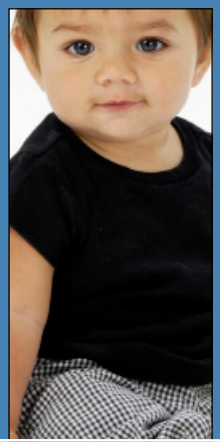
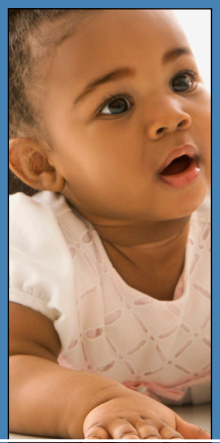
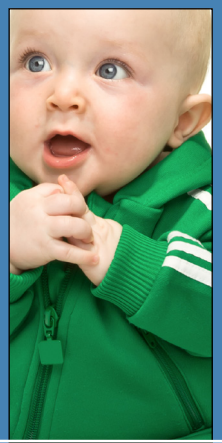
The *Youngest* Americans:

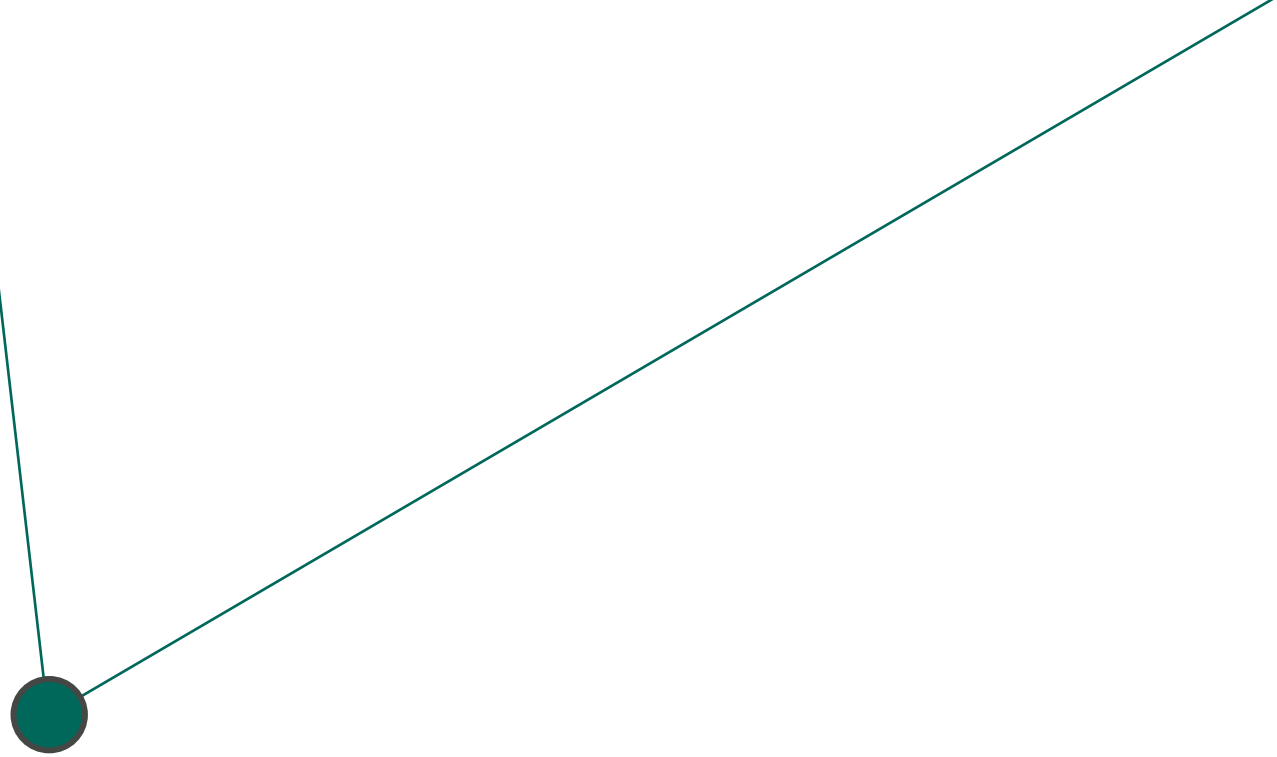
A Statistical Portrait of Infants and Toddlers in the United States




November 2013
by David Murphey, Mae Cooper, and Nicole Forry

ROBERT R. McCORMICK FOUNDATION
Child TRENDS



About Child Trends

Child Trends improves the lives and prospects of children and youth by conducting high-quality research and applying the resulting knowledge to public policies, programs, and systems. For additional information on Child Trends, including free, downloadable research briefs, visit our website at www.childtrends.org. For the latest information on more than 100 key indicators of child and youth well-being, visit the Child Trends DataBank at http://www.childtrends.org/databank/. For summaries of more than 565 experimental evaluations of social interventions for children, visit http://www.childtrends.org/what-works/.

