

Child Health USA 2007



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

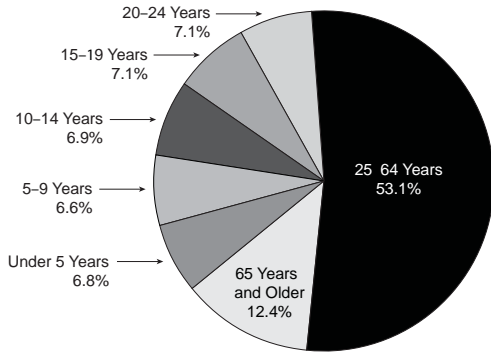
risen 6.4 percent, while the number of children aged 5–19 years has risen nearly 2 percent. The number of adults aged 65 years and older, however, has risen more than 8 percent in the same period.

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.

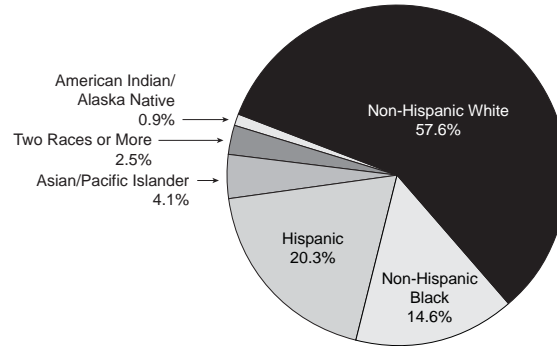
U.S. Resident Population, by Age Group, 2006

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).

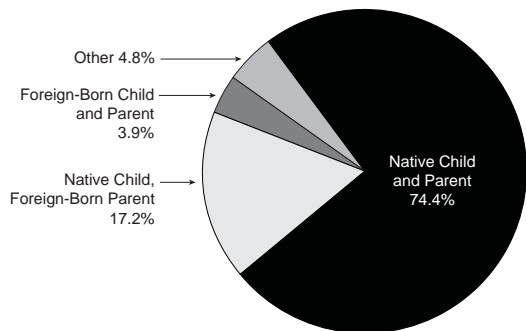
Children's poverty status varies with nativity. In 2006, foreign-born children of foreign-born parents were most likely to live in households with incomes below 100 percent of the poverty level (30.4 percent) and 100–199 percent of the poverty level (30.8 percent). Only 15.4 percent of native-born children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

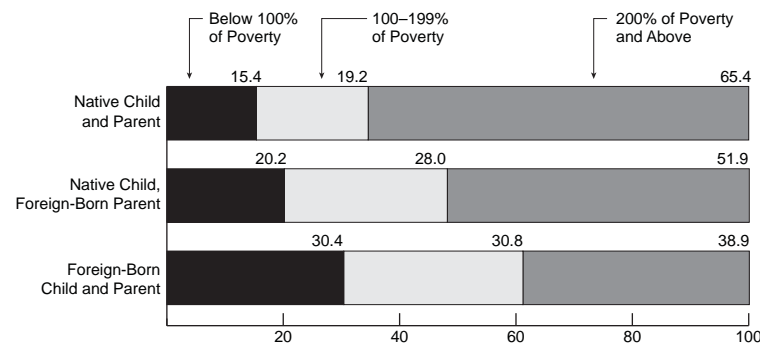
Source (1.2): U.S. Census Bureau, Current Population Survey



*"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).

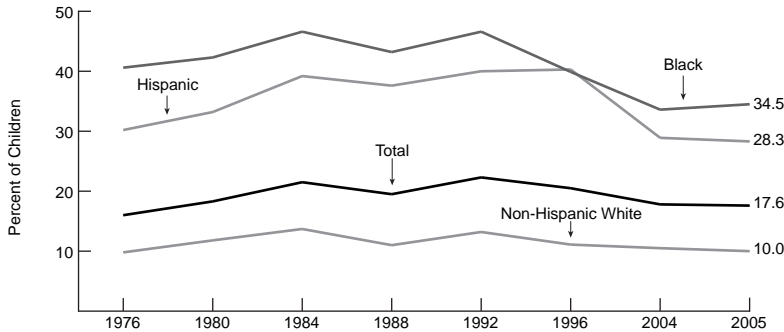
Children in single-parent families are particularly likely to be poor: of children under age 6 living with a single mother, 52.9 percent lived in poverty, which was more than five times the rate of their counterparts in married-couple families. Similarly, 42.8 percent of children under 18 living with 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

