low in 2005. This represents a decline in status dropouts of 35.6 percent since 1972.

Historically, Hispanic students have had higher dropout rates than youth of other races and ethnicities: 22.4 percent in 2005, compared to 10.4 percent of non-Hispanic Blacks and 6.0 percent of non-Hispanic Whites. The high rate among Hispanics, overall, is partly due to the high dropout rate among Hispanics born outside of the United States (36.5 percent). First generation Hispanics, those born in the United States but have at least one parent born outside of the country, have a much lower dropout rate (13.9 percent), while the rate among Hispanics who were born in the United States to American-born parents is comparable to that of other racial/ethnic groups (11.6 percent).

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.

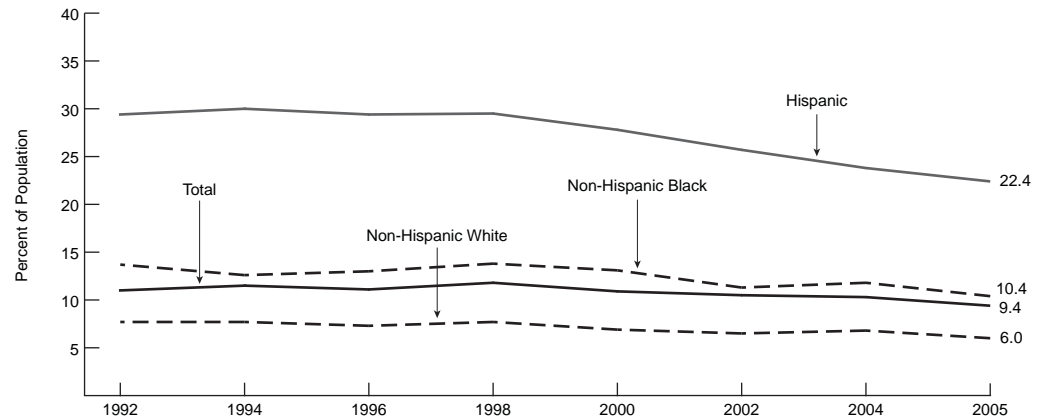
In addition, the National Center for Health Statistics indicates that those who did not complete high school reported worse health outcomes than their peers who did complete high school, as well as reduced access to medical care and higher rates of uninsurance.²

1 “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).

2 National Center for Health Statistics. *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD: 2006.

School Status Dropout* Rates Among Persons Aged 16–24, by Race/Ethnicity: 1992–2005

Source (I.5): U.S. Department of Education, National Center for Education Statistics



*Status dropout 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 2005, the general fertility rate rose slightly to 66.7 births per 1,000 women aged 15–44 years. The birth rate among teenagers aged 15–19 years continued to decline, reaching another record low (40.5 births per 1,000 women aged 15–19). This rate was 35 percent lower than the most recent peak reported in 1991 (61.8 births per 1,000). The highest birth rate was among women aged 25–29 (115.5 per 1,000), followed by women aged 20–24 years (102.2 per 1,000). There was a 2.0 percent

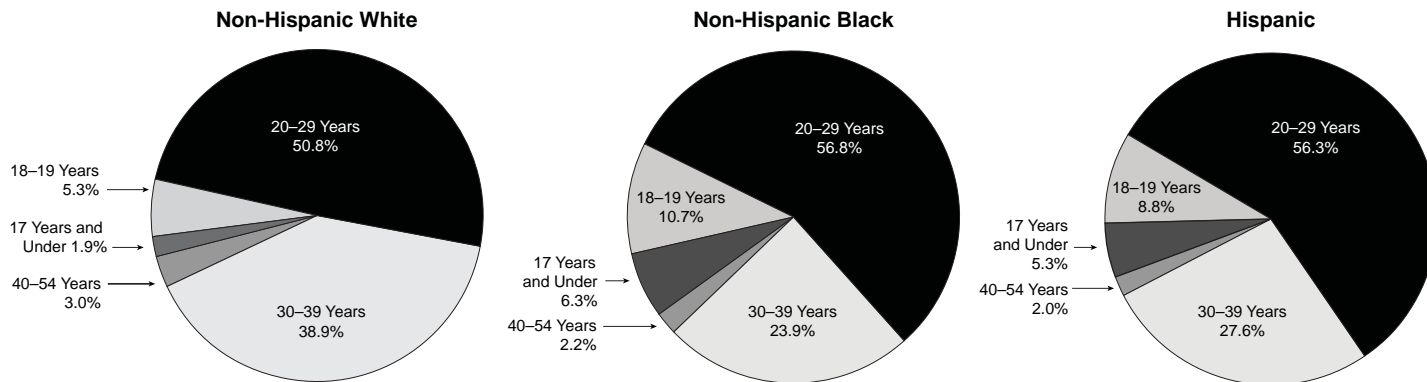
increase in birth rates among women aged 35–39 years and 40–44 years, since 2004, to 46.3 and 9.1 per 1,000, respectively (data not shown).

In 2005, 10.2 percent of births were to women aged 19 years and younger, and 52.5 percent of births were to women in their twenties; more than one-third of births were to women in their thirties, and 2.7 percent were to women aged 40–54 years (data not shown). The average age at first birth was 25.2 years; this is an increase of almost 4 years since 1970.

Among non-Hispanic Black and Hispanic women, more than 56 percent of births were to women in their twenties, while just over half of births to non-Hispanic White women occurred in the same age group. The proportion of births to teenagers was higher among non-Hispanic Black and Hispanic women (17.0 and 14.1 percent, respectively) than to non-Hispanic White women (7.3 percent). Non-Hispanic White women giving birth were more likely to be in the 30- to 54-year-old age range than were either non-Hispanic Black or Hispanic women.

Distribution of Births, by Race/Ethnicity and Maternal Age, 2005*

Source (1.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Totals may not add to 100 percent due to rounding.

WORKING MOTHERS AND CHILD CARE

In 2006, 70.9 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, 63.5 percent were in the labor force and 59.7 percent were employed (the remainder were unemployed and looking for work). Of women with children aged 6–17 years, 76.7 percent were in the labor force and more than 73 percent were employed.

Employed mothers with children aged 6–17 years were more likely than women with younger

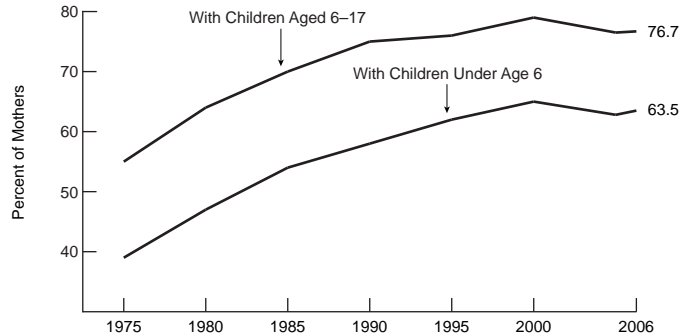
children to be employed full-time (77.8 versus 72.2 percent). Married mothers with a spouse present were less likely than never-married, divorced, separated, and widowed mothers to be in the labor force (68.6 versus 76.6 percent); however, married mothers in the labor force were more likely to be employed than mothers of other marital statuses. The unemployment rate among married mothers was only 3.6 percent, compared to a rate of 8.5 percent among mothers of other marital statuses (data not shown).

In 2005, 40 percent of children under 6 years of age 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 (data not shown). Among children who received child care, 56.9 percent of children aged 3–5 years received center-based care compared to 22.8 percent of children aged 1–2 and 11.8 percent of children less than 1 year of age.

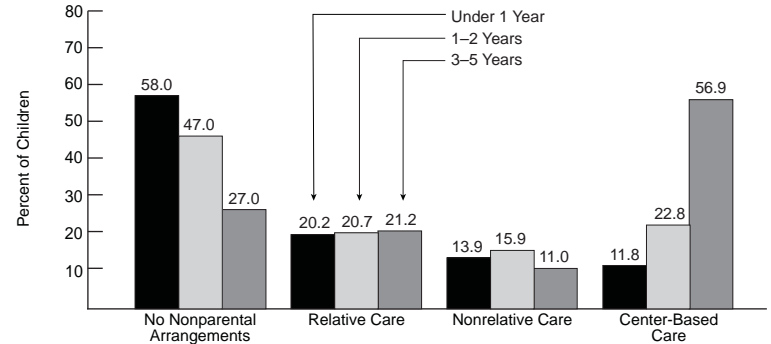
Mothers in the Labor Force, by Age of Child: 1975–2006

Source (1.7): U.S. Department of Labor, Bureau of Labor Statistics



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

Source (1.8): U.S. 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.

CSHCN: CONDITIONS AND FUNCTIONAL IMPACT

HRSA's Maternal and Child Health Bureau defines children with special health care needs (CSHCN) as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." The 2005–2006 National Survey of CSHCN provides information about the prevalence and impact of special health care needs among children in the United States. Children were considered to have special health care needs if their parents answered "yes" to at least one

question in each of three categories. Based on this series of questions, 13.9 percent of children under 18 years of age in the United States, or approximately 10.2 million children, were estimated to have special health care needs. Overall, 21.8 percent of U.S. households with children have at least one CSHCN.

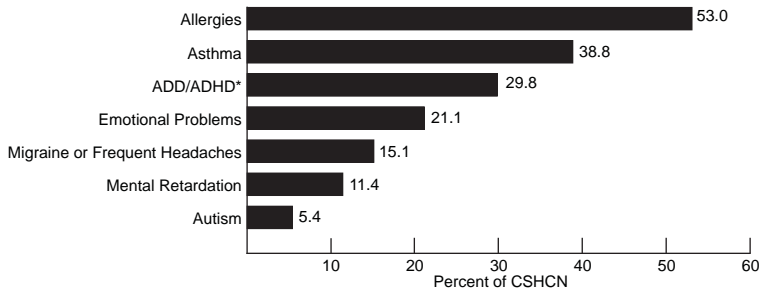
The survey asked parents of CSHCN whether their children had any of a list of 16 conditions (the list was not exhaustive and did not include all conditions that CSHCN might have). Overall, 91 percent of CSHCN were reported to have at least one condition on the list, and 57 percent had two or more conditions. Allergies (53 percent) were the health condition most commonly

reported by parents of CSHCN. Other commonly reported conditions were asthma (39 percent), attention deficit disorder (30 percent), and emotional problems (21 percent).

One important aspect of special health care needs is how those needs impact the child. Based on parents' reports, nearly 38 percent of CSHCN were never affected in their ability to do things other children do because of the nature of their health condition or the treatment they receive to manage their conditions. Another 39 percent were moderately affected some of the time. Nearly one quarter (24 percent) are affected usually, always, or a great deal by their conditions.

Percentage of CSHCN with Selected Conditions, 2005–2006

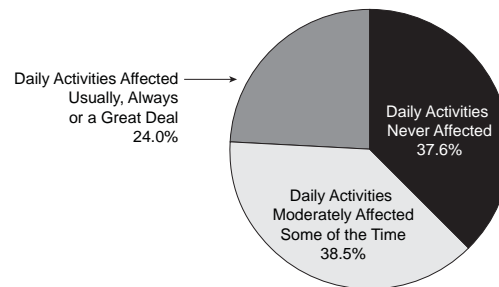
Source (I.9): Centers for Disease Control and Prevention, National Survey of Children with Special Health Care Needs



*Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder

Impact of Child's Condition on Functional Ability, 2005–2006

Source (I.9): Centers for Disease Control and Prevention, National Survey of Children with Special Health Care Needs



Health Status

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

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



Health Status - Infants



BREASTFEEDING

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

Breastfeeding initiation rates in the United States have fluctuated over the past several

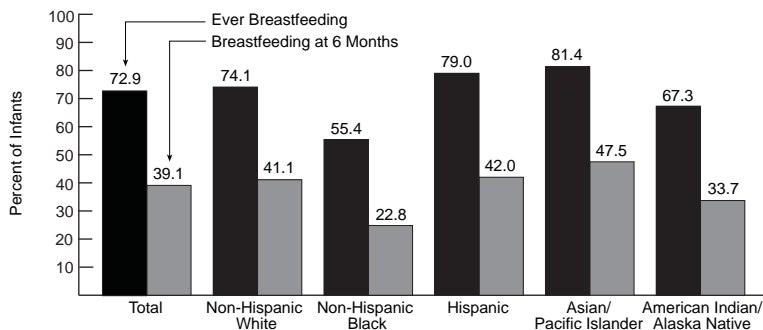
decades, but have increased steadily since the early 1990s. In 2005, 72.9 percent of infants were ever breastfed. Asian/Pacific Islander infants were most likely to be breastfed (81.4 percent), followed by Hispanic and non-Hispanic White infants (79.0 and 74.1 percent, respectively). Breastfeeding rates increased with maternal age, higher educational achievement, and higher income.

The proportion of infants who are breastfed decreases as infant age increases. In 2005, 39.1 percent of infants were breastfed at 6 months,

while 20.1 percent were breastfed at 12 months. Exclusive breastfeeding rates have not shown the same improvement over time as breastfeeding initiation. In 2005, only 13.9 percent of infants were exclusively breastfed at 6 months. As with breastfeeding initiation, exclusive breastfeeding was higher among Hispanic, Asian/Pacific Islander, and non-Hispanic White infants, as well as infants whose mothers were older, more educated, and had higher incomes.

Breastfed Infants,* by Duration and Race/Ethnicity, 2005

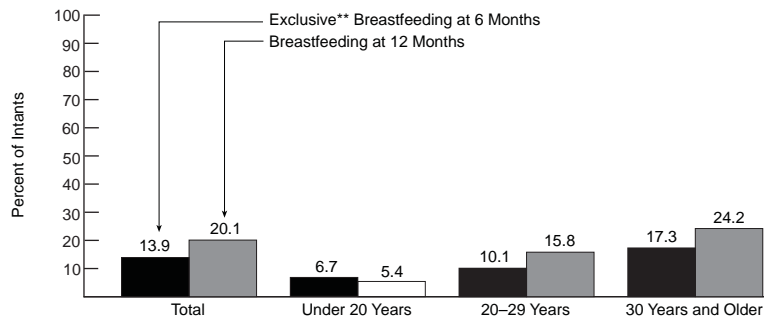
Source (II.1): Centers for Disease Control and Prevention, National Immunization Survey



*Includes exclusive and supplemental breastfeeding.

Breastfed Infants, by Recommended Duration* and Maternal Age, 2005

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

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.

In 2005, 8.2 percent of infants were born at low birth weight (less than 2,500 grams, or 5 pounds 8 ounces); this represents a slight increase (1.2 percent) from the rate recorded in 2004. 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.

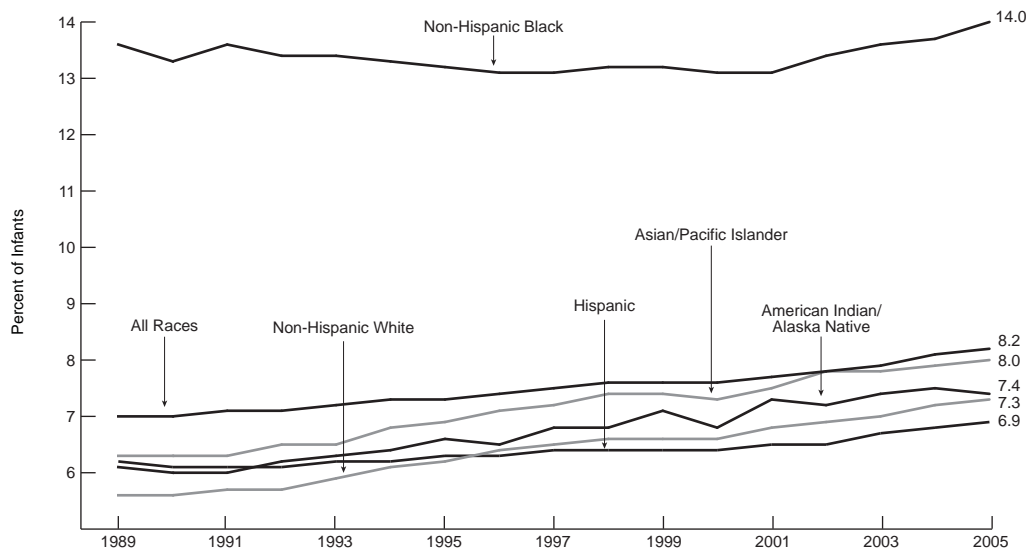
The increase in multiple births, which are at high risk of being born preterm and of low weight, has strongly influenced the increase in low birth weight; however, rates are also on the rise for singleton births.

In 2005, the low birth weight rate was much higher among infants born to non-Hispanic Black women (14.0 percent) than among infants of other racial/ethnic groups. The next highest rate, which occurred among infants born to Asian/Pacific Islanders, was 8.0 percent, followed by a rate of 7.4 percent among American Indian/Alaska Natives. Low birth weight

occurred among 7.3 percent of infants born to non-Hispanic White women, while infants of Hispanic women experienced the lowest rate (6.9 percent). Infants born to mothers of all races and ethnicities, except for American Indian/Alaska Native, saw an increase in low birth weight from 2004.

Low Birth Weight Among Infants, by Race/Ethnicity: 1989–2005

Source (I.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



VERY LOW BIRTH WEIGHT

In 2005, 1.5 percent of live births were infants of very low birth weight (less than 1,500 grams, or 3 pounds 4 ounces). The proportion of very low birth weight infants has slowly climbed from just over one percent in 1980.