Acknowledgements

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Contents

Key Findings

America's youngest children—12 million infants and toddlers—are the leading edge of a demographic transformation in the U.S. They herald a nation more diverse with respect to race/ethnicity, country of origin, language, and family type than at any time in our recent history. They are surrounded by, and engaged with, new technology. Most of our youngest Americans, according to their parents, have at least some of the important characteristics associated with optimal development.

At the same time, they are a generation characterized by marked inequities, with disturbing proportions facing severe disadvantage that imposes both immediate and lasting threats to well-being. Significant numbers are born into families without the human and financial resources to promote their development; disparities by race and Hispanic origin persist; public policy responses have been slow to materialize and, where they exist, often serve only a fraction of the children in need.

Economic Hardship

Many in this generation are starting out with severe economic hardship.

- **Nearly half** (48 percent) of America's infants and toddlers **live in low-income families** (incomes less than twice the poverty line); one-quarter (25 percent) live in families below the official poverty line.
- **One in eight** (13 percent) **is in deep poverty** (that is, their family's income is half or less than the poverty level).
- **Economic disadvantage is concentrated in the families of black and Latino infants and toddlers**; fully two-thirds (66 percent) of these young children are in low-income families.
- **Nearly one in four (24 percent) black and Latino infants and toddlers live in households that are "food-insecure"** (a measure of inability to obtain sufficient healthy food).

Multiple Inequities, Multiple Disadvantages

The deep inequities marked by income and race/ethnicity are often compounded by fragile family configurations. Increasing numbers of America's youngest children (24 percent, in 2012) are raised by a single parent. A small (but increasing) number (16 percent) are in the care of grandparents.

The available research tells us that these circumstances, on average, are riskier for children's optimal development. More troubling is that these children are also disproportionately in families where their parents or other caretakers are poor and poorly educated. The disadvantages of being poor, and with unmarried parents who lack the preparation that would allow them to join the middle class, converge for many of our youngest children, hobbling their progress virtually from their earliest days of life.

While these conditions characterize a significant minority of infants and toddlers, when contrasted with the data suggesting that a majority of the youngest Americans are doing reasonably well, they cast the inequities in a still harsher light.

Although frequently confounded with income, differences by race and Hispanic origin occur in multiple domains.

As a group, **black infants and toddlers** have starkly worse health outcomes than whites; they are —

- 60 percent more likely than whites to experience preterm birth;
- Twice as likely to die in infancy;
- Nearly three times as likely to have parents with significant concerns about their development; and
- Six percent less likely than their white counterparts to get preventive medical care.

As a group, **Latino infants and toddlers** experience a range of social disadvantage; they are—

- Half as likely to have family members read to them, and a third less likely to be sung to or have stories told to, compared with their white, non-Latino peers;
- Nine percent less likely than their non-Latino white counterparts to get preventive medical care;
- Thirty-nine percent more likely to get preventive dental care; however, their teeth are in poorer condition;
- Nearly three times more likely to experience frequent residential moves; and
- Like their black, non-Latino counterparts, their parents (four times more so than the parents of white children) have significant concerns about their development.

Poverty, while pernicious in its effects on development, is not the only experience that can seriously disrupt well-being in multiple domains. Nearly one in four of America's youngest children has experienced one or more circumstances research identifies as having potentially traumatic effects. For this age group, the most common of these is persistent economic hardship, but also common are parents' separation or divorce, and experiencing or witnessing violence. Children with special health care needs are more than twice as likely as those without such needs to have had two or more of these "adverse experiences."

New Contexts for Development

The majority (55 percent) of mothers of infants and toddlers are working.[1] However, their participation in the labor force too frequently fails to guarantee either family economic security or reliable, high-quality care for their children.

1 Bureau of Labor Statistics. (2013). Women in the labor force: A databook. Retrieved from www.bls.gov/cps/wlf-databook-2012.pdf

A third (33 percent) of America's youngest children live in households where English is not the only language spoken—a circumstance that implies both risk and promise for their development.