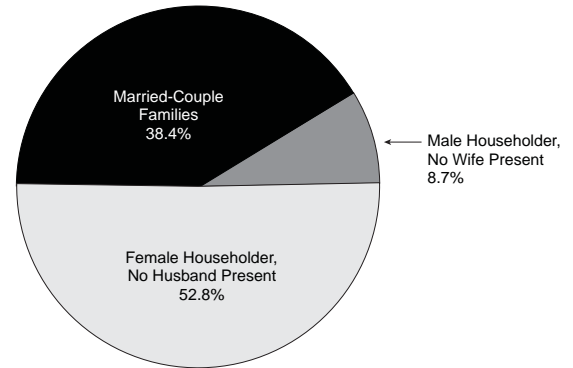
Source (I.3): U.S. Census Bureau, Current Population Survey



*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.

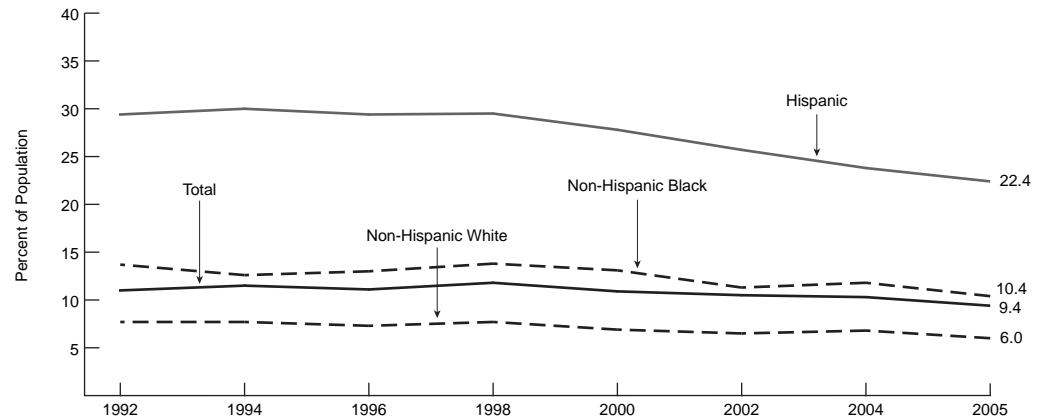
In addition, the National Center for Health Statistics indicates that those who did not complete high school reported worse health outcomes than their peers who did complete high school, as well as reduced access to medical care and higher rates of uninsurance.²

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 (L5): 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

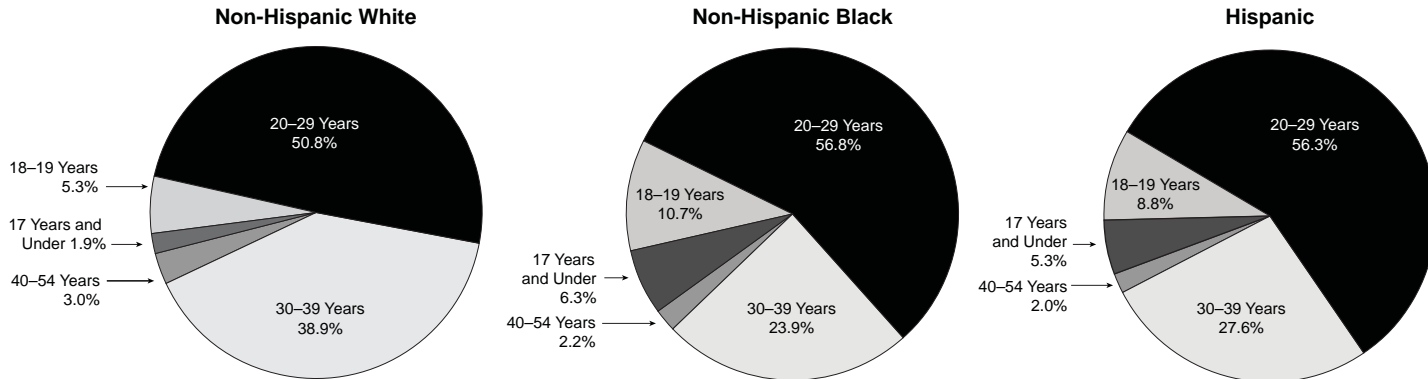
increase in birth rates among women aged 35–39 years and 40–44 years, since 2004, to 46.3 and 9.1 per 1,000, respectively (data not shown).