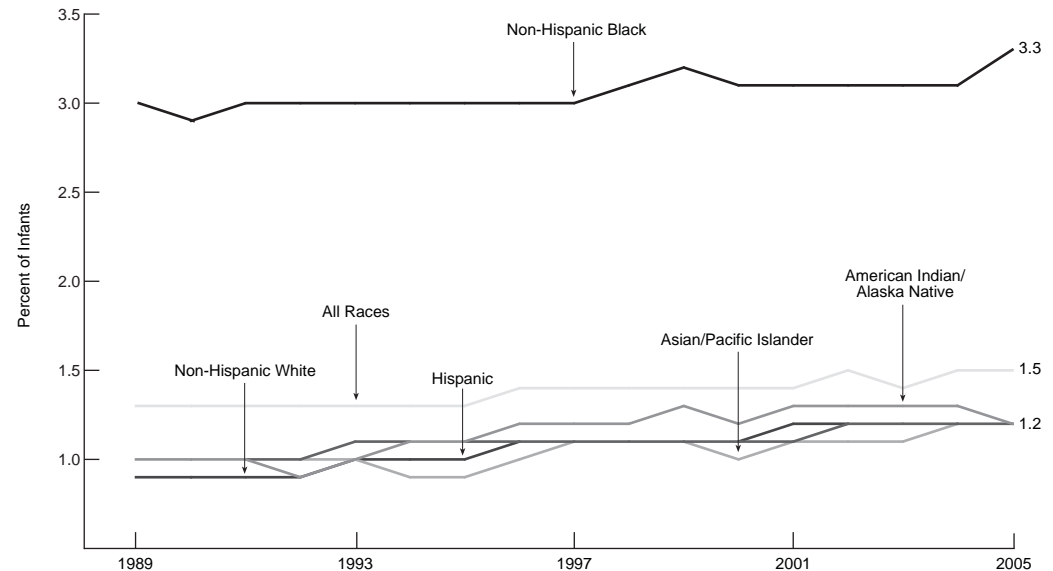
Because the chance of survival increases as birth weight increases, very low birth weight infants have the lowest survival rates. Infants born at such low birth weights are approximately 100 times more likely to die in the first year of life than are infants of normal birth weight. Very low birth weight 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.

Non-Hispanic Black newborns are more than two and a half times more likely than other racial and ethnic groups to be born at a very low birth weight. Among non-Hispanic Black infants, 3.3 percent are born at a very low birth weight, compared to 1.2 percent of non-Hispanic Whites, Hispanics, and American Indian/Alaska Natives, and Asian/Pacific Islanders. This difference is a major contributor to the disparity in infant mor-

tality rates between non-Hispanic Black infants and infants of other racial and ethnic groups.

Very Low Birth Weight Among Infants, by Race/Ethnicity: 1989–2005

Source (I.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



NEONATAL AND POSTNEONATAL MORTALITY

Neonatal. In 2005, 18,770 infants died before reaching 28 days of age, representing a neonatal mortality rate of 4.5 deaths per 1,000 live births. Statistically, 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 2005, 9,670 infants between the ages of 28 days and 1 year died, representing a postneonatal mortality rate of approximately 2.3 deaths per 1,000 live births. This rate represents a 3 percent increase over the previous year.

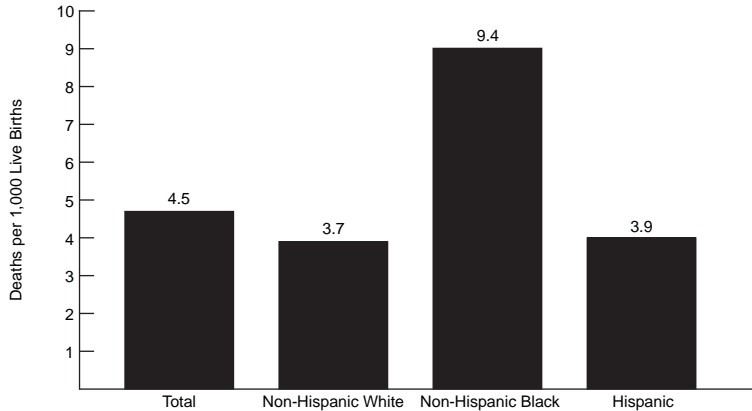
Postneonatal mortality is generally related to Sudden Infant Death Syndrome (SIDS), congenital malformations, and unintentional injuries.

Neonatal and postneonatal mortality rates vary by maternal race and ethnicity; in 2005,

rates were highest among infants born to non-Hispanic Black women (9.4 and 4.9 per 1,000 live births, respectively). Both of these rates are more than twice the respective rates of infants born to non-Hispanic White and Hispanic women.

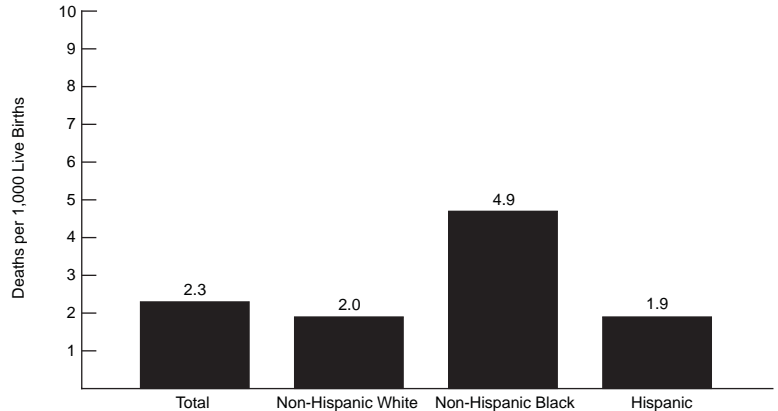
Neonatal Mortality Rates, by Maternal Race/Ethnicity, 2005

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, 2005

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



MATERNAL MORTALITY

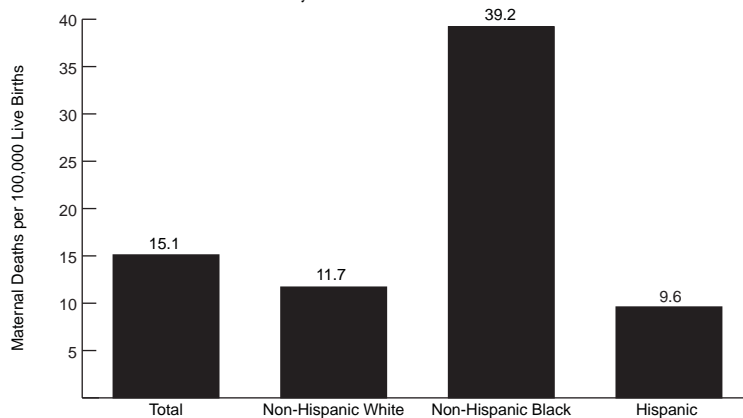
The rate of maternal mortality in the United States has declined dramatically since 1950; however, the maternal mortality rate in 2005 (15.1 per 100,000 live births) was nearly 70 percent higher than the rate reported in 2002 (8.9 per 100,000). According to the National Center for Health Statistics, this increase may largely be due to changes in how pregnancy status is recorded on death certificates.

In 2005, there were a total of 623 maternal deaths resulting from complications during pregnancy, childbirth, or up to 42 days postpartum. The maternal mortality rate among non-Hispanic Black women (39.2 per 100,000 live births) was more than 3 times the rate among non-Hispanic White women (11.7 per 100,000) and more than 4 times the rate of Hispanic women (9.6 per 100,000).

The risk of maternal death increases with age, regardless of race. In 2005, the maternal mortality rate among women aged 35 years and older (38.0 per 100,000 live births) was more than 3 times the rate of women aged 20–24 years (10.7 per 100,000) and more than 5 times that of women under 20 years of age (7.4 per 100,000).

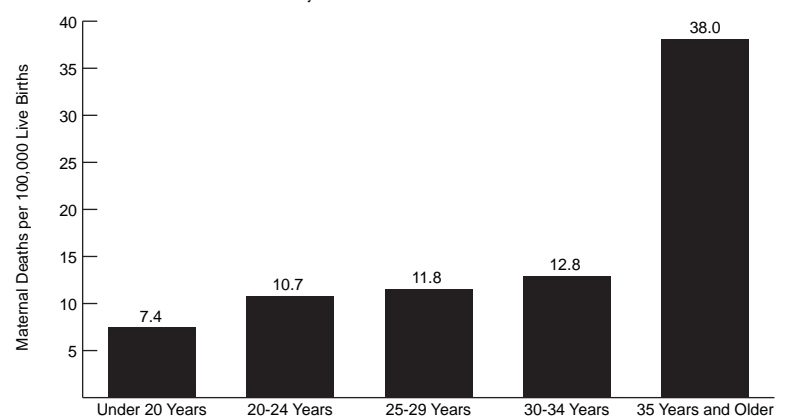
Maternal Mortality Rates, by Race/Ethnicity, 2005

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



Maternal Mortality Rates, by Age, 2005

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



INFANT MORTALITY

In 2005, 28,440 infants died before their first birthday, representing an infant mortality rate of 6.9 deaths per 1,000 live births, a slight increase over the previous year (6.8 deaths per 1,000 live births). The leading cause of infant mortality was congenital malformations, deformations, and chromosomal abnormalities, which accounted for 19.5 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 2005, the mortality rate among non-Hispanic Black infants was 14.3 deaths per 1,000 live births. This is more than twice the rate among non-Hispanic White and Hispanic

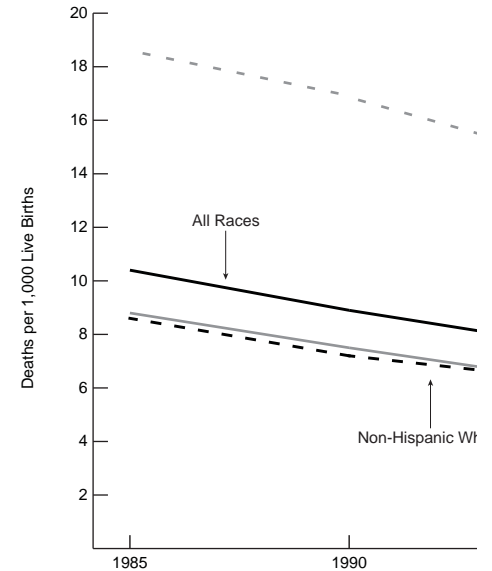
infants (5.7 and 5.8 per 1,000 live births, respectively). Although the trend in infant mortality rates among both non-Hispanic Blacks and non-Hispanic Whites has generally been one of decline throughout the last century, the proportional discrepancy in rates between the two races

remains largely unchanged.

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

Infant Mortality Rates,* by Maternal Race

Source (II.2, 3): Centers for Disease Control and Prevent Statistics System



*Under 1 year of age.

INTERNATIONAL INFANT MORTALITY

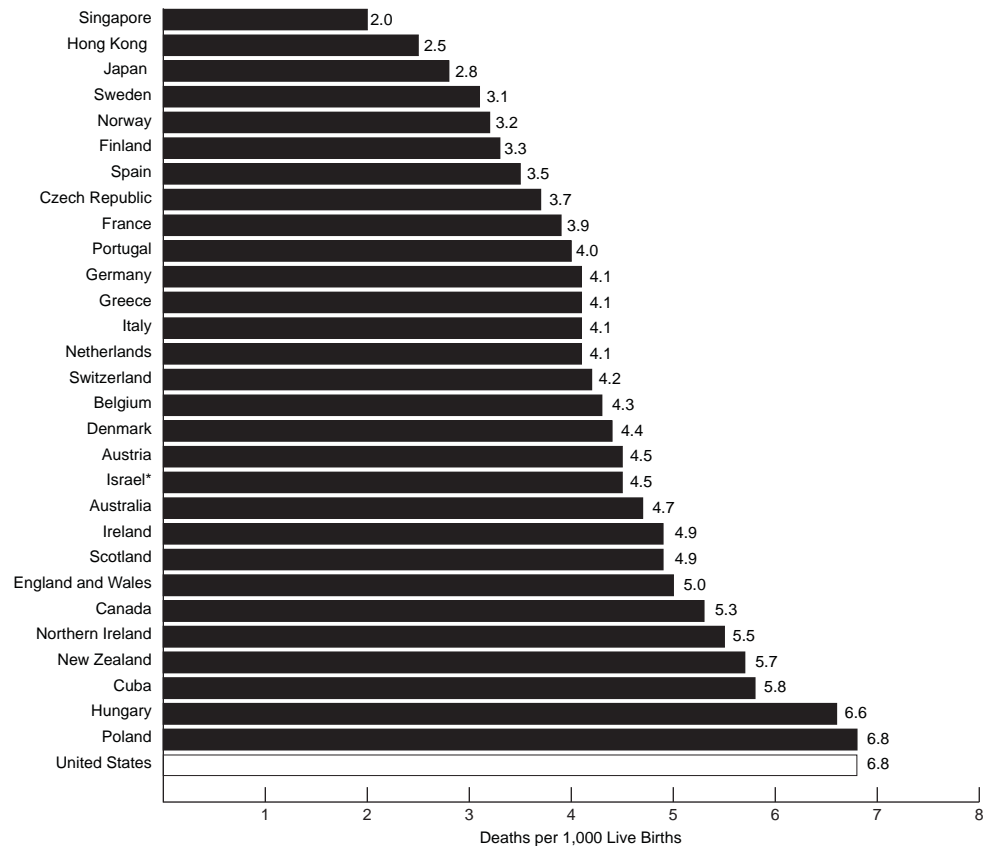
Although the infant mortality rate in the United States has declined significantly in recent decades, it was still ranked below that of many other industrialized nations in 2004 with a rate of 6.8 deaths per 1,000 live births. This represents a slight decline from the rate of 6.9 per 1,000 in 2003 and considerably less than 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.

In 2004, the U.S. infant mortality rate was more than twice that of six other industrialized countries, including Singapore, Hong Kong, Japan, Sweden and Finland. Singapore had the lowest rate (2.0 per 1,000), followed by Hong Kong (2.5 per 1,000) and Japan (2.8 per 1,000).

International Infant Mortality Rates, Selected Countries, 2004

Source (II.4): Centers for Disease Control and Prevention, National Center for Health Statistics



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

Health Status - Children



VACCINE-PREVENTABLE DISEASES

The number of reported cases of vaccine-preventable diseases has generally decreased over the past several decades. In 2005, there were no reported cases of diphtheria in the entire U.S. population, and no cases of tetanus or polio among children under 5 years of age. Only one case of rubella was reported among children under 5 years of age, the first to be reported in this age group since 2001.

From 2004 to 2005, the number of reported cases of measles, mumps, and hepatitis A and B decreased among children under 5 years of age. Rates of hepatitis B infection have declined 98 percent among children under 13 years of age since 1990, 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. The overall incidence of Hepatitis A has also dropped dramatically since routine vaccina-

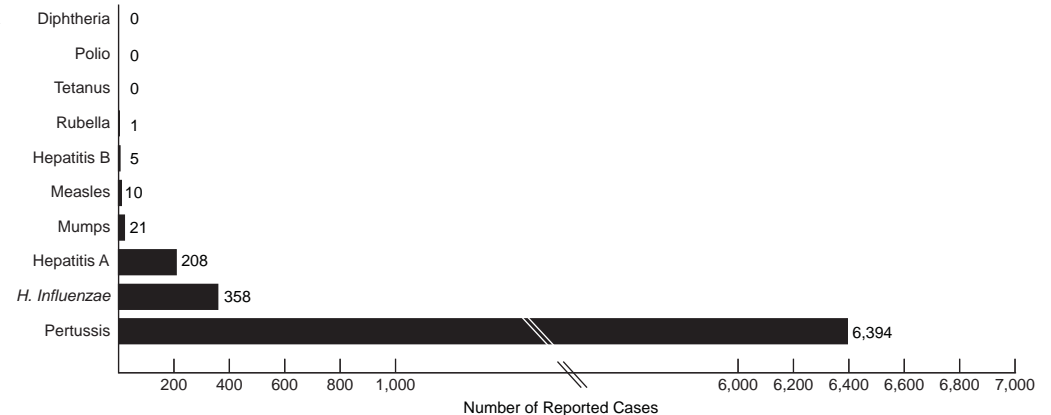
tion for children living in high-risk areas was recommended starting in 1996.

While the number of reported cases of several vaccine-preventable diseases decreased from 2004 to 2005, the number of reported cases of *H. Influenzae*, rubella, and pertussis, increased over the same period. In 2005, the incidence of reported pertussis among the entire U.S. population (8.7 per 100,000 people) increased just slightly after doubling from 2003 to 2004. This rate was highest among children under 6 months

of age who were too young to have received the first three doses of acellular pertussis vaccine. This age group accounted for 13 percent of all reported pertussis cases in 2005.

Reported Cases of Selected Vaccine-Preventable Diseases Among Children Under Age 5, 2005

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



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. AIDS is diagnosed when HIV has weakened the immune system enough that the body has a difficult time fighting infections. Through 2005, an estimated 9,068 AIDS cases in children younger than 13 had ever been reported in the United States. Pediatric AIDS cases represent less than one percent of all AIDS cases ever reported.

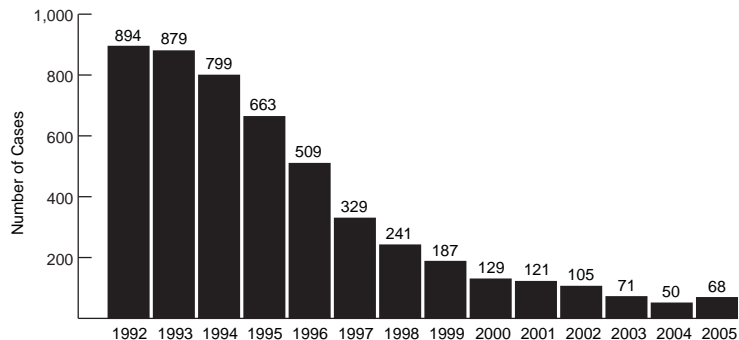
In 2005, an estimated 68 new AIDS cases were diagnosed among children under age 13, nearly all of which were attributed to transmission from the mother before or during birth (perinatal transmission), excluding one case in which the risk factor was not specified. The number of new cases of pediatric AIDS has declined substantially since 1992, when an estimated 894 new 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. In addition, the

Centers for Disease Control and Prevention released new and updated materials in 2004 to further promote universal prenatal HIV testing. 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 Black children account for nearly 62 percent of all pediatric AIDS cases, but compose approximately 15 percent of the total U.S. population under age 13.

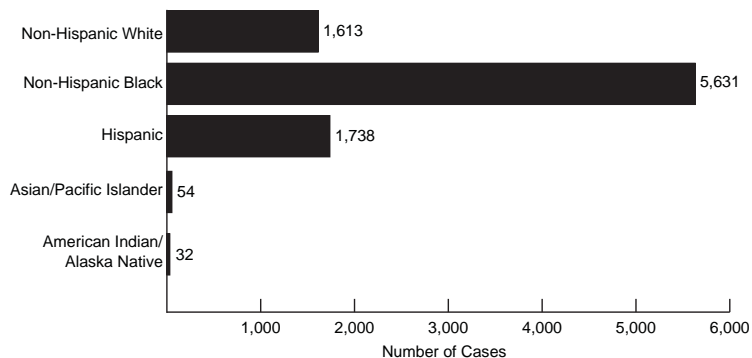
Estimated Numbers of AIDS Cases in Children Under Age 13, by Year of Diagnosis: 1992–2005

Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



Estimated Numbers of AIDS Cases Ever Reported in Children Under Age 13, by Race/Ethnicity: Through 2005*

Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



*Includes children with a diagnosis of AIDS, from the beginning of the epidemic through 2005, but does not include 33 children of unknown or multiple races.