Nearly a third of infants and toddlers have a television in their bedroom—a practice development experts consider ill-advised. Forty-three percent watch at least an hour a day. Infants and toddlers in poor families are more likely to be "heavy" watchers of TV.

Resilience is a frequently remarked-upon feature of young children. More than three-quarters of America's youngest children exhibit some key characteristics associated with positive development: smiling and laughing often, recovering easily from upsets, showing interest and curiosity, and having a strong bond with their parents. However, fewer black children have these optimal developmental markers, compared with their Latino or white peers.

Parents' Needs are Complex, and Too Seldom Adequately Met

Parenting—never an easy responsibility—has also been reshaped by contemporary trends. Today's parents are, on average, older, more educated, and more likely to be unmarried than in the past. Six in ten mothers living with infants and toddlers are thirty or older, and three-quarters of fathers. Among single parents, and among married parents who are poor, one in ten is affected by depression. Supports for infants and toddlers and their families are essential to their well-being. However, in many cases what is available falls far short of what is needed, even according to programs' own eligibility guidelines. Parental leave, high-quality child care, and access to early intervention services, are among the public- or private-sector supports that are out of reach of many families raising infants and toddlers. For example, the U.S. is an outlier internationally in providing no guaranteed paid leave for new parents. Only about one in ten infants and toddlers eligible for a federal child care subsidy receives it. Home visiting—a relatively new service model in the U.S.—is the most recent example of the limited reach of programs intended to support parents: only 25 percent of the most-at-risk families of infants or toddlers receive this promising, preventive intervention.

More than six in ten (61 percent) of infants and toddlers do not receive developmental screening, an important strategy for preventing or intervening early in the course of threats to children's optimal development. Nevertheless, receipt of these screenings has increased in recent years, providing evidence that we can reach and support America's youngest children.

Introduction

Why focus on infants and toddlers?

The period of infancy and toddlerhood (conventionally defined as birth through two years of age) is a time of enormous potentiality. In all the major domains that comprise what it means to be human, development during this stage of life is rapid, dynamic, and keenly sensitive to inputs from the social, physical, and biological environments. Our knowledge of brain development, and of the complex interplay of genetic code and experience, has heightened appreciation of this time as one where fundamental predispositions (patterns of responses and behaviors), for better and worse, become established. These patterns can create trajectories of subsequent development that become increasingly resistant to change as children enter school-age, adolescence, and adulthood. Thus, the infant-and-toddler period is increasingly seen as the time during which opportunities to help set children on a path to flourish are greatest.

Unequal odds from the beginning

To the extent that a society can be judged by how it cares for its most vulnerable members, the status of infants and toddlers can be taken as a measure of our commitment to human capital. The U.S. has a great wealth of resources and is able to provide top-flight medical care, excellent education, cutting-edge technology, and enviable recreational and cultural opportunities for many in our population. However, our progress as a nation is, to a growing extent, held back by gaping disparities—in opportunities and outcomes—that jeopardize our productivity as well as our longstanding commitment to human rights. The "achievement gap," variously identified as threatening our national performance in higher education, in high school graduation, third-grade reading achievement, or kindergarten readiness, in fact begins much earlier—in infancy.[1]

To a great extent, the achievement gap mirrors growing economic inequality; that is, many of the shortfalls ("gaps") stem from poverty and the particular ways that economic stress harms development.[2] However, in addition to income, race/ethnicity, parental education, and family structure often play leading roles in these disparities. And, for better or worse, all of these factors are closely associated—that is, disadvantage (or advantage) in one domain is often accompanied by disadvantage (or advantage) in the others. Our commitment to opportunity, to be effective, has to start at the beginning.

Data on infants and toddlers

As recently as ten, or even five, years ago, there was a dearth of information on America's youngest children. Several groundbreaking, government-sponsored surveys have significantly expanded the scope of these data. Prominent among these are the U.S. Census Bureau's American Community Survey, and the National Survey of Children's Health, sponsored by the Maternal and Child Health Bureau. Another key source of data (not yet released) will be the National Survey of Early Care and Education, funded by the federal Department of Health and Human Services.