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

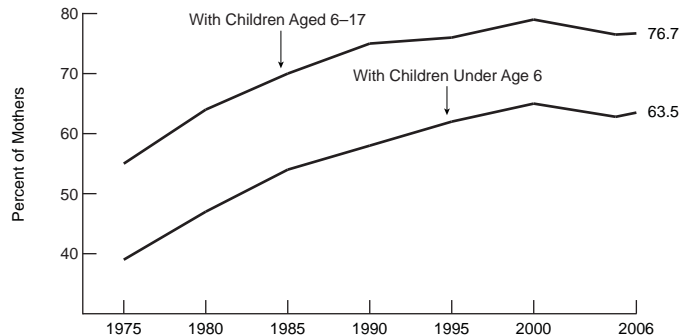
children to be employed full-time (77.8 versus 72.2 percent). Married mothers with a spouse present were less likely than never-married, divorced, separated, and widowed mothers to be in the labor force (68.6 versus 76.6 percent); however, married mothers in the labor force were more likely to be employed 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.

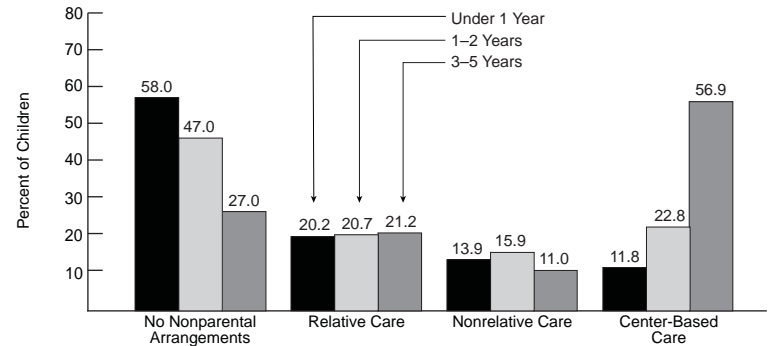
Mothers in the Labor Force, by Age of Child: 1975–2006

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.

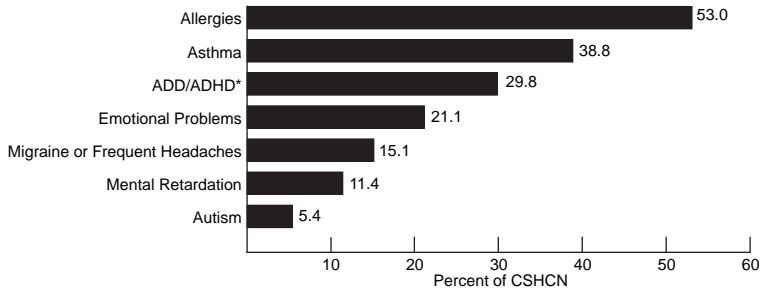
The survey asked parents of CSHCN whether their children had any of a list of 16 conditions (the list was not exhaustive and did not include all conditions that CSHCN might have). Overall, 91 percent of CSHCN were reported to have at least one condition on the list, and 57 percent had two or more conditions.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

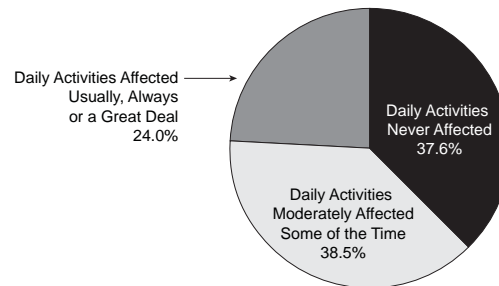
Source (I.9): Centers for Disease Control and Prevention, National Survey of Children with Special Health Care Needs