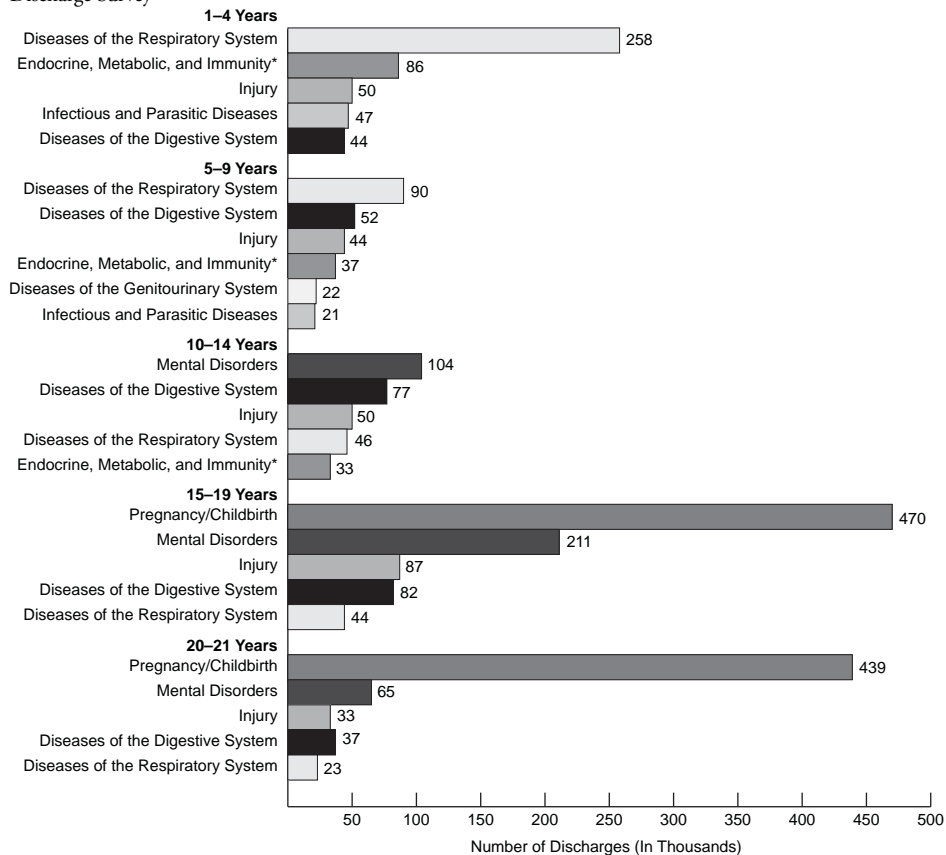
HOSPITALIZATION

In 2005, there were 3.5 million hospital discharges among youth aged 1–21 years, or 4.1 hospital discharges per 100 children. This represents little change from 2004. 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 and adolescents older than 1 year, this category accounted for only 9 percent of the hospital discharges of children aged 1–14 years in 2005. Diseases of the respiratory system were the major cause of hospitalization for children 1–9 years of age, accounting for 31 percent of discharges. Pregnancy and childbirth accounted for 65 percent of hospital discharges of young women aged 15–21 years. Mental disorders were the leading cause of hospitalization among youth aged 10–14 years and the second leading cause among 15- to 19- and 20- to 21-year-olds.

Major Causes of Hospitalization, by Age, 2005

Source (II.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Includes endocrine diseases, nutritional diseases, metabolic diseases, and immunity disorders.

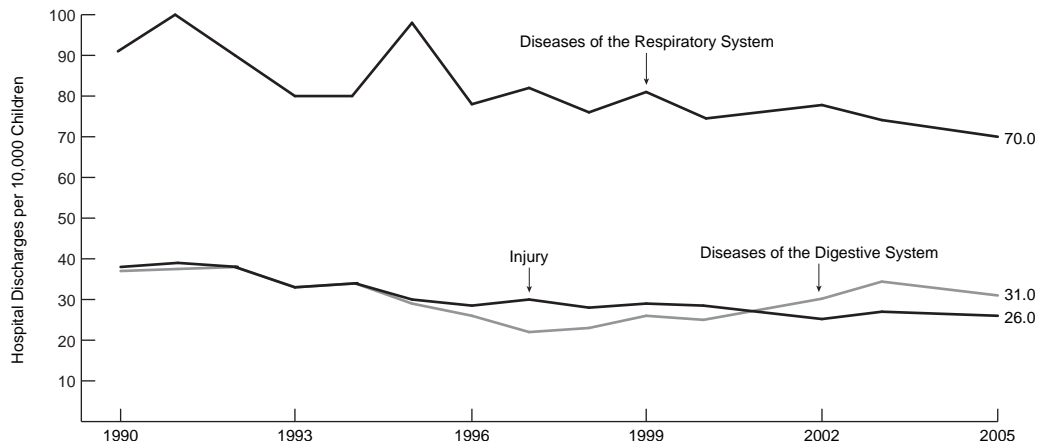
HOSPITAL DISCHARGE TRENDS

Three types of health problems (respiratory diseases, digestive diseases, and injury) accounted for 44 percent of hospital discharges among children aged 1–14 years in 2005. Since 1985, overall hospital discharge rates for children in this age group declined by 37 percent, which is reflected in decreases in discharge rates for each of those three categories.

Between 1990 and 2005, hospital discharge rates for diseases of the respiratory system declined 23.1 percent for children aged 1–14 years; from 91 hospital discharges per 10,000 children in 1990 to a new low of 70 per 10,000 children in 2005. During this period, the rate of discharges due to injury also declined, from 38 to 26 per 10,000 children, or 31.6 percent. Similarly, the hospital discharge rate among children for diseases of the digestive system dropped 16.2 percent.

Discharge Rates Among Children Aged 1–14, by Selected Diagnoses: 1990–2005

Source (II.7): 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 3.3 million referrals, involving an estimated 6 million children, alleging abuse or neglect in 2005. More than half of these reports were made by community professionals, such as teachers, other educational personnel, police officers, medical personnel, and daycare providers.

Investigations determined that an estimated 899,000 children were victims of abuse or neglect in 2005;¹ this is equivalent to a rate of about 12.1 per 1,000 children under 18 years of age. Neglect was the most common type of maltreatment

(7.6 per 1,000 children), followed by physical abuse (2.0 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 2005, the rate of victimization among children from birth to age 3 was 16.5 per 1,000 children of the same age; the rate declined steadily as age increased (data not shown).

A majority of the perpetrators of abuse and neglect, almost 80 percent, were parents. Remaining types of perpetrators included other relatives

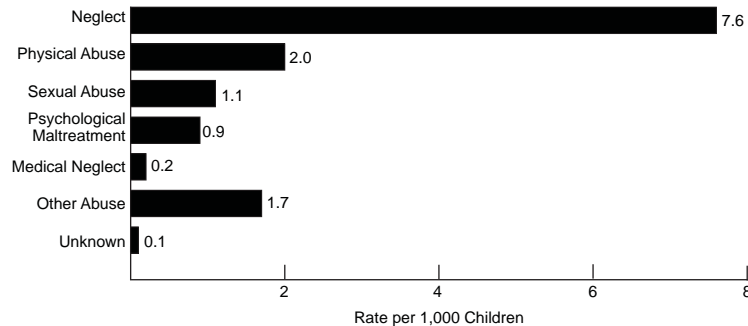
(6.8 percent), unmarried partners of parents (3.8 percent), and professionals such as daycare workers and residential facility staff (0.9 percent). Foster parents accounted for 0.5 percent of perpetrators, while friends and neighbors accounted for 0.6 percent.

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.

1 The increase of approximately 20,000 victims since 2004 is likely due to the inclusion of Puerto Rico and Alaska in 2005.

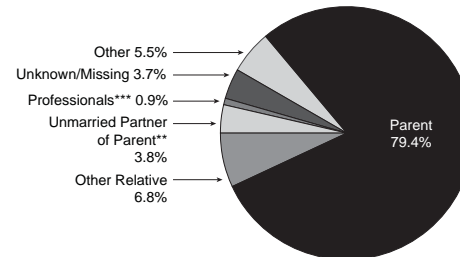
Child Abuse and Neglect Among Children Under Age 18, by Type of Maltreatment, 2005

Source (II.8): Administration on Children, Youth, and Families, National Child Abuse and Neglect Data System



Perpetrators of Child Abuse and Neglect, by Relationship to Victim, 2005*

Source (II.8): Administration on Children, Youth, and Families, National Child Abuse and Neglect Data System



Based on 42 States reporting. **Defined as 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.*

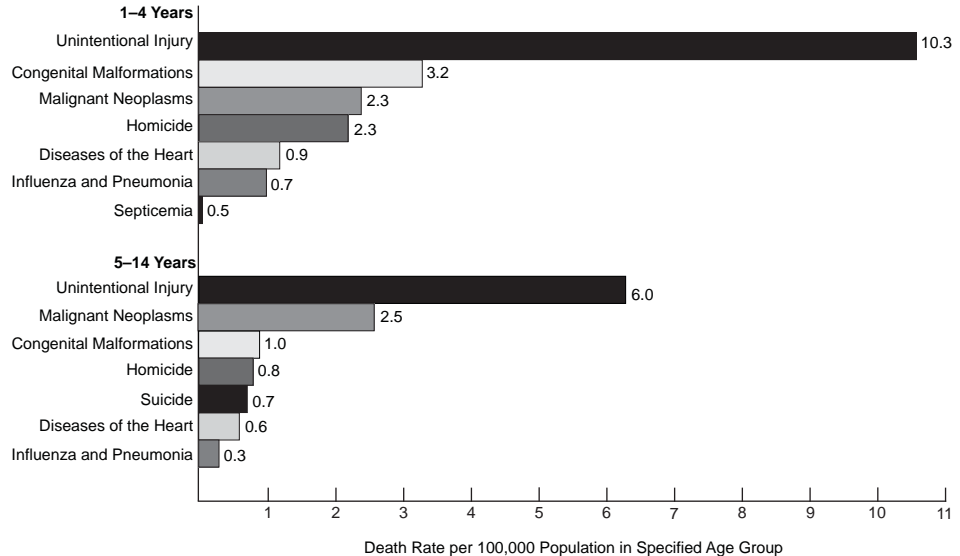
CHILD MORTALITY

In 2005, 11,358 children between the ages of 1 and 14 years died of various causes; this was 261 fewer than in the previous year. The overall mortality rate among 1- to 4-year-olds was 29.4 per 100,000, and the rate among 5- to 14-year-olds was 16.3 per 100,000. The leading cause of death among children in the younger age group continues to be unintentional injury, which accounted for 35.0 percent of all deaths in this age group in 2005. The next most common cause of death was congenital malformations (birth defects), followed by malignant neoplasms (cancer), homicide, and diseases of the heart.

Unintentional injury was also the leading cause of death among older children, accounting for 36.6 percent of deaths among 5- to 14-year-olds. This was followed by malignant neoplasms, congenital malformations, homicide, suicide, and diseases of the heart.

Leading Causes of Death Among Children Aged 1–14, 2005

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



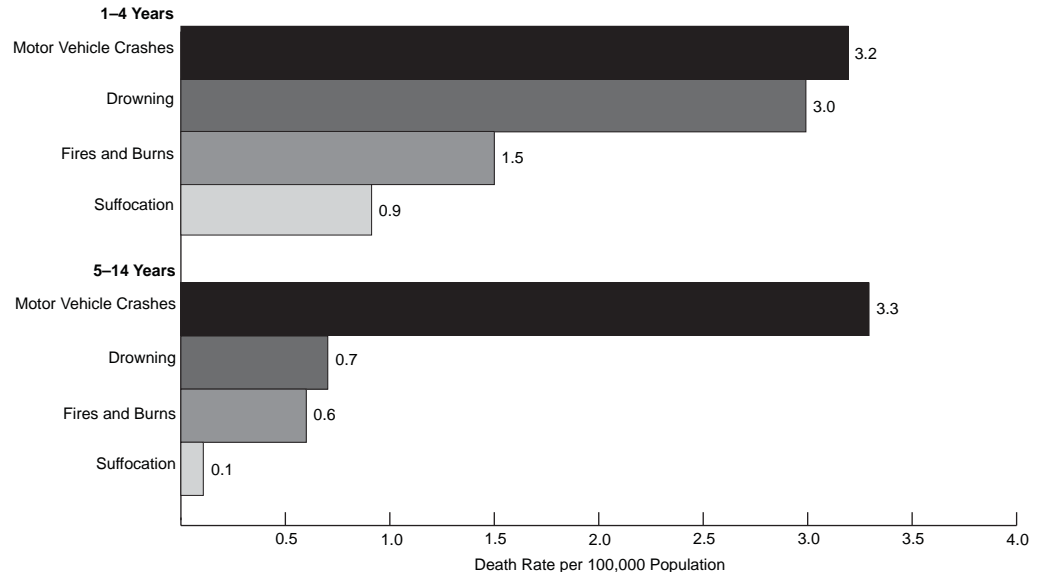
CHILD MORTALITY DUE TO INJURY

In 2005, unintentional injuries caused the deaths of 1,664 children aged 1–4 years and 2,415 children aged 5–14 years. In 2005, motor vehicle crashes, followed by drowning, fires and burns were the most common causes of unintentional injury death among children aged 1–4 and 5–14 years. Unintentional injuries due to motor vehicle crashes caused 3.2 and 3.3 deaths per 100,000 children aged 1–4 and 5–14 years, respectively.

In addition, 375 children aged 1–4 years were the victims of homicide in 2005 and 613 children aged 5–14 years were the victims of homicide or suicide (data not shown).

Deaths Due to Unintentional Injury Among Children Aged 1–14, 2005

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 15–19 years decreased to 40.5 births per 1,000 females in 2005. This is 1.5 percent below the rate in the previous year and represents a 34 percent decrease since the most recent peak in 1991. The birth rate among adolescents aged 10–14 years remained static at 0.7 per 1,000; however, this rate is 50 percent lower than the 1991 rate. Teenage birth rates were highest among older adolescents, aged 18–19 years, at 69.9 per 1,000.

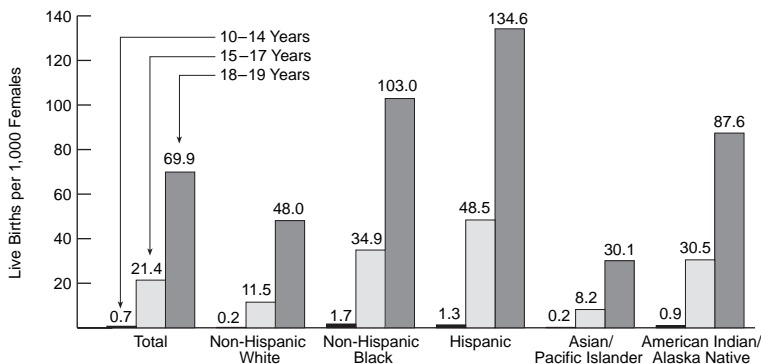
Among younger adolescents aged 10–14 years, birth rates remained the same from 2004 among all races and ethnicities except non-Hispanic Black females who saw a 6 percent increase. Non-Hispanic Black females in this age group also had the highest birth rate (1.7 per 1,000) followed by Hispanic and American Indian/Alaska Native females (1.3 and 0.9 per 1,000, respectively). The lowest birth rates were found among Asian/Pacific Islanders and non-Hispanic Whites (0.2 per 1,000 for both groups).

Teenage birth rates have historically varied considerably by race and ethnicity. Among ado-

lescents aged 15–19 years, Asian/Pacific Islanders had the lowest birth rate in 2005 (17.0 per 1,000), followed by non-Hispanic Whites (25.9 per 1,000). Although non-Hispanic Black teens had one of the highest birth rates for this age group (60.9 per 1,000), they have also experienced the largest percentage decrease since 1991 (48 percent). Comparatively, Hispanic females had the highest birth rate among teens aged 15–19 years (81.7 per 1,000), but had the lowest percentage decrease since 1991 (22 percent). The birth rate for American Indian/Alaska Native females aged 15–19 years was 52.7 per 1,000.

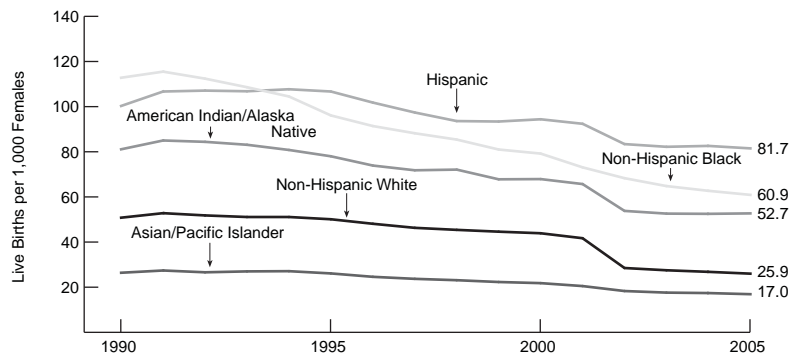
Birth Rates Among Adolescent Females, by Maternal Age and Race/Ethnicity, 2005

Source (I.6): 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: 1990–2005

Source (I.6): 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, while 53.2 percent of students were abstinent (had never had intercourse). Nearly 13 percent of students were not currently sexually active (had not had intercourse in the past 3 months), while 12.6 percent of students were currently sexually active but did not use a condom during their last intercourse. Another 21.3 percent of students were currently sexually active and reported using a condom during their last sexual encounter.