In this report, we present a number of indicators that describe the status of infants and toddlers in the U.S. Where the data allow, we show trends

1 Halle, T., Forry, N., Hair, E., Perper, K., Wandner, L., Wessel, J., & Vick, J. (2009). Disparities in early learning and development: Lessons from the Early Childhood Longitudinal Study-Birth Cohort (ECLS-B). Washington, DC: Child Trends. Available at http://www.childtrends.org/?publications=disparities-in-early-learning-and-development-lessons-from-the-early-childhood-longitudinal-study-birth-cohort-ecls-b

2 Kishiyama, M. M., Boyce, W. T., Jimenez, A. M., Perry, L. M., & Knight, R. T. (2008). Socioeconomic disparities affect prefrontal function in children. Journal of Cognitive Neuroscience, 21(6), 1106-1115. Child Trends DataBank. (2012). Children in poverty. Retrieved from http://www.childtrends.org/?indicators=children-in-poverty

for up to 10 years, in order to display a fuller picture of their direction. For selected indicators, we present international comparisons; these can serve to illustrate both the range of results achieved in different national contexts, and to suggest a basis for concern and aspiration. Of course, children in this group cannot report on their own well-being, so, apart from physiological measures, we must rely heavily on indicators that are indirect—for instance, information provided by parents.

National-level data, however, if not further disaggregated, can obscure important differences among sub-groups of the population. These divides may fall along any number of lines—race, ethnic origin, immigration status, income, education, gender, region of the country, and so on. Understanding these is critical to understanding the origins, and perseverance, of the various achievement gaps. Therefore, as the data allow, we break out the indicator trends by one or more of these factors.

The structure of this report

The organization for the report reflects an ecological perspective, which conceives of child development as influenced by multiple spheres. We present, first, basic demographic data on the number and composition (according to several dimensions) of America's youngest children. Second, we survey what the indicators have to say about the health and well-being of infants and toddlers, and the risk and protective factors that are closely linked with those conditions.

Next, we consider parental well-being. Our lives are always linked to those of others, but this is especially true for infants and toddlers, for whom nearly every aspect of development is mediated by parents or other caregivers. Parents provide the "envelope" in which the earliest weeks and months of development proceed, and their own health and well-being play a key role in determining how well children thrive during the first few years. Thus, we cannot talk about how infants and toddlers are doing without some reference to how their parents are doing. Following this section are indicators that describe the contexts of neighborhood and family.

Our final section describes the extent to which our country's array of formal supports for the youngest children and their families—from both the private and public sectors—is meeting their needs. The sphere of policy and practice, while seemingly distal to the daily lives of families, nevertheless, by commission or omission, wields a great deal of influence.

The report ends with observations about the composite portrait drawn here, identifying some common threads in the data. There are big Humpty-Dumpty-like challenges in such an exercise, but we feel obliged to leave readers with something more than fragments.

What indicators can (and can't) do

Because indicators deal with populations, rather than with individuals, they both reveal and conceal important features. On the one hand, indicators can by no means account for the unique circumstances and stories of individuals, any one of which may diverge markedly from the picture conveyed by aggregate data. On the other, a different order of information emerges from the fact that larger numbers can illuminate underlying phenomena not necessarily apparent within the orbits of individual experience. Thus, indicators often confirm, but sometimes challenge, what is "common knowledge." Indicators cannot tell "why" or "how," but rather "who" and "what" (and sometimes "when"). Indicators are ideal, therefore, for laying the foundation for an informed conversation and for further investigation. Indicators, in spite of their imperfections, help keep us—all those with a stake in expanding well-being—honest with respect both to our shortcomings and our progress.

This is an indicators report whose subject is infants and toddlers. A major challenge for any such report is to preserve, in what is necessarily a focus on numbers and trends, the knowledge that what are represented here are diverse, complex lives with very real joys and sorrows. Every parent knows their baby is remarkably unique; but even those who are not parents can appreciate how each individual represents a particular combination of genes and experiences not to be duplicated. Readers are urged to keep in mind that behind the tables and charts, there are lives rich in promise and expectation.

Notes on terminology

In this report we use the terms "Hispanic" and "Latino" interchangeably. Hispanics or Latinos can be of any race; however, we have chosen to represent categories that are mutually exclusive. Thus, in this report, except where otherwise indicated, "white," "black," "Asian/Pacific Islander," and "American Indian/Alaska Native" refer to the members of those groups not also identified as Hispanic/Latino. Each of these labels of convenience, of course, can obscure the diversity typical of all of these broad categories. For instance, "black" families include African-Americans who have lived in this country for generations, as well as those whose roots are in the Caribbean region, and more recent immigrants. Likewise, Latino families are likely to identify their heritage with any of a number of Central and South American nations.