*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

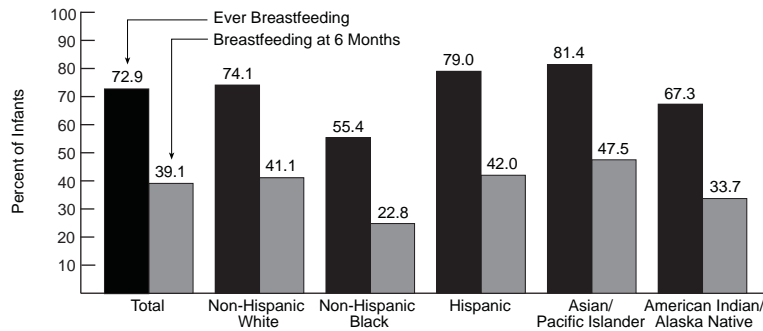
decades, but have increased steadily since the early 1990s. In 2005, 72.9 percent of infants were ever breastfed. Asian/Pacific Islander infants were most likely to be breastfed (81.4 percent), followed by Hispanic and non-Hispanic White infants (79.0 and 74.1 percent, respectively). Breastfeeding rates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

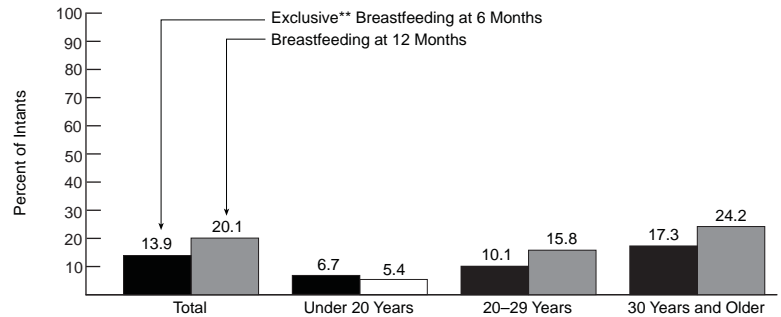
Source (II.1): Centers for Disease Control and Prevention, National Immunization Survey



*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.

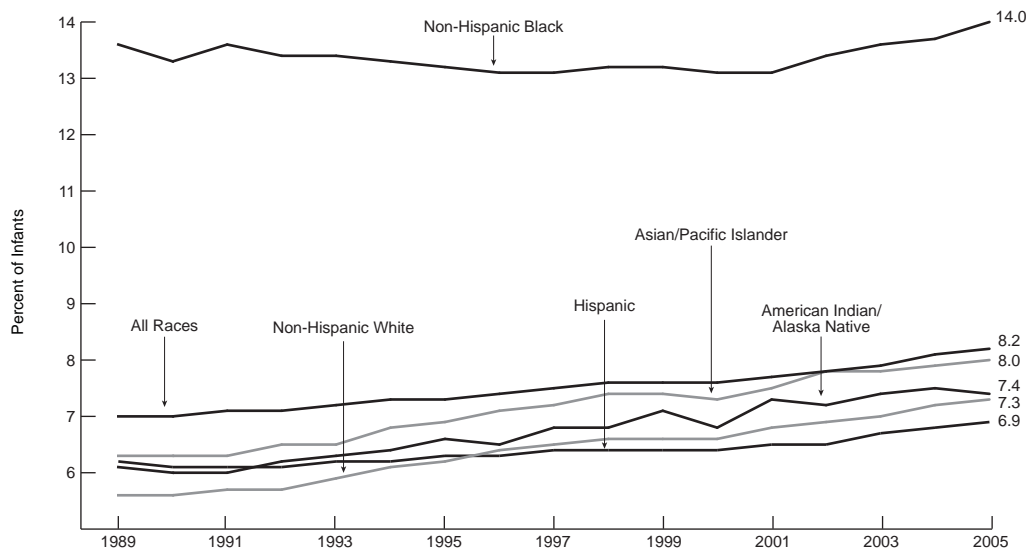
The increase in multiple births, which are at high risk of being born preterm and of low weight, has strongly influenced the increase in low birth weight; however, rates are also on the rise for singleton births.

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.