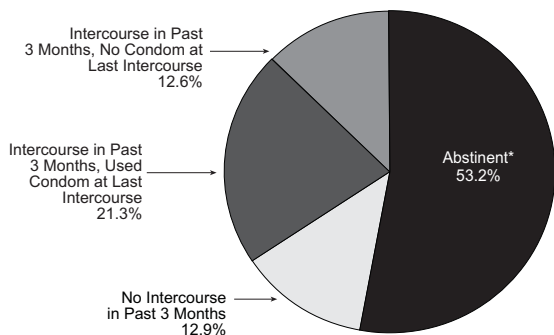
Sexual activity and condom use varied by race and ethnicity in 2005. Non-Hispanic Black students were most likely to report ever having sexual intercourse (67.6 percent), and also most likely to report condom use during their last sexual encounter (68.9 percent of sexually active students). Hispanic students were second most likely to report ever having had sexual intercourse (51.0 percent), followed by non-Hispanic White students (41.8 percent; data not shown).

In 2005, sexual activity increased with grade level, while condom use decreased. Among 12th grade students, 49.4 percent reported being cur-

rently sexually active: 27.4 percent used a condom during their last intercourse, while 22.0 percent did not. In other words, 55.5 percent of sexually active 12th graders used a condom during their last sexual encounter. In contrast, 21.9 percent of 9th graders were sexually active, 74.4 percent of whom used a condom during their last sexual encounter: 5.6 percent of 9th graders were sexually active and not using a condom, while 16.3 percent were sexually active and used a condom during their last sexual encounter.

Sexual Activity Among High School Students, 2005

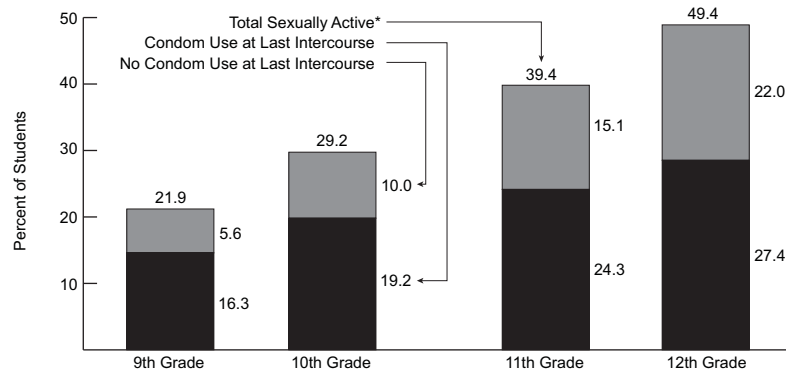
Source (II.9): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



*Have never had intercourse.

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

Source (II.9): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



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

SEXUALLY TRANSMITTED INFECTIONS

Overall, adolescents (aged 15–19 years) and young adults (aged 20–24 years) are at much higher risk than older adults of contracting certain sexually transmitted infections (STIs), such as chlamydia, gonorrhea and genital human papillomavirus (HPV). Within each of these age groups, reported rates of chlamydia and gonorrhea infections were highest among non-Hispanic Black youth.

Chlamydia continues to be the most common STI among adolescents and young adults, with rates of 1,621 and 1,719 cases per 100,000,

respectively, in 2005. Rates were highest among non-Hispanic Blacks aged 15–19 and 20–24 (5,503 and 5,360 per 100,000, respectively), followed by American Indian/Alaska Natives (2,675 and 2,979 per 100,000, respectively). Rates of gonorrhea were 438 and 507 per 100,000 adolescents and young adults, respectively, and were also higher among non-Hispanic Blacks and American Indian/Alaska Natives.

HPV is the most common STI in the United States. A recent study indicated that 24.5 percent of females aged 14–19 and 44.8 percent aged 20–24 had an HPV infection in 2003–2004.¹ There are many different types of HPV, and

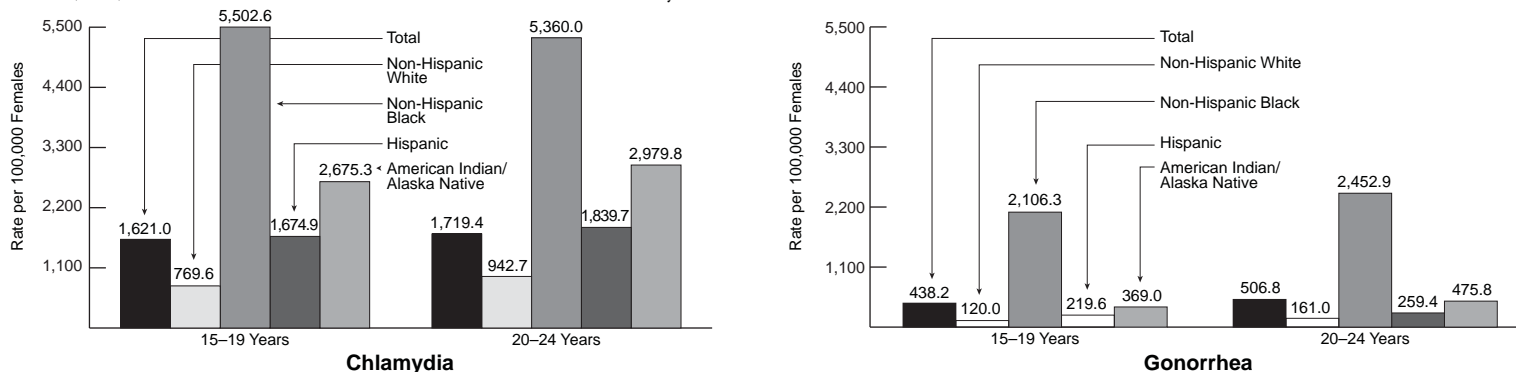
some, which are referred to as “high-risk” can cause cancer. Although cervical cancer in women is the most serious health problem caused by HPV, it is highly preventable with regular Pap tests and follow-up care. A vaccine for certain types of HPV was approved in 2006 by the Food and Drug Administration (FDA) for use in females aged 9–26 years.²

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

2 Centers for Disease Control and Prevention, Division of STD Prevention. HPV and HPV vaccines: information for healthcare providers. June 2006. Available from: <http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine-bcp.htm>, viewed 5/31/07.

Reported Rates of Sexually Transmitted Infections Among Adolescents and Young Adults, by Age and Race/Ethnicity, 2005

Source (II.10): 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 HIV has weakened the immune system enough that the body has a difficult time fighting infections. In 2005, there were an estimated 19,134 people aged 13–24 years living with HIV/AIDS,¹ representing 4.0 percent of all cases.

An estimated 5,132 people aged 13–24 years were diagnosed with HIV/AIDS in 2005, representing 13.7 percent of all new cases. While the 13- to 14- and 15- to 19-year-old age groups accounted for only 43 and 1,213 new HIV/AIDS cases, respectively, this represents an increase since 2004 of 30 percent among adolescents aged 13–14 years and 16.6 percent among those aged 15–19. Comparatively, the age group with the next highest percentage increase was 50- to 54-year-olds (11.6 percent).

The number of AIDS cases diagnosed among people aged 13–24 years was 2,369 in 2005, and 41,146 since the epidemic began in the early 1980s (data not shown). Among people who died with AIDS in 2005, 1.3 percent (213 per-

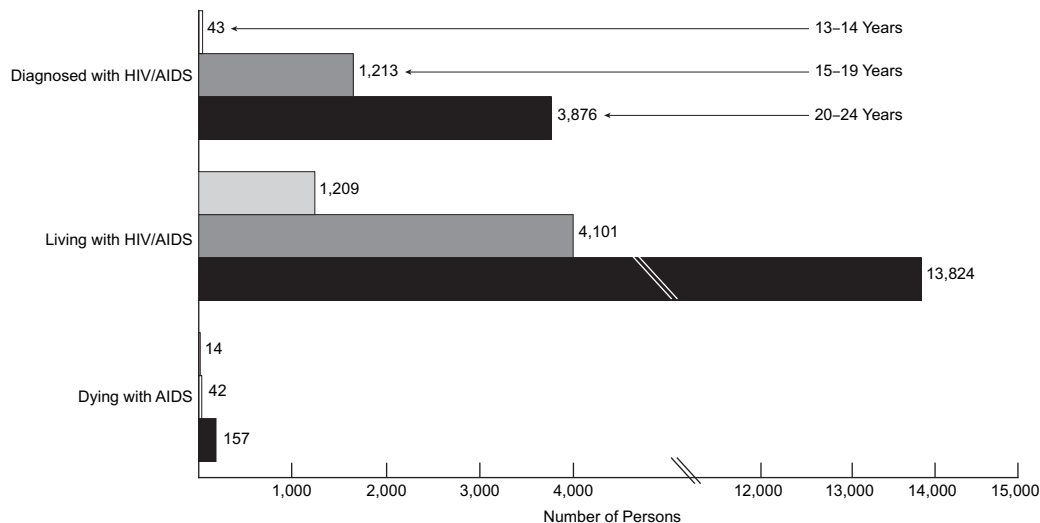
sons) were adolescents and young adults. Since the beginning of the epidemic, 9,887 people in this age group have died with the disease. While the estimated number of people diagnosed with HIV/AIDS increased 6.6 percent in 2005, the number of deaths of people with the disease has decreased in recent years due, in part, to the availability of effective prescription drugs to

combat the disease. Part D of HRSA’s Ryan White HIV/AIDS Program provides family-centered, comprehensive care to children, youth and women with HIV/AIDS and their families.

1 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 in 33 states and dependent areas with confidential name-based reporting.

Number of Persons Aged 13–24 Diagnosed with and Living with HIV/AIDS,* and Dying with AIDS, by Age, 2005

Source (II.6): Centers for Disease Control and Prevention, HIV/AIDS Surveillance System



**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 in 33 States and dependent areas with confidential name-based reporting.*

PHYSICAL ACTIVITY

Results from the 2005 Youth Risk Behavior Surveillance System 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.

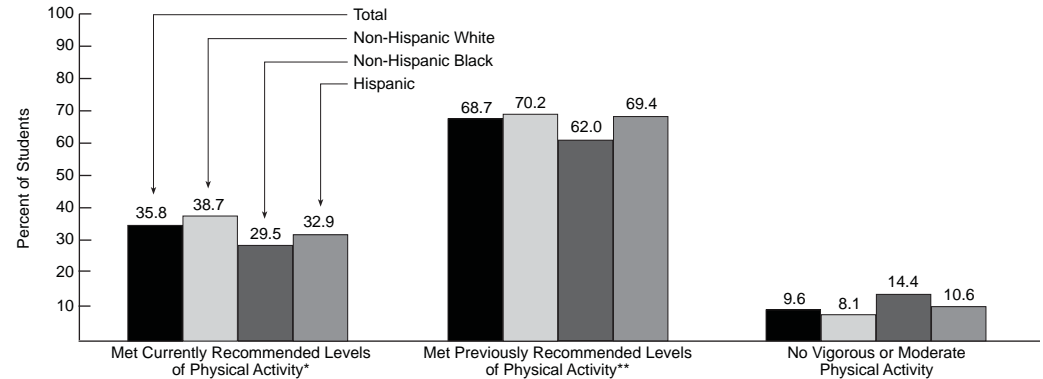
In 2005, a total of 56.0 percent of high school students reported playing on one or more sports teams in the past year. This was also more common among children in younger grades (60.4 percent of 9th-graders) than in the older grades (49.2 percent of 12th-graders). High school students also reported sedentary activities, such as using a computer or watching television. More than 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.9): 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 2005, 21.8 percent of youth aged 12–17 years, or 5.5 million youth, 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 proportion of youth receiving treatment in 2005 represents a 3.1 percent decrease from 2004. Overall, there was little difference by age group or race and ethnicity; however, females were more likely than males to

receive treatment (24.1 versus 19.6 percent). Males and females aged 14–15 were more likely to receive treatment than youth of other ages.

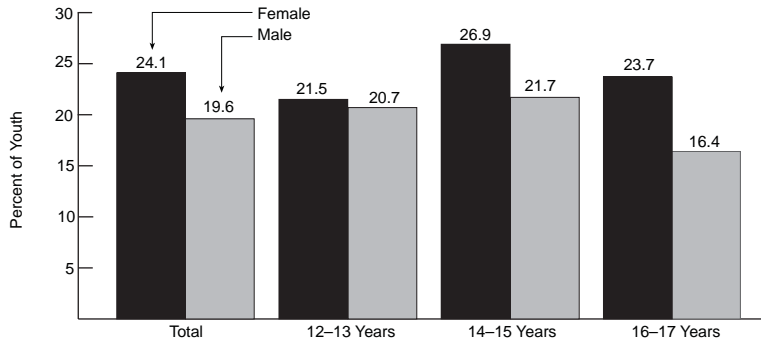
Youth with lower family incomes were more likely to receive treatment than those with higher family incomes. For instance, nearly 25 percent of youth with family incomes of less than \$20,000 received mental health treatment, compared to 19.9 percent of those with family incomes of \$75,000 or more.

Among youth who received mental health treatment or counseling in 2005, 28.9 percent

also used illicit drugs in the past year. Illicit drug use among those receiving treatment increased with age. Just over 16 percent of 12- to 13-year-olds receiving treatment used illicit drugs in the past year, compared to 25.4 percent of those aged 14–15 and 46.2 percent of 16- to 17-year-olds. Females receiving mental health treatment were more likely than males to report illicit drug use in the past year (31.4 versus 25.8 percent; data not shown).

Mental Health Treatment/Counseling* in the Past Year Among Youth Aged 12–17, by Age and Sex, 2005

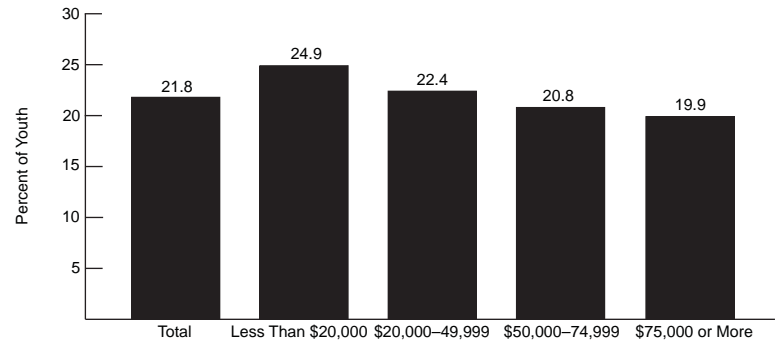
Source (II.11): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Having received treatment or counseling from any of 10 specific sources for emotional or behavioral problems not caused by drug or alcohol use.

Mental Health Treatment/Counseling* in the Past Year Among Youth Aged 12–17, by Family Income, 2005

Source (II.11): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



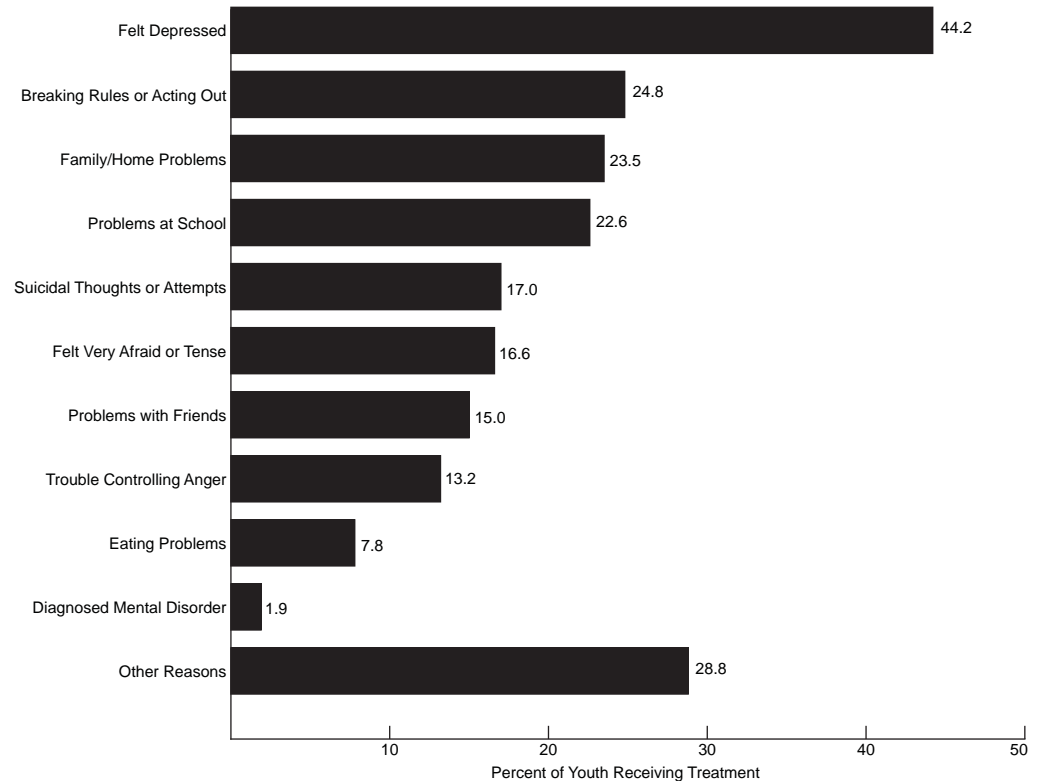
*Having received treatment or counseling from any of 10 specific sources for emotional or behavioral problems not caused by drug or alcohol use.

Depression was the leading reason reported for mental health treatment among 12- to 17-year-olds (44.2 percent). Other common reasons for treatment included breaking rules or “acting out” (24.8 percent), problems at home or with family members (23.5 percent), and problems at school (22.6 percent). (Survey respondents were able to report more than one reason for seeking treatment.)

The most common source of mental health treatment among youth receiving treatment was at school with a counselor, psychologist, or in regular meetings with a teacher (47.3 percent). The second most common source reported was with a therapist or psychologist (46.9 percent). Use of a partial day hospital or treatment program was reported by 7.9 percent of youth receiving treatment, and an overnight or longer stay in a residential treatment center was reported by 9.5 percent (data not shown). (Youth receiving treatment could indicate any number of 10 possible sources of care.)

Reasons for Mental Health Treatment/Counseling* in the Past Year Among Youth Aged 12–17 Who Received Treatment, 2005

Source (II.11): Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



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

CIGARETTE SMOKING

Between 2005 and 2006, cigarette smoking declined slightly among 8th-, 10th- and 12th-graders, according to the annual Monitoring the Future Study. The largest decrease in the percentage of students who had smoked at least once in the previous 30 days occurred among 12th-graders, from 23.2 percent in 2005 to 21.6 percent in 2006. Only 8.7 percent of 8th-graders and 14.5 percent of 10th-graders reported past-month cigarette use in 2006, compared to 9.3 and 14.9 percent, respectively, the year before.