When in the text we state that a data point for one group is higher (or lower) than the corresponding point for another group (for example, males and females, whites and blacks, poor and near-poor), the difference is statistically significant. If differences are not so described, the reader may assume they are not statistically significant.

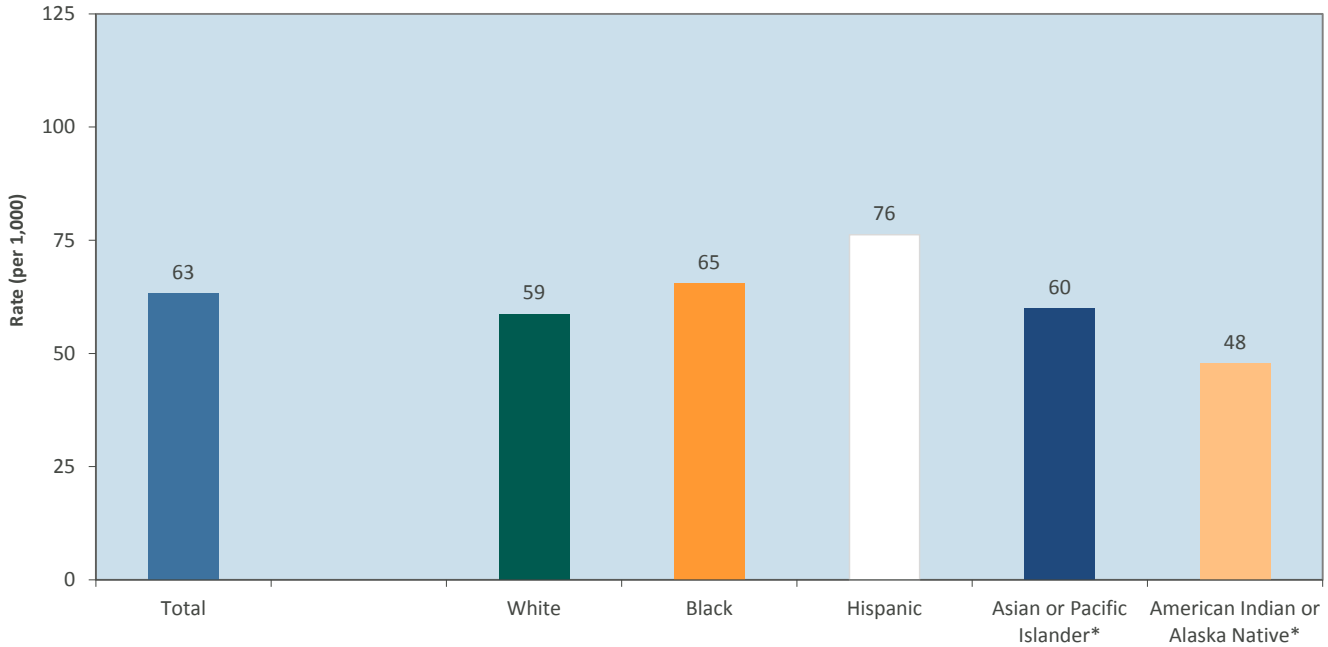
For readers interested in more detail, the Appendix tables include all data points represented by the report charts, as well as, for many of the indicators, additional subgroup data.

The Indicators

Demographics

fertility

Fertility Rates (per 1,000 women ages 15-44), by Race/Hispanic Origin, 2011



*Includes Hispanics of that race

Source: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

In 2011 (the latest year for which data are complete), just under four million babies were born in the U.S. The U.S. fertility rate—the number of births per 1,000 women of childbearing age—is lower than at any time these data have been recorded. With fewer babies born, there are implications in a number of areas, not the least of which is a future workforce that will be smaller, and responsible for supporting the needs of a growing elderly population.