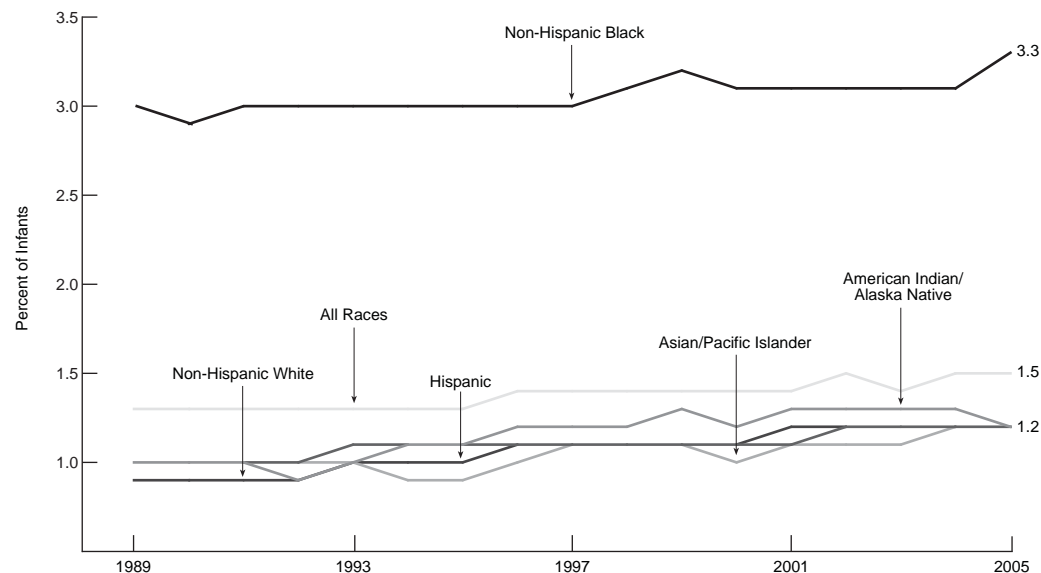
Because the chance of survival increases as birth weight increases, very low birth weight infants have the lowest survival rates. Infants born at such low birth weights are approximately 100 times more likely to die in the first year of life than are infants of normal birth weight. Very low birth weight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

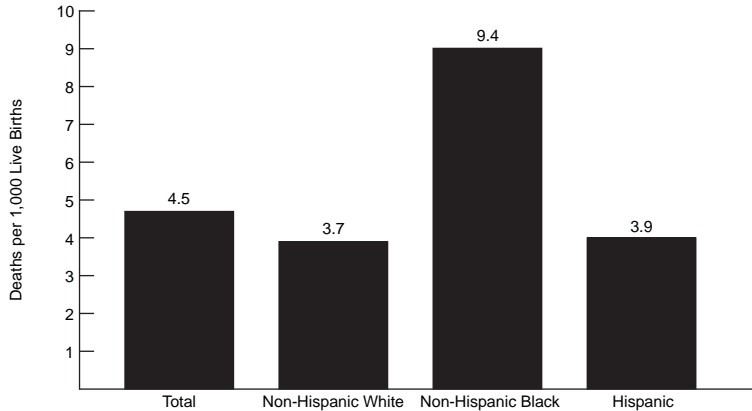
Postneonatal mortality is generally related to Sudden Infant Death Syndrome (SIDS), congenital malformations, and unintentional injuries.

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.

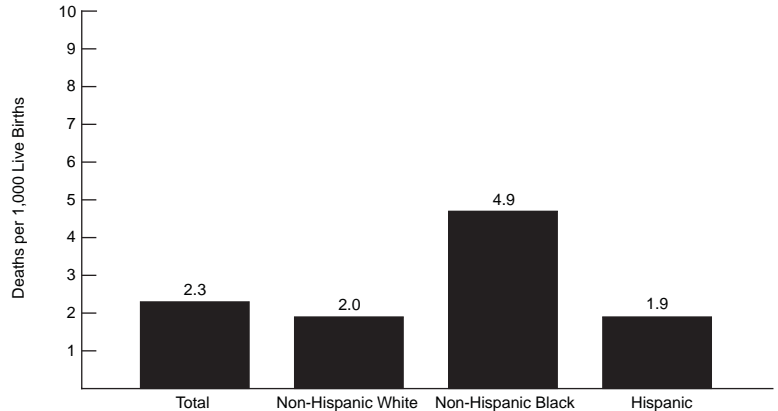
Neonatal Mortality Rates, by Maternal Race/Ethnicity, 2005