Since past-month use peaked among 8th and 10th-graders in 1996, both groups have seen a substantial decline (58.6 and 52.3 percent, respectively). Among 12th-graders, the most recent peak occurred in 1997 (39 percent) but has seen a somewhat more modest decline of 40.8 percent. Factors that appear to have contributed to the decline include increases in perceived risk and personal disapproval of smoking, higher cigarette prices, and anti-smoking advertising campaigns.

The teen smoking rate increased substantially between 1991 and 1996. Increases occurred in virtually every sociodemographic group: male and female; those planning on attending college

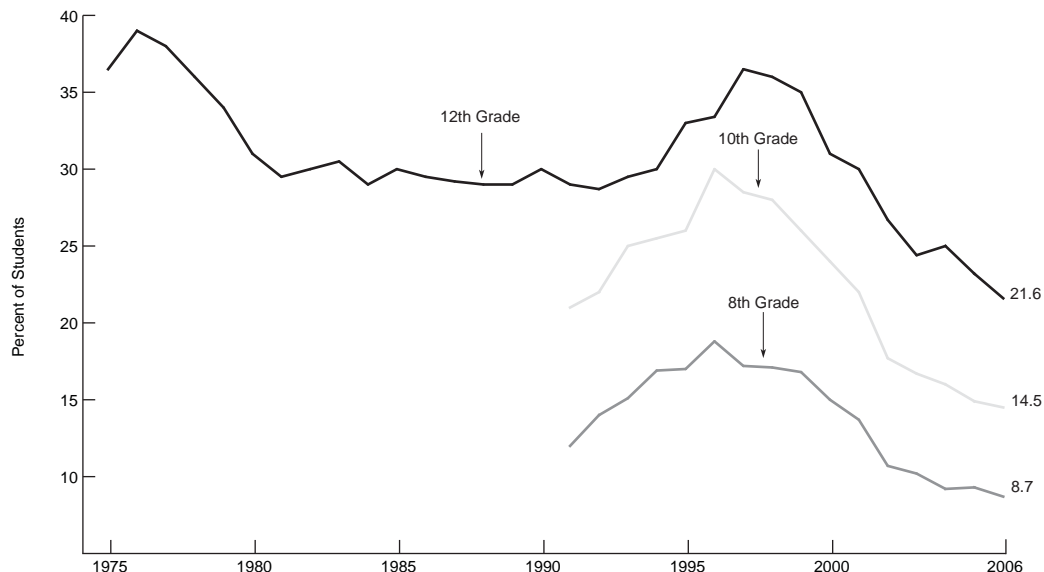
and not; those living in all four regions of the country; those living in rural and urban areas; and those of different races and ethnicities.

Since 1996, cigarette smoking among adolescents has declined across all demographic groups consistently, which is likely to have important long-term health consequences for this generation of adolescents. Despite this decline, certain

subgroups were still more likely than others to smoke. Students who did not intend to graduate from a 4-year college program were more likely to smoke than those who did have a 4-year college plan (23.2 versus 7.1 percent). White adolescents were most likely to smoke cigarettes (9.3 percent), followed by Hispanic (8.8 percent) and Black adolescents (6.0 percent).

Any Cigarette Use Among Students in the Past 30 Days, by Grade: 1975–2006

Source (II.12): University of Michigan, Monitoring the Future Study



SUBSTANCE ABUSE

Prevalence. In 2005, 9.9 percent of adolescents aged 12–17 years reported using illicit drugs in the past month; however, this varied with age. Among youth aged 12–13 years, 3.8 percent reported drug use in the past month, compared to 8.9 percent of those aged 14–15 years and 17.0 percent of those aged 16–17 years. Illicit drug use did not vary widely between Hispanic, non-Hispanic White, and non-Hispanic Black adolescents (ranging from 9.4 to 11.0 percent); however, more than 19 percent of American Indian/Alaska Native adolescents and only 3.3 percent of Asians reported past-month use (data not shown).

In 2005, marijuana was the most commonly used illicit drug (6.8 percent), followed by the non-medical use of psychotherapeutic drugs, such as pain relievers, tranquilizers, and stimulants (3.3 percent). Males aged 12–17 years were slightly more likely to use marijuana than females (7.5 versus 6.2 percent).

Alcohol was the most commonly used drug among adolescents, with 16.5 percent reporting past-month use in 2005. Alcohol use was more common among female adolescents than males (17.2 versus 15.9 percent). Illicit drug use among

adolescents who smoked cigarettes in the past month (46.7 percent) or were heavy drinkers¹ (59.9 percent) was much higher than among adolescents who didn't smoke (5.5 percent) or drink (5.0 percent). Among those adolescents who both smoked cigarettes and drank heavily in the past month, 70.9 percent also used an illicit drug.

Perception of Risk and Access to Drugs. In 2005, 34.0 percent of adolescents perceived smoking marijuana once a month to be a great risk, while 48.8 percent perceived the same risk regarding cocaine use. Smoking one or more packs of cigarettes a day was considered a great risk by 68.3

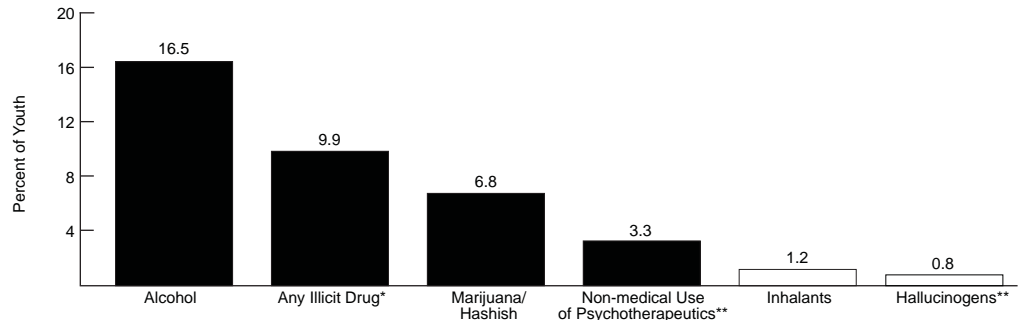
percent of adolescents, which represents a significant increase since 2002 (63.1 percent). Drinking five or more drinks on one or two occasions per week was considered to be a great risk by 38.4 percent of adolescents.

While only 15.5 percent of adolescents reported being approached by someone selling drugs in the past month, 51.0 percent reported that marijuana would be fairly or very easy to obtain. The same was reported by 24.9 percent of teens regarding cocaine, 15.7 percent for LSD, and 14.0 percent for heroin.

1 Heavy drinking is defined as consuming 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Past Month Drug Use Among Adolescents Aged 12–17, 2005

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



*Includes marijuana/hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutic drugs used non-medically.

**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.

VIOLENCE

Violence among adolescents is a critical public health issue in the United States. In 2005, homicide was the second leading cause of death among persons aged 15–24 years.

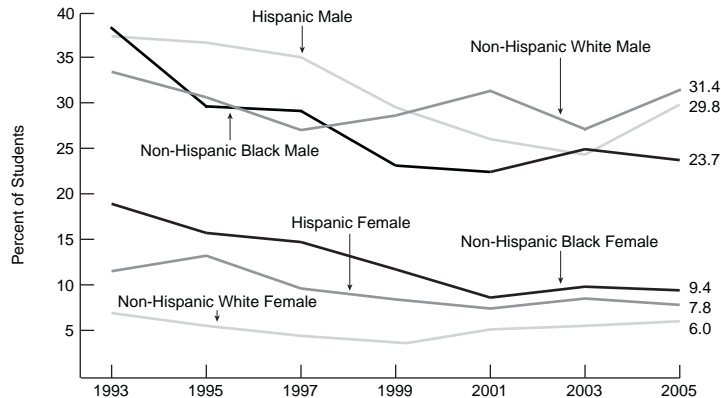
Results from the 2005 Youth Risk Behavior Surveillance System indicate that 18.5 percent of high school students had carried a weapon (such as a gun, knife, or club) at some point during the preceding 30 days. Males were more than four times as likely as females to carry a weapon (29.8 versus 7.1 percent). 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, respectively), and non-Hispanic Black females were more likely than non-Hispanic White and Hispanic females (9.4 versus 6.0 and 7.8 percent, respectively). 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. Nearly 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.

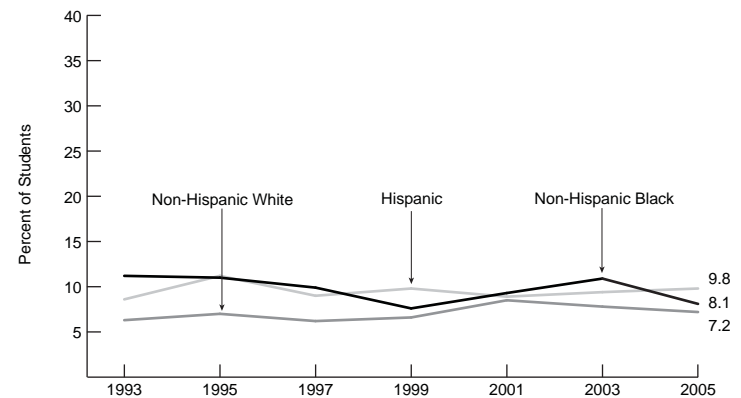
High School Students Who Carried a Weapon in the Past 30 Days, by Sex and Race/Ethnicity: 1993–2005

Source (II.9): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



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

Source (II.9): Centers for Disease Control and Prevention, Youth Risk Behavior Survey



ADOLESCENT MORTALITY

In 2005, 13,703 deaths were reported among adolescents aged 15–19 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 48.3 percent of all deaths among adolescents in 2005. This is equivalent to a rate of 31.4 deaths per 100,000 adolescents, a 5 percent decrease from 2004. Homicide and suicide were the next leading causes of death, accounting for 15.2 and

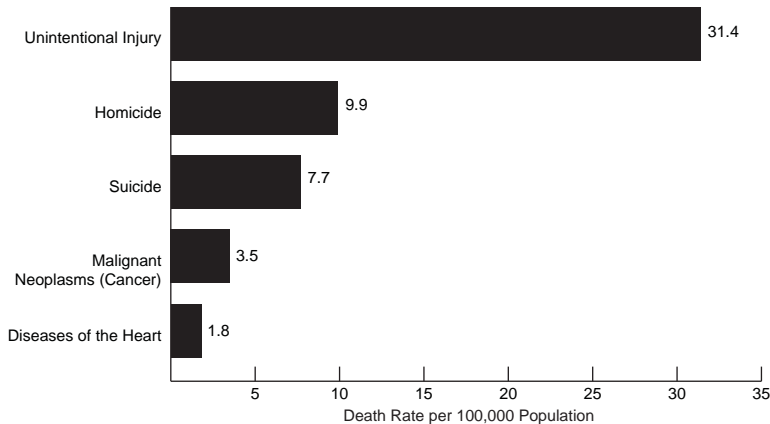
11.8 percent, respectively, of all deaths within this age group. After a 12 percent increase in the adolescent suicide rate between 2003 and 2004, the rate declined about 8.5 percent to 7.7 suicides per 100,000 adolescents in 2005.

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 2005, and accounted for 46 percent of injury-related deaths among adolescents. Alcohol is a significant contributor to these deaths: recent data sug-

gest that nearly one-third of adolescent drivers killed in crashes had been drinking. Firearms were the next leading cause of fatal injury, accounting for 25 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 12.3 per 100,000 population in 2005, about half the rate of motor vehicle injury deaths (23.0 per 100,000).

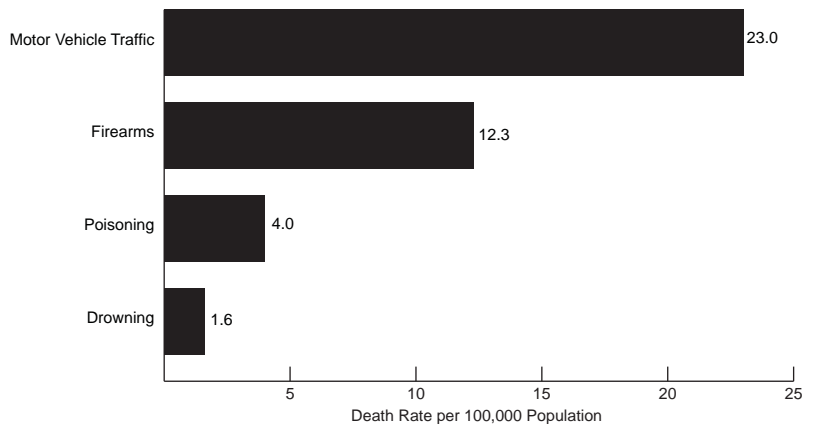
Leading Causes of Death Among Adolescents Aged 15–19, 2005

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, 2005

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 death among adolescents are motor vehicle crashes and firearms. In 2005, the latest year for which data are available, motor vehicle traffic caused the deaths of 4,829 adolescents 15–19 years of age. The vast majority of those killed were in motor vehicle crashes 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 Surveillance System 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.¹

In 2005, 2,623 adolescents aged 15–19 years were killed by firearms, a rate of 12.4 per 100,000 adolescents. Of these, homicide accounted for 66 percent of firearm deaths, suicide accounted for 28 percent, and 4 percent were considered unintentional. The 2005 Youth

Risk Behavior Surveillance System indicated that 5.4 percent of high school students carried a gun on one or more days during the past month, a behavior that could contribute to firearm mortalities.¹

¹ Centers for Disease Control and Prevention. Youth risk behavior surveillance: United States, 2005. *MMWR*, Vol. 55, No. SS-5; 2006.

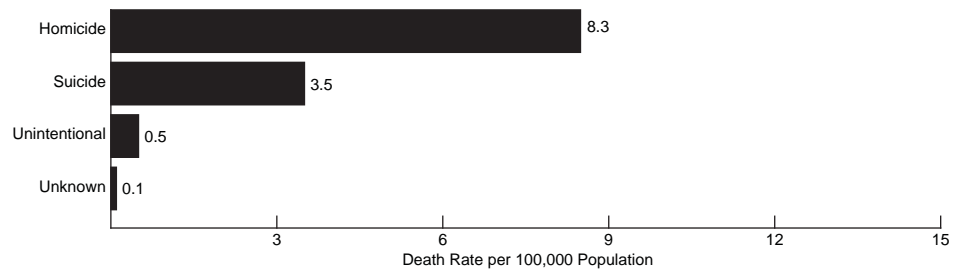
Adolescent Mortality from Traffic Injuries and Firearm Injuries, 2005

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

Traffic Mortality by Person Injured



Firearms Mortality by Intent



Health Services Financing and Utilization

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

Children may receive health coverage through a number of sources, including private insurance, either employer-based or purchased directly, and public programs, such as Medicaid or the State Children's Health Insurance Program (SCHIP). Eligibility for public programs is based on a family's income compared to the Federal poverty level. Nearly every State has SCHIP programs that help expand coverage to children who would otherwise be uninsured. Despite the progress achieved through public programs, approximately 8.7 million children remain uninsured in the United States.

This 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 2006, 8.7 million children younger than 18 years of age had no health insurance coverage; this represents 11.7 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 race and ethnicity and family income. Non-Hispanic White children were most likely to have private insurance coverage in 2006 (76.9 percent), while fewer than half of

non-Hispanic Black and Hispanic children had private coverage during the same period (49.4 and 40.9 percent, respectively). Non-Hispanic Black children were most likely to have public coverage (43.5 percent); Hispanic children were the most likely to be uninsured (22.1 percent).

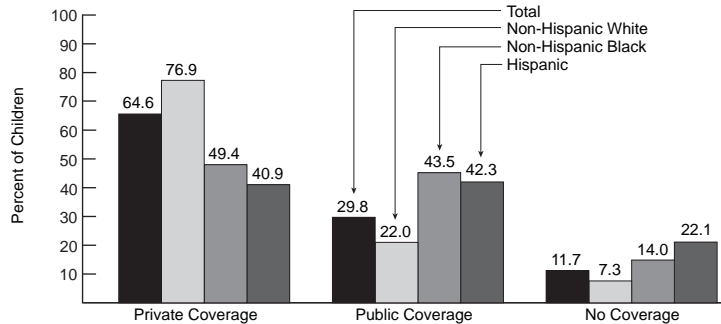
As family income increases, private health insurance coverage among children rises, while the proportion of children with public coverage and no coverage decreases. In 2006, children with family incomes below 100 percent of poverty were the most likely to have public coverage (67.2 percent) or be uninsured (19.3 per-

cent), and were least likely to have private coverage (19.5 percent). The majority of children with family incomes of 200 to 299 percent or 300 percent or more of poverty were privately insured (72.7 and 90.0 percent, respectively).

In 1997, SCHIP was created in response to the growing number of uninsured children in low-income working families. In 2006, more than 6.6 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,* 2006

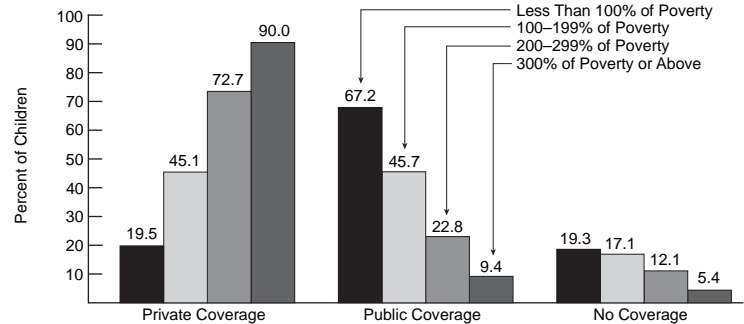
Source (III.1): U.S. Census Bureau, Current Population Survey



*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,** 2006

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



*The U.S. Census Bureau poverty threshold for a family of four was \$20,444 in 2006. **Totals equal more than 100 percent because children may have more than one type of coverage.

CSHCN: HEALTH INSURANCE AND NEEDED SERVICES

The National Survey of Children with Special Health Care Needs (CSHCN) asked the parents of CSHCN whether their child had insurance in the past 12 months and what kind of insurance they had. Health insurance included private insurance provided through an employer or union or obtained directly from an insurance company; public insurance, such as Medicaid, the State Children’s Health Insurance Program (SCHIP), or military health care; or some other plan that pays for health services obtained from doctors, hospitals, or other health professionals.