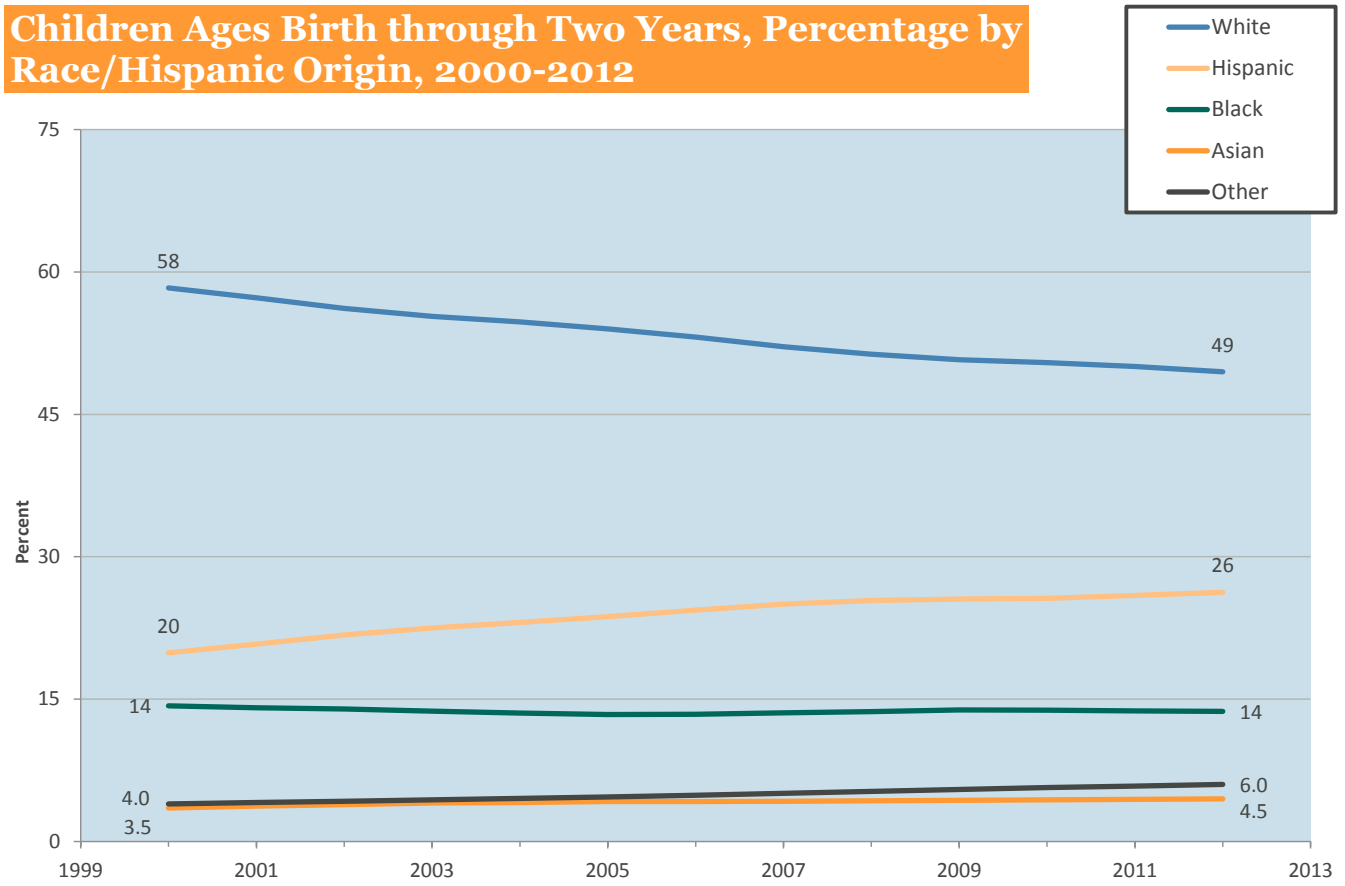
Within this overall picture, there are some notable trends. First, birth rates for women 35 and older, while accounting for a relatively small number of all babies, are showing some increase. This may be of concern, because infants born to older mothers have a higher risk of birth defects, such as Down syndrome.[1]

Second, while fertility rates for Latinos and blacks have also declined, they are substantially higher than rates for whites. Together with immigration, they account for the rapidly changing complexion of our population, starting with its youngest members, who will make the U.S. a majority Hispanic-and-non-white nation by 2043.[2]

1 Gill, S. K., Broussard, C., Devine, O., Green,R. G., Rasmussen, S. A., Reefhuis, J. and the National Birth Defects Prevention Study. (2012). Association between maternal age and birth defects of unknown etiology--United States, 1997-2007. Birth Defects Research Part A.: Clinical and Molecular Teratology, 94, 1010-1018.