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

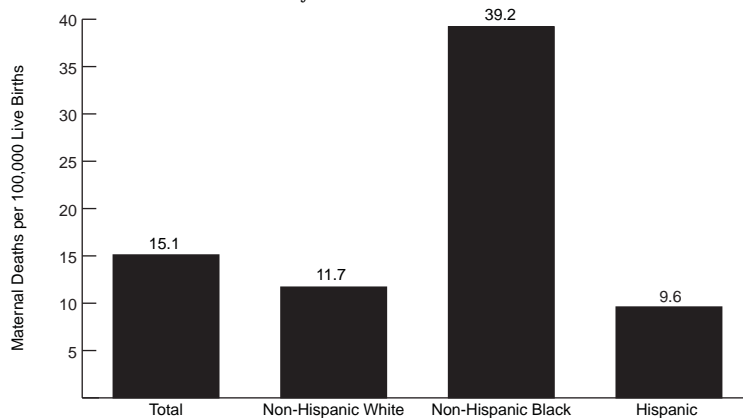
The rate of maternal mortality in the United States has declined dramatically since 1950; however, the maternal mortality rate in 2005 (15.1 per 100,000 live births) was nearly 70 percent higher than the rate reported in 2002 (8.9 per 100,000). According to the National Center for Health Statistics, 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).

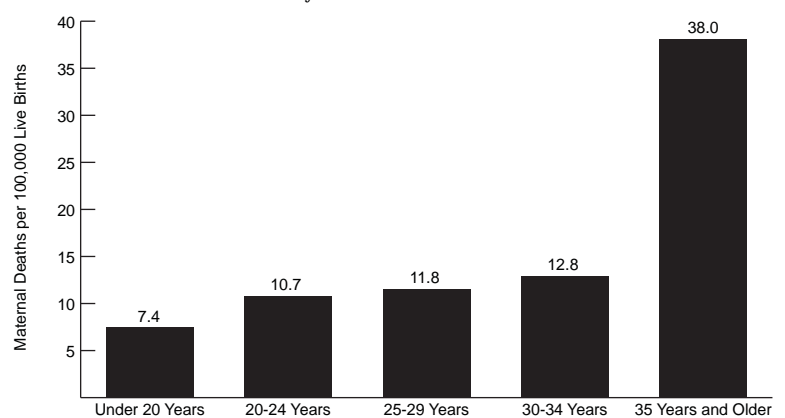
Maternal Mortality Rates, by Race/Ethnicity, 2005

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

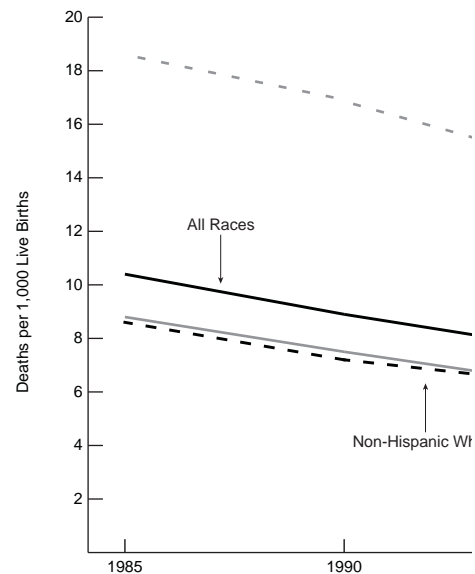
infants (5.7 and 5.8 per 1,000 live births, respectively). Although the trend in infant mortality rates among both non-Hispanic Blacks and non-Hispanic Whites has generally been one of decline throughout the last century, the proportional discrepancy in rates between the two races