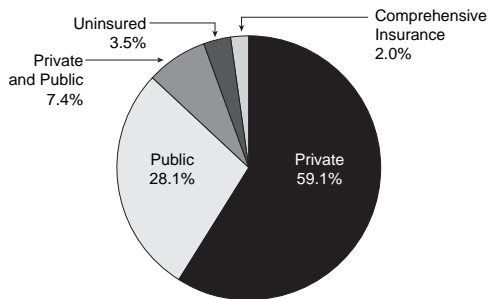
Overall, 91.2 percent of CSHCN were reported to have been insured for all of the previous 12 months, while the remaining 8.8 percent were uninsured for all or some part of the year. At the time of the interview, almost 97 percent of CSHCN were reported to have some type of insurance: 59.1 percent had private insurance and 28.1 percent had public insurance. Another 7.4 percent of CSHCN had both private and public insurance, and 3.5 percent were uninsured at the time of the interview.

CSHCN require preventive health care and dental services and acute care when they are sick in addition to a variety of other services to man-

age their conditions, maintain their abilities, and promote their development. The health service needed most often by CSHCN is prescription medication: 86 percent of these children are reported to need prescription drugs. Just over half of CSHCN need the care of medical specialists, such as cardiologists or pulmonologists. Other services needed by a smaller proportion of children include eyeglasses or vision care (33 percent of CSHCN), mental health care (25 percent), dental care other than preventive care (24 percent), and physical, occupational, or speech therapy (23 percent).

Health Insurance Coverage for CSHCN,* by Type of Coverage, 2005–2006

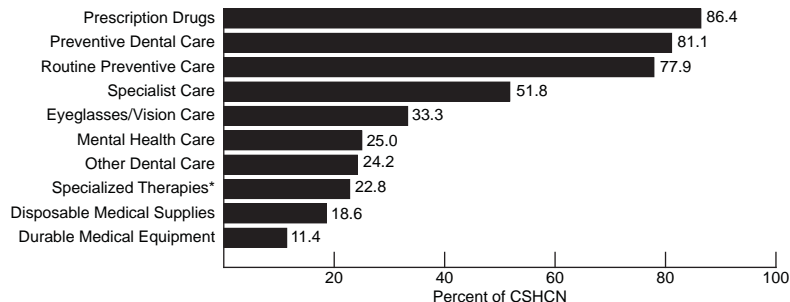
Source (I.9): Centers for Disease Control and Prevention, National Survey of Children with Special Health Care Needs



*Insurance coverage at the time of interview.

Percent of CSHCN Needing Specific Health Services, 2005–2006

Source (I.9): Centers for Disease Control and Prevention, National Survey of Children with Special Health Care Needs



*Types of therapies include physical, occupational or speech.

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 complete series of vaccines. In 2005, 80.8 percent of children aged 19–35 months had received the recommended 4:3:1:3:3 series of vaccines. This series comprises four doses of diphtheria, tetanus, and pertussis vaccine, three doses of poliovirus vaccine, one dose of measles-mumps-rubella vaccine, three doses of *Haemophilus influenzae* type b (Hib) vaccine, and three doses of the Hepatitis B vaccine. Overall, 76.1 percent had received the recommended series plus the varicella (chicken pox) vaccine.

Since 2000, the greatest increases in vaccination rates have occurred with the varicella vaccine (added to the schedule in 1996) and the diphtheria, tetanus, and pertussis vaccine (DTP). These rates have risen 29.6 and 4.9 percent, respectively. Vaccination rates for other vaccines have also risen during this time period, ranging from 0.5 percent (Hib vaccine) to nearly 3 percent (Hepatitis B vaccine).

While there was no difference in vaccination coverage by race and ethnicity regarding the

4:3:1:3:3 series of vaccines, racial and ethnic disparities were evident regarding the coverage of three individual vaccines: the DTP vaccine; the varicella vaccine; and the pneumococcal conjugate vaccine (PCV; data not shown). Non-Hispanic Black and Hispanic children were less likely than non-Hispanic White children to have received 4 or more doses of the DTP and PCV vaccines, while non-Hispanic White children were less likely to have received the varicella vaccine.

Each year, the CDC publishes an update of the recommended childhood immunization schedule (see facing page). The 2007 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 between 6 months and 5 years of age.

Vaccination Rates Among Children Aged 19–35 Months, by Race/Ethnicity, 2005

Source (III.2): Centers for Disease Control and Prevention, National Immunization Survey

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Asian
Complete Series 4:3:1:3:3:1 (with Varicella)	76.1	76.0	76.3	75.6	77.1
Series 4:3:1:3:3 (without Varicella)	80.8	82.1	79.3	78.8	80.5
4+ DTP	85.7	87.1	84.0	83.6	88.8
3+ Polio	91.7	91.4	91.0	92.3	92.9
1+ MMR*	91.5	91.4	91.9	91.1	91.9
3+ Hib	93.9	94.2	92.9	94.2	89.3
3+ HepB	92.9	93.1	92.7	92.7	92.7
1+ Varicella	87.9	86.1	90.6	89.2	91.9

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

Recommended Immunization Schedule for Children Aged 0–6 Years, United States, 2007

Source (III.3): Department of Health and Human Services, Centers for Disease Control and Prevention

	BIRTH	1MO	2MO	4MO	6MO	12MO	15MO	18MO	19–23MO	2–3YR	4-6YR
Hepatitis B ¹	HepB	HepB		see footnote 1		HepB		HepB Series			
Rotavirus ²			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP		DTaP				DTaP
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴		Hib	Hib			
Pneumococcal ⁵			PCV	PCV	PCV		PCV			PCV PPV	
Inactivated Poliovirus			IPV	IPV		IPV					IPV
Influenza ⁶						Influenza (Yearly)					
Measles, Mumps, Rubella ⁷						MMR					MMR
Varicella ⁸						Varicella					Varicella
Hepatitis A ⁹						HepA (2 doses)				HepA Series	
Meningococcal ¹⁰											MPSV4

● Range of Recommended Ages ● Catch-Up Immunization ● Certain High-risk Groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and

feasible. 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 dose of the series. Providers should consult the respective Advisory

Committee on Immunization Practices 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 <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

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

At birth: • Administer monovalent HepB to all newborns before hospital discharge. • If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. • If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week). • If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose: • 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 older. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of 3 doses or more of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose: • It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

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

• Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks. • Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks. • Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks) • The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose. • Administer the final dose in the series at age 4–6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks) • If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. • TriHIBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged 12 months or older.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV]) • Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged 2 years or older in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV]) • All children aged 6–59 months and dose contacts of all children aged 0–59 months are recommended to receive influenza vaccine. • Influenza vaccine is recommended annually for children aged 59 months or older with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41. • For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV. • Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged 3 years or older. • Children aged under 9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by 4 weeks or more for TIV and 6 weeks or more for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months) • Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided 4 or more weeks have elapsed since the first dose and both doses are administered at age 12 months or older.

8. Varicella vaccine. (Minimum age: 12 months) • Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that 3 or more months have elapsed since the first dose and both doses are administered at age 12 months or older. If second dose was administered 28 days or more following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months) • HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart. • Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits. • HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). (Minimum age: 2 years) • Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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 among children in 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 12 months of age.

During Federal Fiscal Year 2005, only 27.6 percent of children eligible for services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program received preventive dental service.

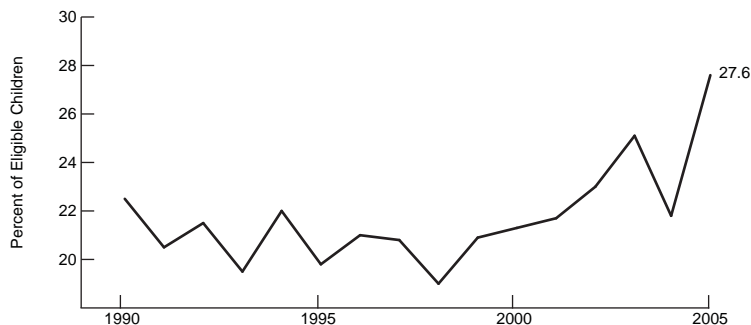
In 2005, 72.6 percent of children aged 1–18 years had seen a dentist in the past year. Frequency of dental visits among children varies by family income and race/ethnicity. Children with family incomes of 200 percent or more of the poverty level were more likely to have seen a dentist in the past year than children living with

family incomes below 200 percent of the poverty level (78.2 versus 63.8 percent).

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 (76.5 percent), while Hispanic children were least likely (63.0 percent). Approximately 70 percent of both non-Hispanic Black children and children of other races (including Asian/Pacific Islander, American Indian/Alaska Native and those of multiple races) visited a dentist in the past year (data not shown).

Receipt of EPSDT Preventive Dental Service Among Children, Birth Through Age 20: 1990–2005*

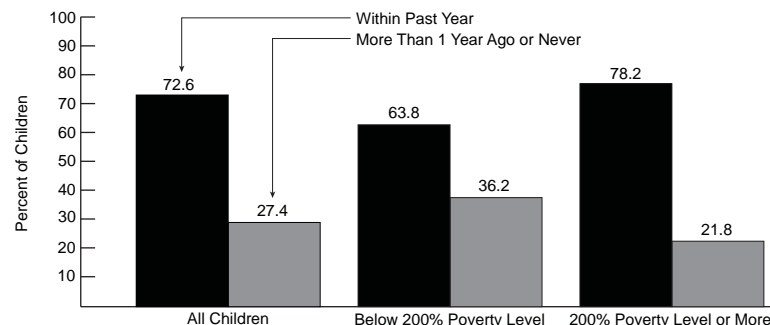
Source (III.4): Centers for Medicare and Medicaid Services



*Not all States and Territories reported data in all years.

Receipt of Dental Care Among Children Aged 1–18, by Poverty Level,* 2005

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The poverty level was equal to \$19,971 for a family of four in 2005.

TIMING OF PHYSICIAN VISITS

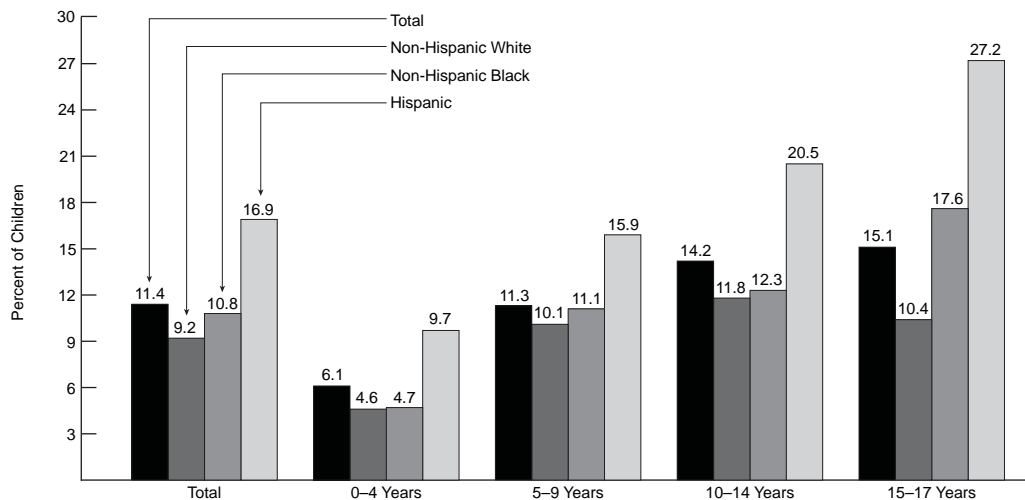
The American Academy of Pediatrics recommends that children have eight health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence. In 2005, 11.4 percent of children under 18 years of age had not seen a physician or other health care professional in the previous year (not including overnight hospitalization, trips to the emergency room, home visits, or dental visits). Older children were less likely than younger children to have seen a physician. More than 15 percent of 15- to 17-year-olds had not had a physician visit in the previous year, compared to only 6.1 percent of children under 5 years of age.

Physician visits varied with race and ethnicity across all age groups in 2005. Almost 17 percent of all Hispanic children did not see a physician, compared to 9.2 percent of non-Hispanic White children and 10.8 percent of non-Hispanic Black children. In every age group, Hispanic children were the least likely to have seen a physician in the previous year, while non-Hispanic White children were most likely to have seen a physician. Non-Hispanic White children and non-

Hispanic Black children had similar rates except among children aged 15–17 years (10.4 and 17.6 percent, respectively). Hispanic children aged 15–17 years were the most likely not to have seen a physician in the past year (27.2 percent).

Children Reported to Have Not Seen a Physician or Other Health Care Professional in the Past 12 Months, by Age and Race/Ethnicity,* 2005

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The sample of American Indian/Alaska Natives, Asian/Pacific Islanders and children of more than one race was too small to produce reliable results.

RECEIPT OF PREVENTIVE CARE

In 2005, nearly 73 percent of children under 18 years of age were reported by their 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 health care 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 visit per year, only 66.7 percent of children aged 10–14 years and 64.8 percent of children aged 15–17 years had a well-child visit in the past year. Younger children (aged birth to 4 years) were the most likely to have had a well-child visit in the past year (85.4 percent).

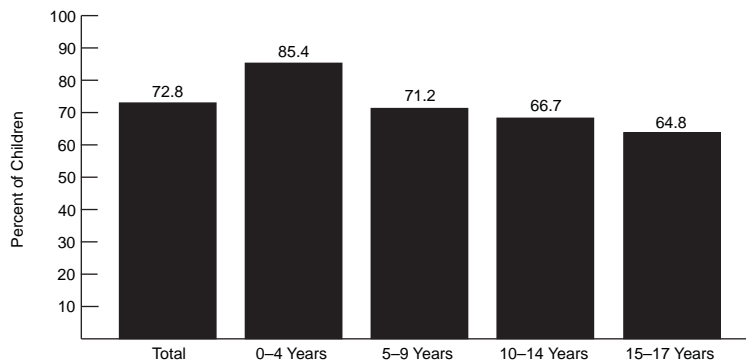
The likelihood of children receiving preventive care also varied by race and ethnicity. Non-Hispanic Black children were the most likely to have had a preventive medical visit in the past year

(77.6 percent), followed by non-Hispanic White children (73.7 percent). Hispanic children were least likely to have had a preventive visit (67.1 percent).

In 2005, children with family incomes above the poverty level were more likely to receive a preventive visit than children with family incomes below the poverty level (73.9 versus 69.3 percent; data not shown).

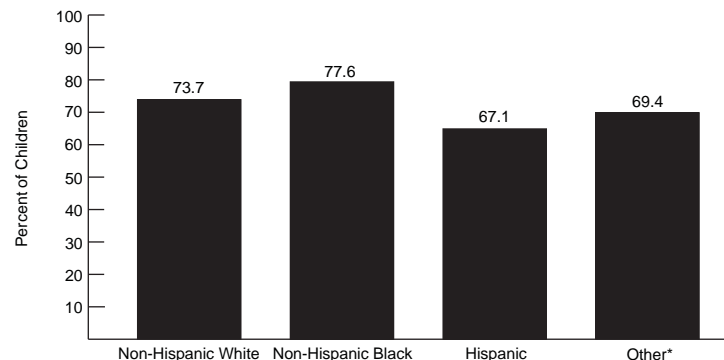
Receipt of Preventive Medical Care in the Past Year Among Children Under Age 18, by Age, 2005

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Receipt of Preventive Medical Care in the Past Year Among Children Under Age 18, by Race/Ethnicity, 2005

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Includes American Indian/Alaska Natives, Asian/Pacific Islanders and children of more than one race.

PLACE OF PHYSICIAN CONTACT

In 2005, a doctor's office or HMO was the usual place of sick care (not including routine or preventive care) for 77.5 percent of children in the United States, a proportion that varies by family income and race and ethnicity. 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 poverty level.

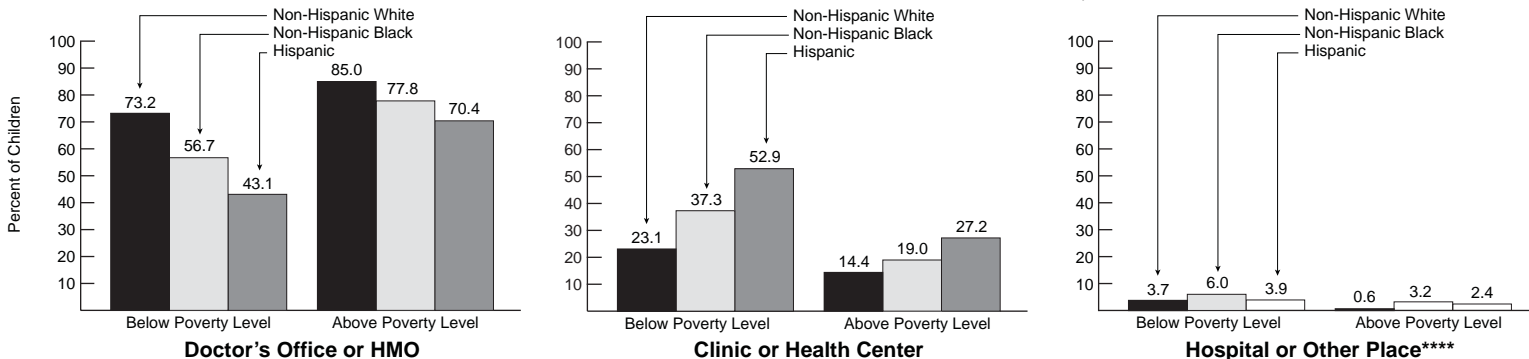
Among children with family incomes below the poverty level, 73.2 percent of non-Hispanic

White children received care at a doctor's office or HMO, compared to 56.7 percent of non-Hispanic Black children and 43.1 percent of Hispanic children. Hispanic children were more likely than non-Hispanic children to receive non-routine care at a clinic or health center when they were sick, with nearly 53 percent whose family incomes were below poverty and 27.2 percent above poverty receiving care at such a location. Comparatively, only 23.1 percent of low-income and 14.4 percent of higher-income non-Hispanic White children received care from clinics or health centers.

Only a small proportion of children used a hospital emergency room, hospital outpatient department, or some other source as their primary source of sick care, but children with family incomes below the poverty level were more likely to do so than children with higher family incomes. For instance, 6.0 percent of non-Hispanic Black children and 3.9 percent of Hispanic children with family incomes below the poverty level regularly received care from these sources, while those with family incomes above the poverty level were less likely to do so (3.2 and 2.4 percent, respectively.)