2 U.S. Census Bureau. (2012). U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now. Press release, December 12, 2012. Retrieved from http://www.census.gov/news-

Children Ages Birth through Two Years, Percentage by Race/Hispanic Origin, 2000-2012



Source: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/national/totals/2012/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html

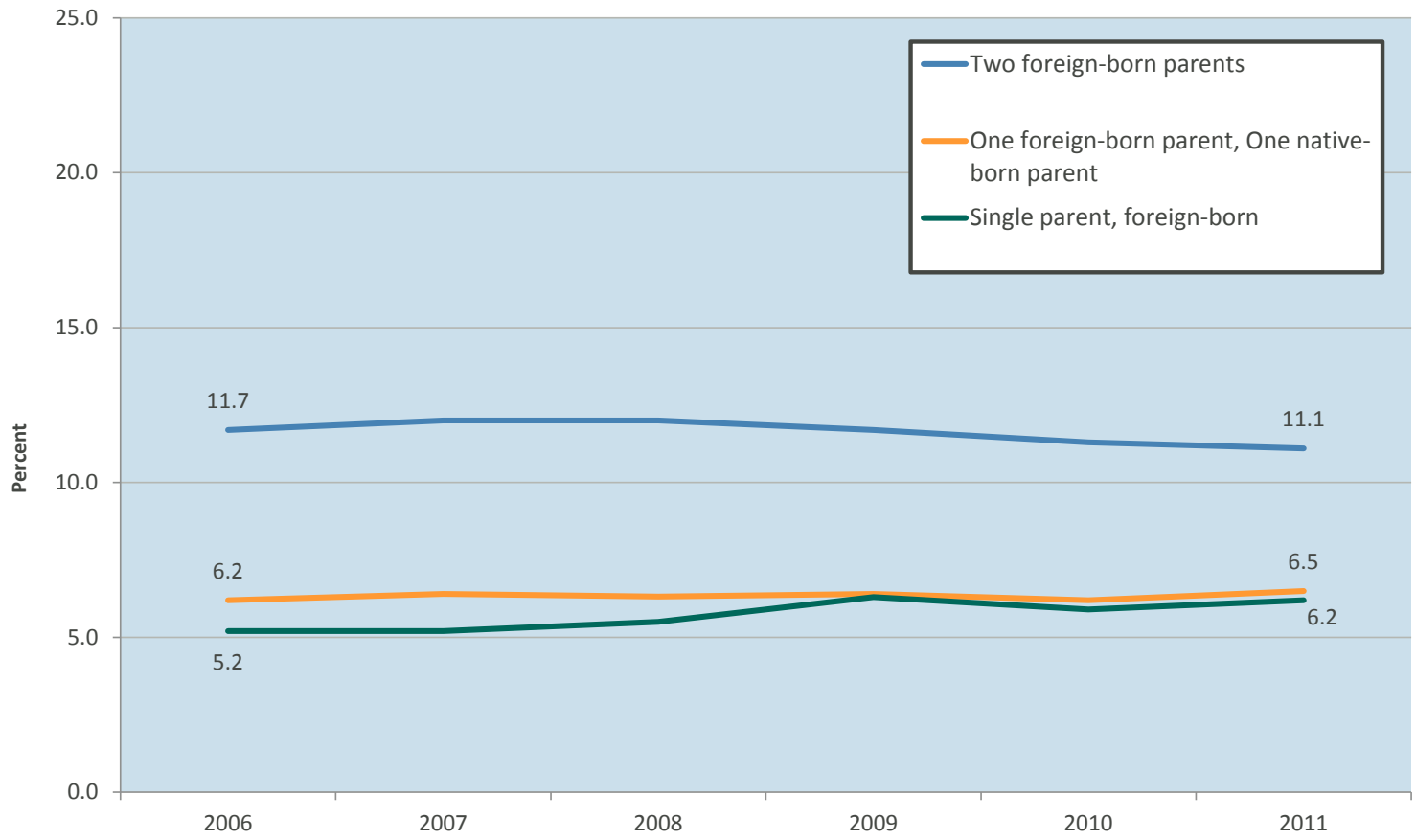
number of children and selected sub-populations

In 2012, there were an estimated 12 million babies and toddlers in the U.S. Infants less than one year of age accounted for about four million of these.