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

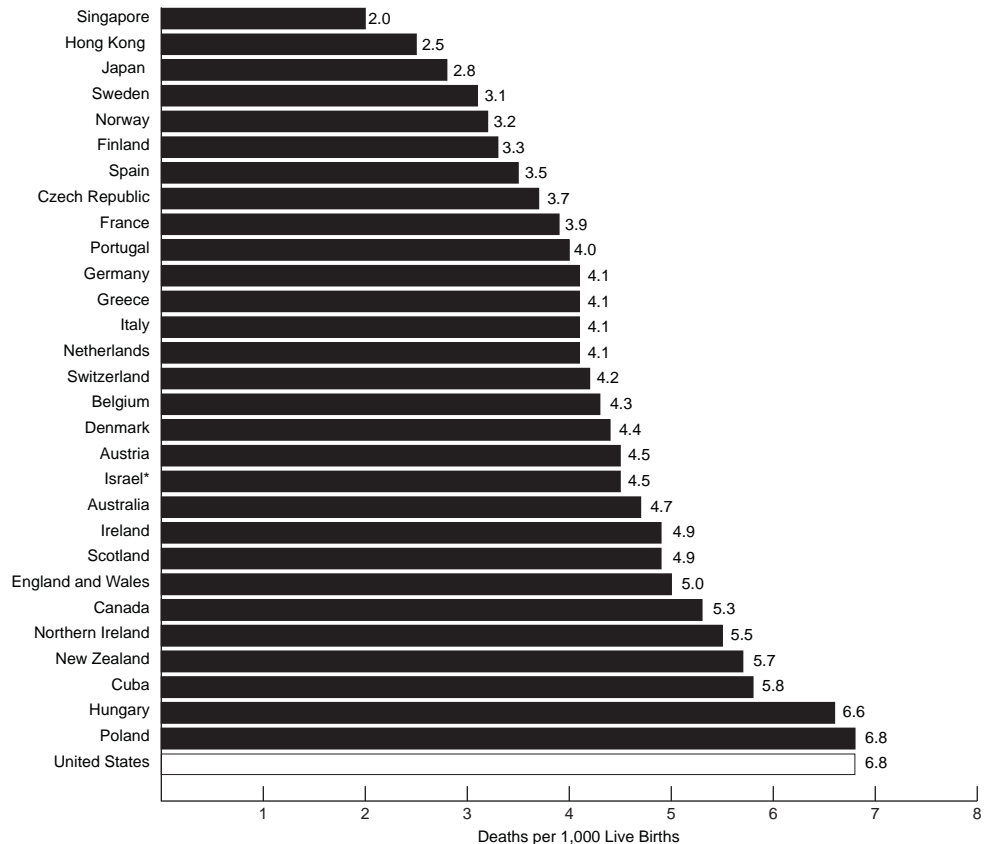
Although the infant mortality rate in the United States has declined significantly in recent decades, it was still ranked below that of many other industrialized nations in 2004 with a rate of 6.8 deaths per 1,000 live births. This represents a slight decline from the rate of 6.9 per 1,000 in 2003 and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

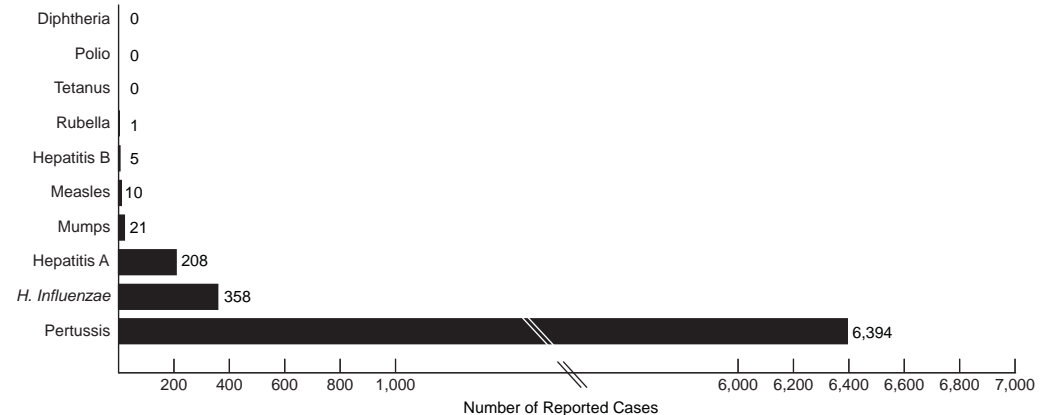
tion for children living in high-risk areas was recommended starting in 1996.

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.