Place of Physician Contact,* by Poverty Level** and Race/Ethnicity,*** 2005

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The place where the child usually goes when sick; does not include routine or preventive care visits. **The U.S. Census Bureau poverty threshold for a family of four was \$19,971 in 2005. ***The sample of American Indian/Alaska Natives, Asian/Pacific Islanders and children of more than one race or "other" races was too small to produce reliable results. ****Includes hospital emergency rooms, hospital outpatient departments, and "some other place."

EMERGENCY DEPARTMENT UTILIZATION

In 2005, more than 21 percent of children went to a hospital emergency room or emergency department (ER/ED) at least once. Children with family incomes above the poverty level (\$19,971 for a family of four) were less likely than children in poverty to have visited the ER/ED. Nearly 27 percent of low-income children made one to three emergency room visits during the year, compared to 18.7 percent of children in higher-income families. Similarly, 2.5 percent of low-income children and less than 1

percent of children with family incomes above the poverty level made four or more visits to the ER/ED.

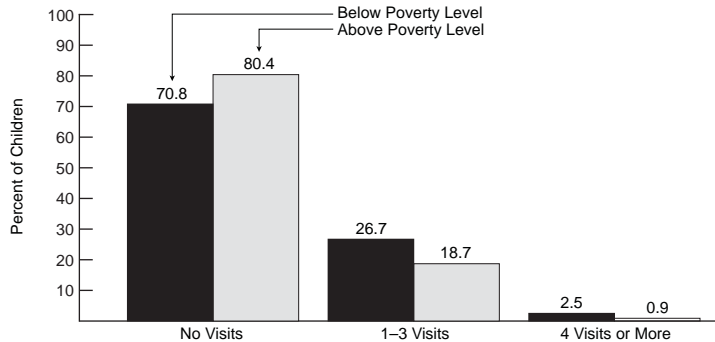
The use of ER/EDs also varied by other demographic factors including age and race and ethnicity. Younger children used the ER/ED more often than older children and adolescents; 25.4 percent of children under 5 years of age made 1–3 visits to the emergency room compared to 18.2 percent of 5- to 9-year-olds and fewer than 16.5 percent of adolescents aged 10–14 and 15–17 years. Similarly, 2.0 percent of children under 5 years made 4 or more visits to the

ER/ED compared to 1.1 percent of those aged 5–9 and fewer than 1 percent each of 10- to-14-year-olds and 15- to 17-year-olds.

Non-Hispanic Black children were most likely to visit the ER/ED in 2004 (24.2 percent), followed by non-Hispanic White children (20.1 percent), and Hispanic children (19.5 percent). Non-Hispanic children of other races (including Asian/Pacific Islanders, American Indian/Alaska Natives, and children of multiple races) had the lowest percentage of children with at least one ER/ED visit (18.0 percent; data not shown).

Visits to the Emergency Room/Emergency Department Among Children Under Age 18, by Poverty Level,* 2005

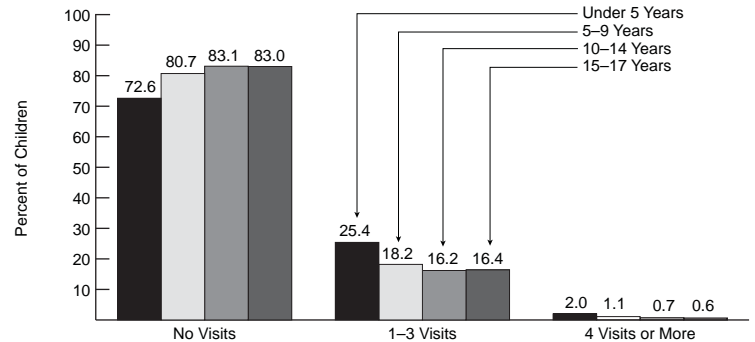
Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The U.S. Census Bureau poverty threshold for a family of four was \$19,971 in 2005.

Visits to the Emergency Room/Emergency Department Among Children Under Age 18, by Age, 2005

Source (III.5): 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 2005, 83.9 percent of women in 37 States, Washington DC, and New York City received prenatal care during the first trimester of pregnancy.

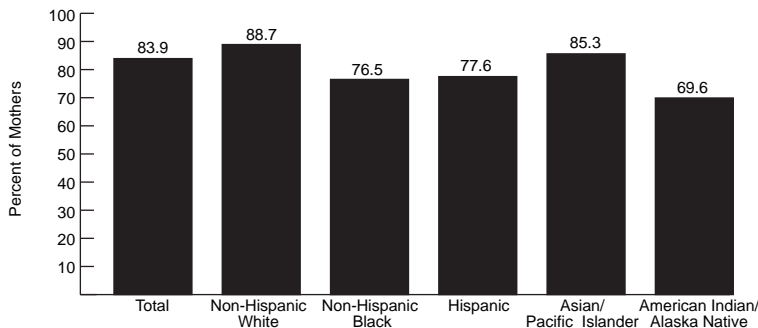
The increase in prenatal care utilization over the past 15 years has been especially remarkable among racial and ethnic groups with historically low rates of prenatal care. The proportion of non-Hispanic Black, Hispanic, and American Indian/Alaska Native women receiving early prenatal care increased by 20 percent or more since 1990; however, disparities still exist. In 2005, non-Hispanic White women had the highest rates of early prenatal care utilization (88.7 percent), followed by Asian/Pacific Islander women (85.3 percent), Hispanic women (77.6 percent), and non-Hispanic Black women (76.5 percent);

American Indian/Alaska Native women had the lowest rate (69.6 percent).

Late or No Prenatal Care. The percentage of women beginning prenatal care in the third trimester or going without prenatal care remained steady in 2005 at 3.5 percent. American Indian/Alaska Natives, Hispanic and non-Hispanic Black women were 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, 2005*

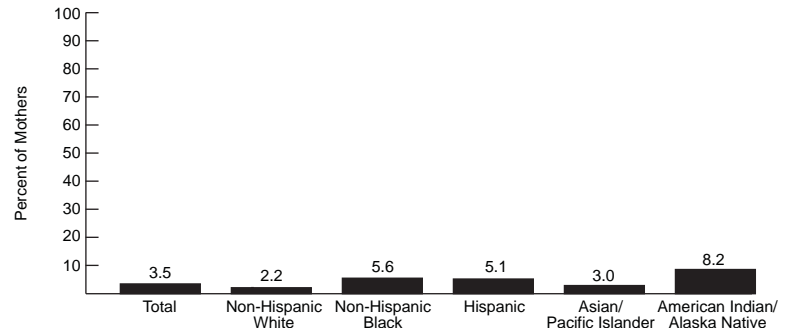
Source (I.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*2005 data include 37 States, Washington DC, and New York City.

Mothers Receiving Late or No Prenatal Care, by Race/Ethnicity, 2005*

Source (I.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*2005 data include 37 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, preterm birth, health care financing, Medicaid enrollment and expenditures, and SCHIP enrollment.

The following pages reveal important disparities in these measures across States. For instance, the proportion of infants born at low birth weight (less than 2,500 grams or 5 pounds 8 ounces) was highest in the District of Columbia and several southern States, including Alabama, Louisiana, Mississippi, and South Carolina. With the exception of Alabama, births to unmarried women were also highest in these states, as well as in Delaware and New Mexico.

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 2006

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

State	Type of SCHIP Program	Date Implemented	Upper Eligibility	Total SCHIP Enrollment	State	Type of SCHIP Program	Date Implemented	Upper Eligibility	Total SCHIP Enrollment
Alabama	Separate	02/01/98	200%	84,257	Montana	Separate	01/01/99	150%	17,304
Alaska	Medicaid	03/01/99	175%	22,227	Nebraska	Medicaid	05/01/98	185%	44,981
Arizona	Separate	11/01/98	200%	96,669	Nevada	Separate	10/01/98	200%	39,317
Arkansas	Combo	10/01/98	200%	3,440	New Hampshire	Combo	05/01/98	300%	12,393
California	Combo	03/01/98	250%	1,391,405	New Jersey	Combo	03/01/98	350%	120,884
Colorado	Separate	04/22/98	200%	69,997	New Mexico	Medicaid	03/31/99	235%	25,155
Connecticut	Separate	07/01/98	300%	23,110	New York	Separate	04/15/98	250%	688,362
Delaware	Combo	02/01/99	200%	10,751	North Carolina	Combo	10/01/98	200%	247,991
District of Columbia	Medicaid	10/01/98	200%	6,332	North Dakota	Combo	10/01/98	140%	6,318
Florida	Combo	04/01/98	200%	303,595	Ohio	Medicaid	01/01/98	200%	218,529
Georgia	Separate	11/01/98	235%	343,690	Oklahoma	Medicaid	12/01/97	185%	116,012
Hawaii	Medicaid	07/01/00	300%	22,031	Oregon	Separate	07/01/98	185%	59,039
Idaho	Combo	10/01/97	185%	24,727	Pennsylvania	Separate	05/28/98	200%	188,765
Illinois	Combo	01/05/98	200%	316,781	Rhode Island	Combo	10/01/97	250%	25,492
Indiana	Combo	10/01/97	200%	133,696	South Carolina	Medicaid	10/01/97	185%	68,870
Iowa	Combo	07/01/98	200%	49,575	South Dakota	Combo	07/01/98	200%	14,584
Kansas	Separate	01/01/99	200%	48,934	Tennessee*		10/01/97		
Kentucky	Combo	07/01/98	200%	64,861	Texas	Separate	07/01/98	200%	585,461
Louisiana	Medicaid	11/01/98	200%	142,389	Utah	Separate	08/03/98	200%	51,967
Maine	Combo	07/01/98	200%	31,114	Vermont	Separate	10/01/98	300%	6,314
Maryland	Combo	07/01/98	300%	136,034	Virginia	Combo	10/22/98	200%	137,182
Massachusetts	Combo	10/01/97	300%	190,640	Washington	Separate	02/01/00	250%	15,000
Michigan	Combo	05/01/98	200%	118,501	West Virginia	Separate	07/01/98	220%	39,855
Minnesota	Combo	10/01/98	280%	5,343	Wisconsin	Medicaid	04/01/99	185%	56,627
Mississippi	Separate	07/01/98	200%	83,359	Wyoming	Separate	12/01/99	200%	7,715
Missouri	Medicaid	09/01/98	300%	106,577					

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

Medicaid Enrollees, Expenditures, and Reported EPSDT Utilization for Children Under 21, FY 2004

Source (IV.2, IV.3): Centers for Medicare and Medicaid Services

State	Medicaid Enrollees*	Per Enrollee Expenditure**	Participation Ratio***	State	Medicaid Enrollees*	Per Enrollee Expenditure**	Participation Ratio***
Alabama	491,853	\$1,880.18	47%	Montana	65,113	\$2,536.63	54%
Alaska	88,347	\$4,493.54	51%	Nebraska	157,025	\$2,201.22	52%
Arizona	670,534	\$2,279.82	61%	Nevada	150,620	\$1,617.51	38%
Arkansas	379,001	\$2,130.60	25%	New Hampshire	NR	\$2,483.13	NR
California	6,071,277	\$1,352.43	39%	New Jersey	534,765	\$2,223.72	54%
Colorado	303,090	\$1,953.42	48%	New Mexico	329,214	\$2,415.37	49%
Connecticut	274,773	\$2,134.73	61%	New York	2,113,319	\$2,708.01	94%
Delaware	79,449	\$2,706.08	32%	North Carolina	858,750	\$2,348.96	72%
District of Columbia	90,822	\$3,493.72	73%	North Dakota	43,893	\$2,144.94	41%
Florida	1,626,835	\$1,877.67	56%	Ohio	1,154,022	\$2,005.30	47%
Georgia	1,109,058	\$1,821.56	50%	Oklahoma	NR	\$1,672.24	NR
Hawaii	121,477	\$1,842.34	67%	Oregon	273,778	\$1,971.84	55%
Idaho****	145,333	\$2,061.55	33%	Pennsylvania****	941,719	\$2,603.95	57%
Illinois****	1,146,996	\$1,487.99	73%	Rhode Island	112,508	\$4,034.41	54%
Indiana	593,195	\$1,828.82	54%	South Carolina	640,690	\$1,818.43	33%
Iowa	228,738	\$2,391.59	100%	South Dakota	83,268	\$2,282.76	43%
Kansas	212,357	\$2,434.86	87%	Tennessee	775,232	\$1,864.99	47%
Kentucky	318,008	\$2,537.93	44%	Texas	2,712,573	\$1,876.39	62%
Louisiana	733,403	\$1,537.94	64%	Utah	172,342	\$1,986.96	49%
Maine	NR	\$5,275.23	NR	Vermont	73,351	\$2,993.23	84%
Maryland	493,167	\$2,606.13	54%	Virginia	494,199	\$1,785.67	56%
Massachusetts	480,203	\$3,459.01	74%	Washington	661,357	\$1,515.80	55%
Michigan	1,006,133	\$1,837.88	42%	West Virginia****	216,516	\$1,916.62	50%
Minnesota	400,984	\$3,138.35	100%	Wisconsin	467,934	\$1,585.51	65%
Mississippi	460,033	\$1,600.98	32%	Wyoming	52,770	\$2,124.46	36%
Missouri	684,632	\$1,734.64	63%				

* Unduplicated number of individuals under age 21 determined to be eligible for EPSDT services (FY 2004 416 Report).

** Represents total Medicaid vendor payments divided by Medicaid eligibles under 21 (FY 2004 MSIS Report).

***The ratio of Medicaid eligibles receiving any initial and periodic screening services to the number of eligibles who should have received such services.

****Enrollee and Participation Ratio data are based on FY 2003 data.

NR = Not reported.

Health Insurance Status of Children Through Age 18, 2005*

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

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Public Insurance**	Percent Uninsured***	State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Public Insurance**	Percent Uninsured***
Alabama	64.1%	38.2%	4.6%	Montana	56.6%	24.5%	14.0%
Alaska	56.8%	44.6%	8.5%	Nebraska	70.4%	27.7%	5.4%
Arizona	52.5%	30.9%	17.3%	Nevada	69.2%	17.5%	14.9%
Arkansas	55.4%	39.9%	11.6%	New Hampshire	77.5%	16.8%	5.5%
California	53.0%	31.0%	13.9%	New Jersey	72.1%	17.2%	10.9%
Colorado	65.2%	20.2%	13.6%	New Mexico	48.4%	38.6%	20.5%
Connecticut	71.3%	19.7%	8.0%	New York	61.4%	32.7%	8.2%
Delaware	65.8%	26.8%	11.9%	North Carolina	57.1%	30.5%	12.4%
District of Columbia	45.7%	48.4%	6.7%	North Dakota	67.0%	23.9%	9.0%
Florida	54.6%	27.1%	18.5%	Ohio	67.0%	25.9%	8.1%
Georgia	54.3%	36.2%	11.5%	Oklahoma	53.6%	39.5%	11.0%
Hawaii	68.0%	34.4%	5.7%	Oregon	59.3%	27.8%	10.5%
Idaho	60.4%	24.3%	11.7%	Pennsylvania	68.3%	26.8%	7.3%
Illinois	67.2%	23.1%	10.3%	Rhode Island	64.6%	31.9%	7.8%
Indiana	63.3%	27.8%	10.2%	South Carolina	57.1%	34.5%	10.5%
Iowa	71.3%	24.6%	5.4%	South Dakota	59.9%	28.8%	9.0%
Kansas	65.9%	27.6%	6.1%	Tennessee	60.2%	33.7%	9.2%
Kentucky	62.4%	34.3%	7.3%	Texas	50.4%	31.6%	19.0%
Louisiana	58.4%	32.3%	9.0%	Utah	64.6%	23.4%	12.7%
Maine	59.3%	36.3%	8.0%	Vermont	59.0%	42.6%	6.2%
Maryland	68.5%	26.0%	8.2%	Virginia	68.9%	27.5%	8.7%
Massachusetts	71.7%	23.5%	4.4%	Washington	62.9%	30.9%	9.0%
Michigan	70.3%	27.3%	5.3%	West Virginia	61.2%	38.9%	7.8%
Minnesota	73.6%	17.2%	6.3%	Wisconsin	70.5%	24.4%	7.1%
Mississippi	48.3%	43.1%	12.3%	Wyoming	59.8%	29.5%	10.9%
Missouri	60.3%	29.8%	8.3%				

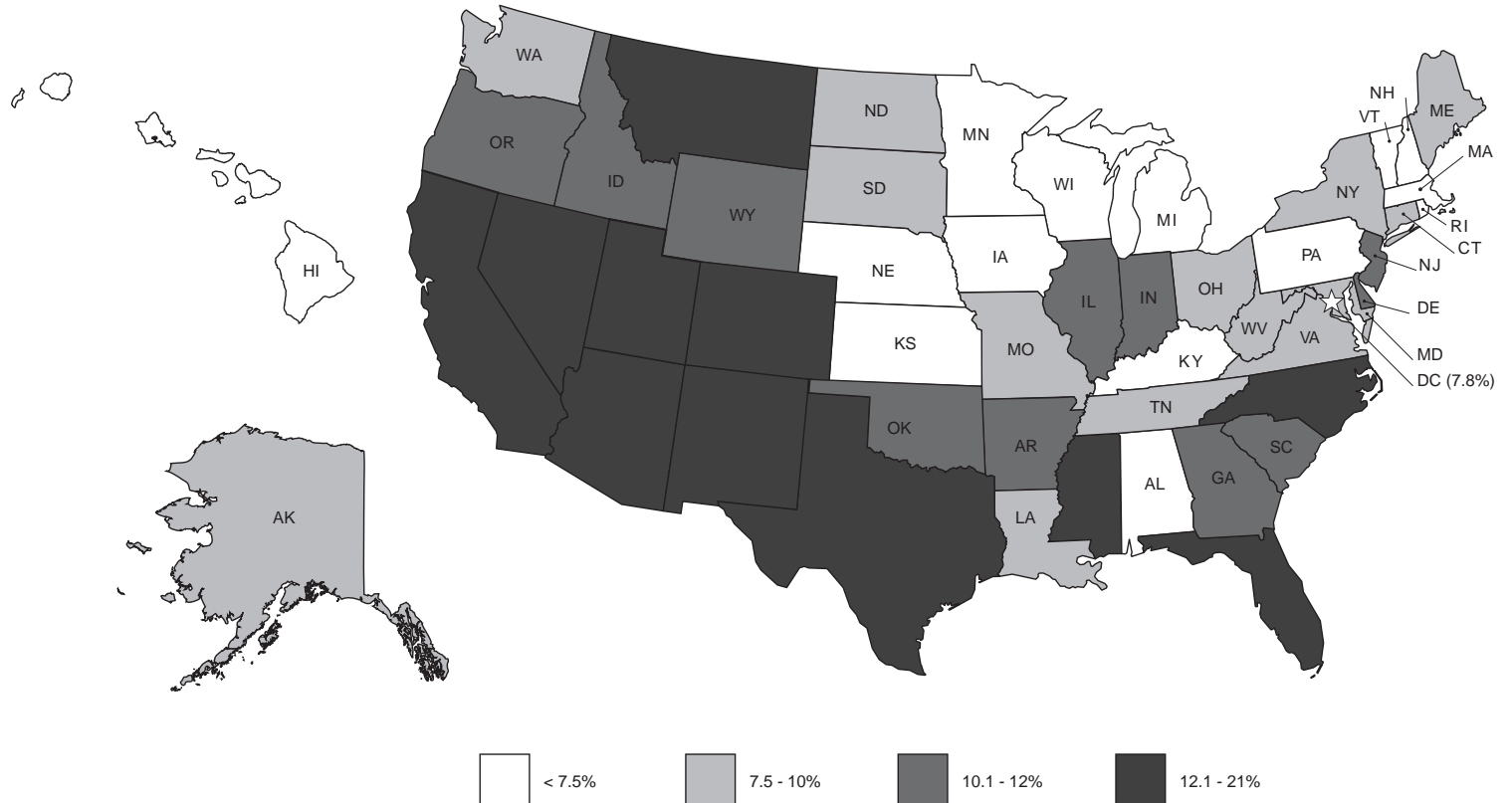
*Data reflect changes made to 2005 Current Population Survey estimates which were released on April 17th, 2007.