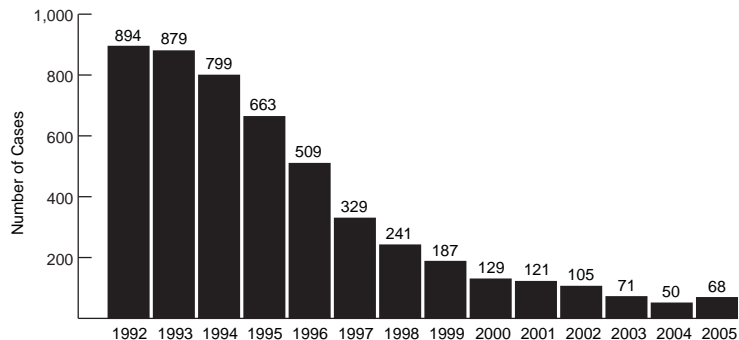
In 2005, an estimated 68 new AIDS cases were diagnosed among children under age 13, nearly all of which were attributed to transmission from the mother before or during birth (perinatal transmission), excluding one case in which the risk factor was not specified. The number of new cases of pediatric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

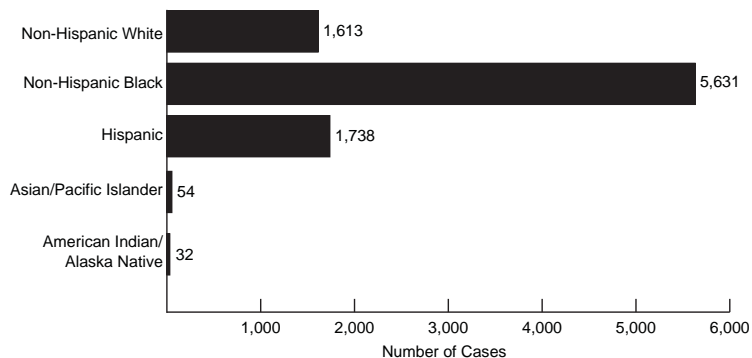
Estimated Numbers of AIDS Cases in Children Under Age 13, by Year of Diagnosis: 1992–2005

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.

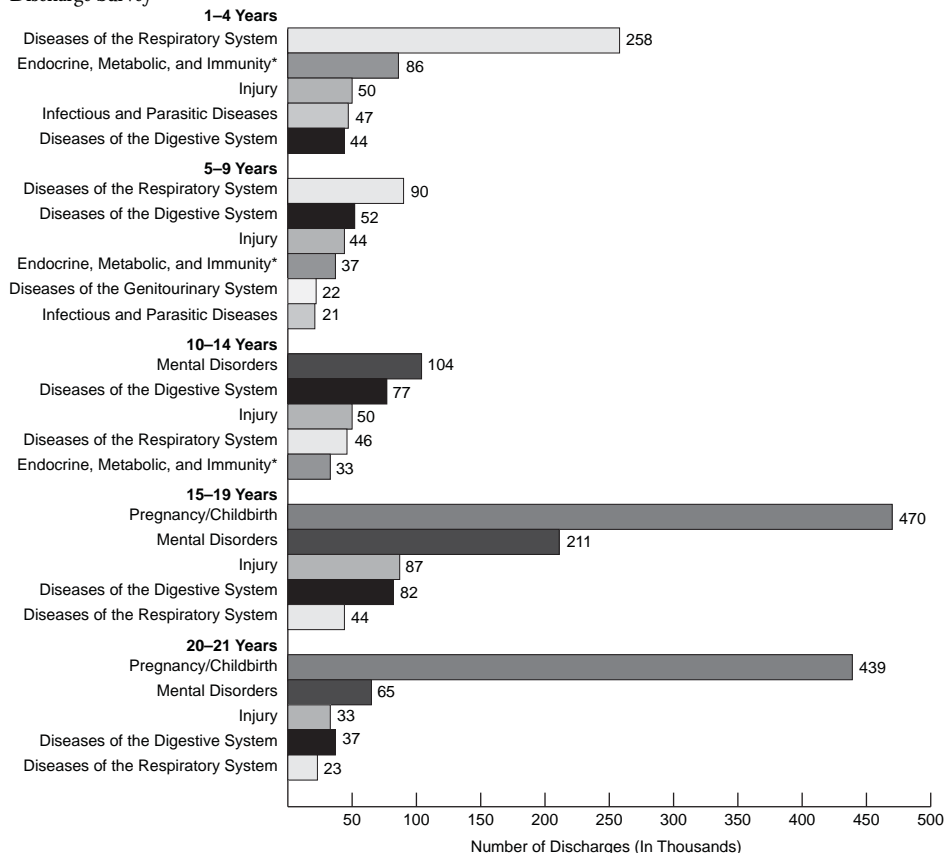
HOSPITALIZATION

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