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

*** See map on facing page.

Percent of Children Through Age 18 Who Are Uninsured, by State, 2005

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



Percent of Infants Born at Low Birth Weight, Preterm Births, and Births to Unmarried Women, by State and Race of Mother, 2005

Source (I.6): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

State	Low Birth Weight			Preterm Birth			Births to Unmarried Women				State	Low Birth Weight			Preterm Birth			Births to Unmarried Women			
	Total*	Non-Hispanic White	Black	Total*	Non-Hispanic White	Black	Total*	White	Black	Hispanic		Total*	Non-Hispanic White	Black	Total*	White	Black	Total*	White	Black	Hispanic
United States	8.2	7.3	14.0	12.7	11.7	18.4	36.9	25.3	69.9	48.0	Missouri	8.1	7.0	14.3	13.3	12.1	19.9	37.8	30.2	76.9	48.5
Alabama	10.7	8.8	15.5	16.7	14.6	21.9	35.7	20.9	70.4	21.5	Montana	6.6	6.3	N/A	11.4	10.9	N/A	34.6	28.0	43.1	43.7
Alaska	6.1	5.7	15.5	10.6	9.5	16.8	36.0	23.4	51.9	37.7	Nebraska	7.0	6.5	13.1	12.2	11.6	17.1	30.9	24.3	69.7	47.1
Arizona	6.9	6.9	13.0	13.2	12.1	20.2	43.1	26.5	61.0	54.4	Nevada	8.3	7.8	14.8	13.9	13.1	20.8	40.9	30.0	69.5	49.1
Arkansas	8.9	7.7	14.5	13.4	12.3	18.1	40.2	29.9	77.1	44.6	New Hampshire	7.0	6.8	11.3	10.5	10.2	20.9	27.3	27.1	37.4	46.9
California	6.9	6.5	12.6	10.7	10.0	15.5	35.7	21.3	64.0	45.8	New Jersey	8.2	7.1	13.4	12.5	11.1	17.4	31.4	14.5	66.3	55.8
Colorado	9.2	8.9	15.3	12.3	11.7	16.5	27.1	18.3	52.6	41.2	New Mexico	8.5	8.8	14.4	13.1	12.7	17.5	50.8	30.4	57.9	56.6
Connecticut	8.0	6.8	13.5	10.4	9.6	15.2	32.2	18.6	67.4	62.6	New York	8.3	7.0	13.2	12.1	10.5	17.2	38.7	21.3	67.8	62.9
Delaware	9.5	7.7	14.9	14.0	12.4	18.4	44.3	30.3	70.6	62.0	North Carolina	9.2	7.9	14.6	13.7	12.2	18.8	38.4	23.0	69.1	51.9
DC	11.2	7.1	14.1	15.9	9.4	19.5	56.0	5.9	77.2	67.5	North Dakota	6.4	6.3	N/A	11.5	10.9	N/A	32.2	25.4	25.4	35.2
Florida	8.7	7.6	13.6	13.8	12.2	18.5	42.8	31.5	68.4	45.2	Ohio	8.7	7.8	13.9	13.0	12.1	18.0	38.9	31.3	76.2	56.1
Georgia	9.5	7.5	14.4	13.6	12.1	18.0	40.6	23.5	67.2	46.9	Oklahoma	8.0	7.5	14.2	13.1	12.7	18.1	39.1	31.3	73.4	46.2
Hawaii	8.2	6.6	10.8	12.2	9.8	12.0	36.3	24.6	27.1	47.4	Oregon	6.1	6.0	11.4	10.2	10.0	13.6	33.3	29.5	64.7	45.7
Idaho	6.7	6.7	N/A	11.4	11.2	N/A	22.9	19.5	26.7	37.9	Pennsylvania	8.4	7.3	13.5	11.9	10.8	16.7	36.5	27.1	76.2	61.3
Illinois	8.5	7.3	15.1	13.1	11.8	19.6	37.1	22.5	78.1	46.7	Rhode Island	7.8	7.1	10.3	12.1	11.0	14.0	38.5	28.3	66.5	60.7
Indiana	8.3	7.8	13.4	13.5	12.8	18.5	40.2	33.6	77.8	54.4	South Carolina	10.2	7.8	15.3	15.6	13.3	20.4	43.3	26.3	74.1	44.7
Iowa	7.2	7.0	12.5	11.8	11.6	17.6	32.5	29.4	73.1	47.5	South Dakota	6.6	6.6	N/A	11.5	10.9	N/A	36.2	26.2	38.5	49.5
Kansas	7.2	6.9	13.7	12.2	11.9	16.9	34.2	28.0	72.4	48.8	Tennessee	9.5	8.4	14.9	14.7	13.7	19.8	40.2	29.3	75.0	50.4
Kentucky	9.1	8.8	13.5	15.2	14.8	19.8	35.5	31.2	74.3	49.5	Texas	8.3	7.7	14.2	13.6	12.8	18.8	37.6	24.3	64.7	43.2
Louisiana	11.5	8.7	16.0	16.5	13.3	21.4	48.0	29.0	76.7	37.5	Utah	6.8	6.6	10.6	11.4	11.0	17.0	17.7	12.6	44.4	40.2
Maine	6.8	6.8	9.0	10.7	10.7	11.7	35.0	35.0	35.5	43.1	Vermont	6.2	6.2	N/A	9.0	9.0	N/A	32.3	32.4	40.8	34.7
Maryland	9.1	7.1	13.1	13.3	11.3	17.0	37.1	22.3	60.0	51.2	Virginia	8.2	7.2	12.7	12.3	11.2	16.7	32.2	20.6	63.7	47.1
Massachusetts	7.9	7.3	11.9	11.3	10.7	15.8	30.2	21.8	58.4	63.8	Washington	6.1	5.6	9.8	10.6	9.9	13.5	30.9	25.9	52.9	46.0
Michigan	8.3	7.0	14.7	12.5	11.1	19.4	36.6	27.1	75.7	46.5	West Virginia	9.6	9.4	13.1	14.4	14.3	19.6	36.5	35.2	75.4	43.7
Minnesota	6.5	6.0	11.3	10.7	10.4	13.2	29.8	23.1	59.4	50.9	Wisconsin	7.0	6.3	13.6	11.4	10.6	17.9	32.5	24.5	82.2	48.9
Mississippi	11.8	8.7	16.1	18.8	15.6	23.1	49.4	26.2	77.1	50.4	Wyoming	8.6	8.8	N/A	13.1	13.1	N/A	32.8	28.6	61.5	48.3

N/A: Figure does not meet standards of reliability or precision or no data is available.
*Includes races other than White and Black.

Infant and Neonatal Mortality Rates (Deaths per 1,000 Live Births), by State and Race of Mother, 2005

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

State	Infant Mortality			Neonatal Mortality			State	Infant Mortality			Neonatal Mortality		
	Total*	White**	Black**	Total*	White	Black		Total*	White**	Black**	Total*	White	Black
United States	6.87	5.73	13.73	4.54	3.79	9.07	Missouri	7.50	6.36	14.63	4.72	4.00	9.33
Alabama	9.40	7.18	14.67	5.74	4.58	8.55	Montana	6.99	6.66	N/A	4.14	4.14	N/A
Alaska	5.93	4.74	N/A	2.96	N/A	N/A	Nebraska	5.62	5.17	N/A	3.29	3.06	N/A
Arizona	6.88	6.60	12.62	4.50	4.52	5.76	Nevada	5.77	5.22	13.67	3.49	3.26	7.46
Arkansas	7.88	6.36	14.85	4.79	3.70	9.63	New Hampshire	5.27	5.01	N/A	4.30	4.13	N/A
California	5.34	5.01	13.64	3.63	3.47	8.34	New Jersey	5.23	4.02	11.01	3.47	2.77	6.95
Colorado	6.44	6.03	16.33	4.77	4.52	12.17	New Mexico	6.14	5.56	N/A	3.64	3.65	N/A
Connecticut	5.82	4.91	13.45	4.19	3.80	8.14	New York	5.81	5.03	9.33	4.03	3.59	5.96
Delaware	9.02	5.98	18.89	6.70	4.52	13.74	North Carolina	8.80	6.52	16.35	6.13	4.32	11.99
District of Columbia	14.05	8.75	16.95	9.91	N/A	11.92	North Dakota	5.96	5.84	N/A	4.29	4.03	N/A
Florida	7.20	5.67	12.02	4.53	3.52	7.72	Ohio	8.26	6.71	16.92	5.58	4.47	11.77
Georgia	8.15	5.90	12.60	5.41	3.68	8.82	Oklahoma	8.05	7.27	15.35	4.79	4.35	9.75
Hawaii	6.47	6.26	N/A	4.18	3.91	N/A	Oregon	5.86	5.85	N/A	3.79	3.80	N/A
Idaho	6.11	6.06	N/A	4.03	3.98	N/A	Pennsylvania	7.30	6.18	14.12	5.17	4.41	9.74
Illinois	7.42	5.70	16.35	4.98	3.87	10.75	Rhode Island	6.46	5.79	N/A	5.04	4.67	N/A
Indiana	8.01	6.95	17.01	5.46	4.61	12.45	South Carolina	9.41	7.12	13.80	5.82	4.38	8.59
Iowa	5.34	5.05	13.93	3.46	3.22	N/A	South Dakota	7.24	6.04	N/A	4.54	4.53	N/A
Kansas	7.37	6.64	17.59	4.89	4.44	10.55	Tennessee	8.86	7.41	13.96	5.65	4.32	10.28
Kentucky	6.64	6.01	13.15	4.00	3.67	7.66	Texas	6.57	5.72	14.07	4.13	3.61	8.83
Louisiana	10.06	7.04	14.87	5.76	4.10	8.37	Utah	4.46	4.39	N/A	3.01	2.96	N/A
Maine	6.87	6.88	N/A	4.82	4.74	N/A	Vermont	6.67	6.39	N/A	4.13	3.94	N/A
Maryland	7.30	5.06	11.61	5.25	3.49	8.56	Virginia	7.47	5.80	14.10	5.14	4.01	9.56
Massachusetts	5.15	4.84	8.18	3.72	3.51	6.14	Washington	5.09	4.81	10.87	3.07	2.90	6.15
Michigan	7.92	5.80	18.26	5.47	3.89	13.06	West Virginia	8.11	7.93	N/A	5.09	5.07	N/A
Minnesota	5.10	4.52	10.58	3.26	2.86	7.54	Wisconsin	6.61	5.44	17.66	4.48	3.77	11.48
Mississippi	11.35	6.64	17.20	6.70	3.08	11.20	Wyoming	6.77	6.94	N/A	4.70	4.73	N/A

N/A: Figure does not meet standards of reliability or precision.

*Includes races other than White or Black.

**Includes Hispanics.

City Data

The following section presents data on the health of infants living in cities compared to that of infants nationwide. Included are data on low and very low birth weight for infants that were born in U.S. cities with over 100,000 residents and infant mortality for infants born in cities with more than 250,000 residents.

The following measures indicate that the health status of infants living in large U.S. cities is generally poorer than that of infants in the Nation as a whole. In 2005, the percentage of infants born at low birth weight was 7 percent higher in cities compared to the national average (8.8 versus 8.2 percent). The infant mortality rate was also higher in cities, which may be at least partly attributable to the higher rate of low birth weight. In 2004, the city infant mortality rate was 7.4 per 1,000 live births, compared to a rate of 6.8 per 1,000 nationwide.



BIRTH WEIGHT

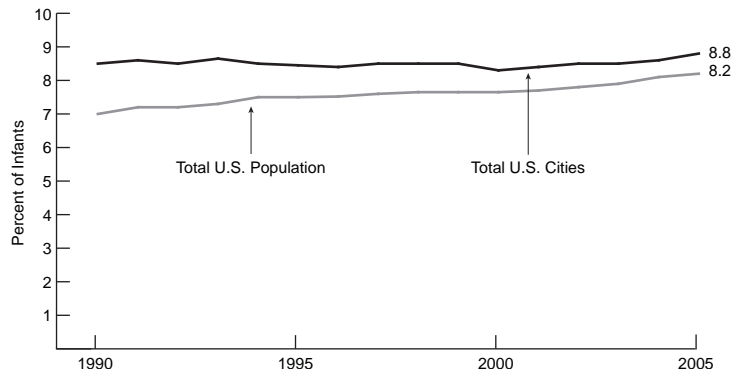
Low Birth Weight. Disorders related to short gestation and low birth weight are the second leading cause of neonatal mortality in the United States. In 2005, 118,980 babies born to residents of U.S. cities with populations over 100,000 were of low birth weight (weighing less than 2,500 grams, or 5 pounds 8 ounces); this represents 8.8 percent of infants in U.S. cities. The 2005 percentage of urban infants born at low birth weight was 7 percent higher than the percentage among

all U.S. infants (8.2 percent), though this gap has decreased somewhat since 1990.

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 2005, nearly 1.7 percent of live births in cities with populations over 100,000 were of very low birth weight. This exceeded the rate of very low birth weight nationwide by 12 percent.

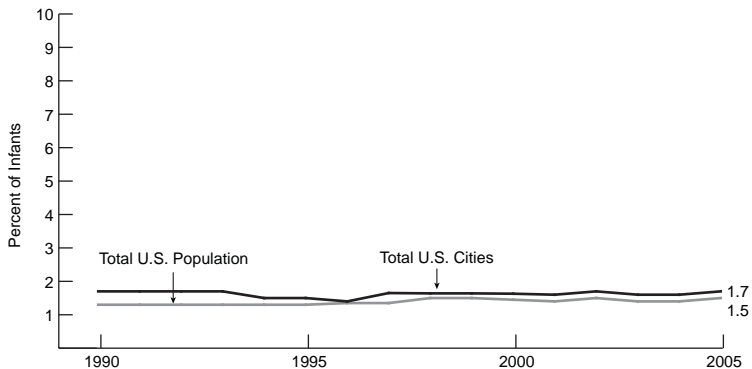
Infants Born at Low Birth Weight in U.S. Cities with Populations over 100,000: 1990–2005

Source (II.2): 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: 1990–2005

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

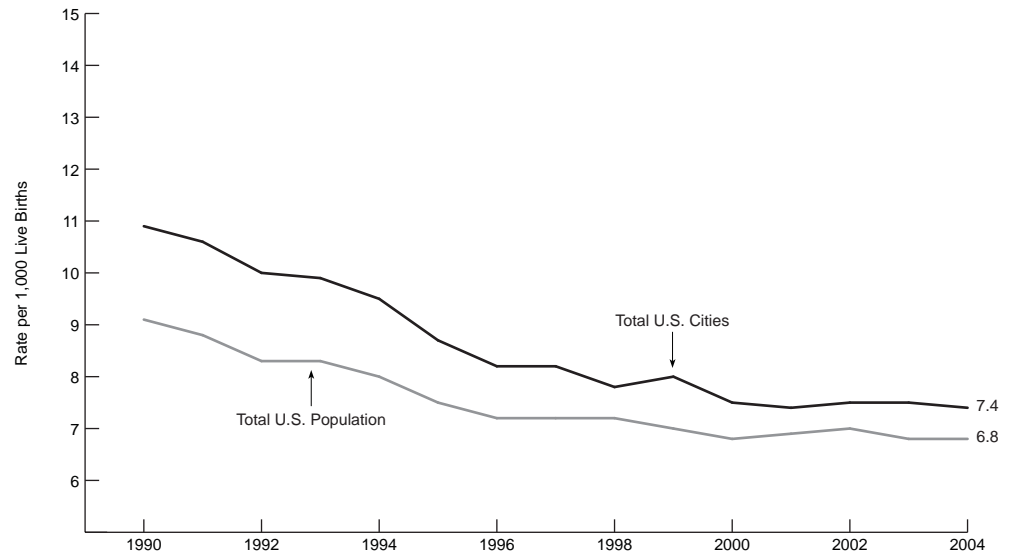


INFANT MORTALITY

In 2004, 6,482 infants born to residents of cities in the United States with populations over 250,000 died in the first year of life. The infant mortality rate in U.S. cities was 7.4 deaths per 1,000 live births, which was higher than the rate for the Nation as a whole (6.8 per 1,000). Although the infant mortality rate in cities has consistently been higher than the rate nationwide, it has declined over the past decade, and the disparity in infant mortality rates between infants in cities and the Nation as a whole has decreased by 50 percent. Between 1990 and 2004, the infant mortality rate in cities has declined by nearly one-third, while the nationwide decline during the same period was 25.3 percent. Declines in infant mortality rates since 2000, however, have been relatively small for both cities and the population as a whole.

Infant Mortality Rates in U.S. Cities:* 1990–2004

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 after 2002 reflect cities with populations over 250,000.

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Contributors

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