Infants and toddlers are at the leading edge of a transformation that will result, by 2030, in a U.S. child population that is "majority minority"—that is, a population where non-Latino white children, while still the largest single group, are no longer the majority. In fact, that milestone has already been reached in the case of infants and toddlers. The Census Bureau projects that white non-Latinos comprised 49 percent of this population in 2012. Latinos and blacks were 26 and 14 percent, respectively, with all other races accounting for another 11 percent. By 2060, it is projected that four in ten infants and toddlers (40 percent) will be Latino; non-Latino whites will be less than one in three; and black infants and toddlers will be around one in eight.[1]

1 U.S. Census Bureau. National population projections, Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060. Downloadable files. http://www.census.gov/population/projections/data/national/2012/downloadablefiles.html

Percentage of Children Ages Birth through Two Living with Immigrant Parents, 2006-2011



Source: Child Trends' calculations from the American Community Survey, Public Use Microdata Sample.

Ours has always been a nation of immigrants. Following an often-used definition of "immigrant children," as of 2012 nearly one in four infants and toddlers had at least one parent who was born outside the U.S. Nearly six in ten of this group are Hispanic/Latino. Nearly one in three immigrant children is poor, and a majority (58 percent) live in low-income families. Close to half lived with two foreign-born parents; and 26 percent lived with a single parent who was foreign-born.

poverty

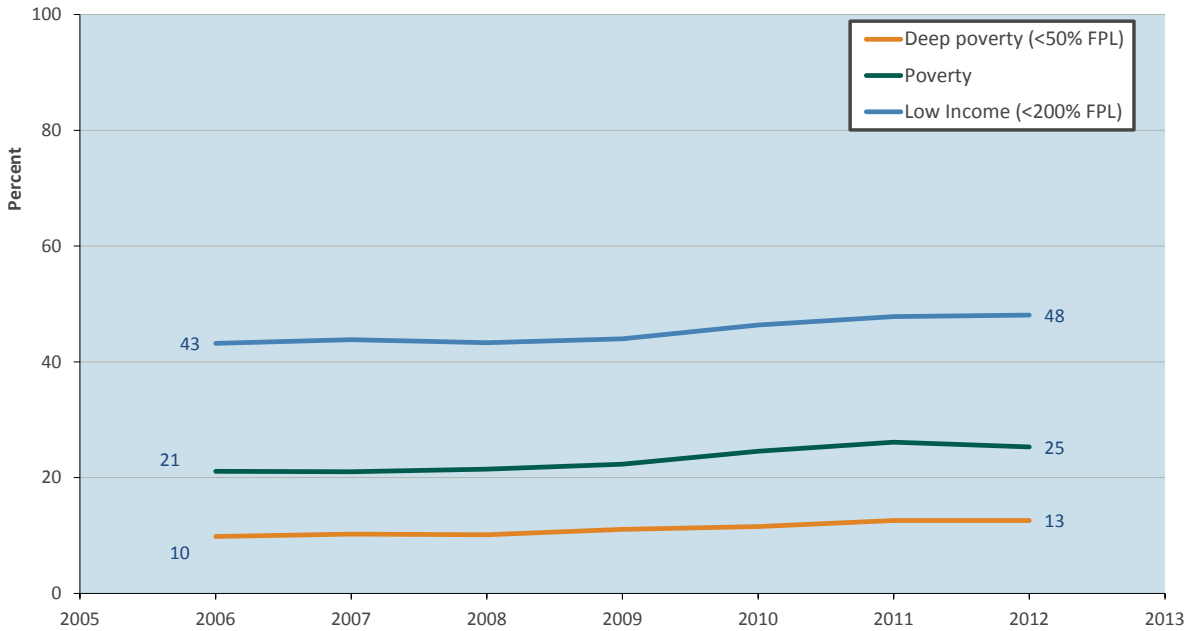
Poverty constrains more than material resources. Sustained poverty imposes chronic stress on families, affecting parental health and functioning, potentially undermining relationships between parents, and between parent and child. The list of negative child outcomes associated with poverty is long, including increased likelihood of illness and injuries, psychological and behavioral problems, diminished cognitive development and school achievement, and shorter life expectancy.[1]

Researchers have identified that early and chronic poverty are more damaging to child development than is poverty that occurs later in life, or for relatively short spells. The "depth" of poverty also matters—the greater the gap between the cost of basic needs, and family income, the greater the risks to children.[2]

Conventionally, poverty in the U.S. is defined by income thresholds for families of varying size and configuration, annually updated by the Census Bureau. Though widely seen as flawed, the poverty measure remains the standard for most reporting, particularly for trend data.[3] Many experts believe that doubling the thresh-

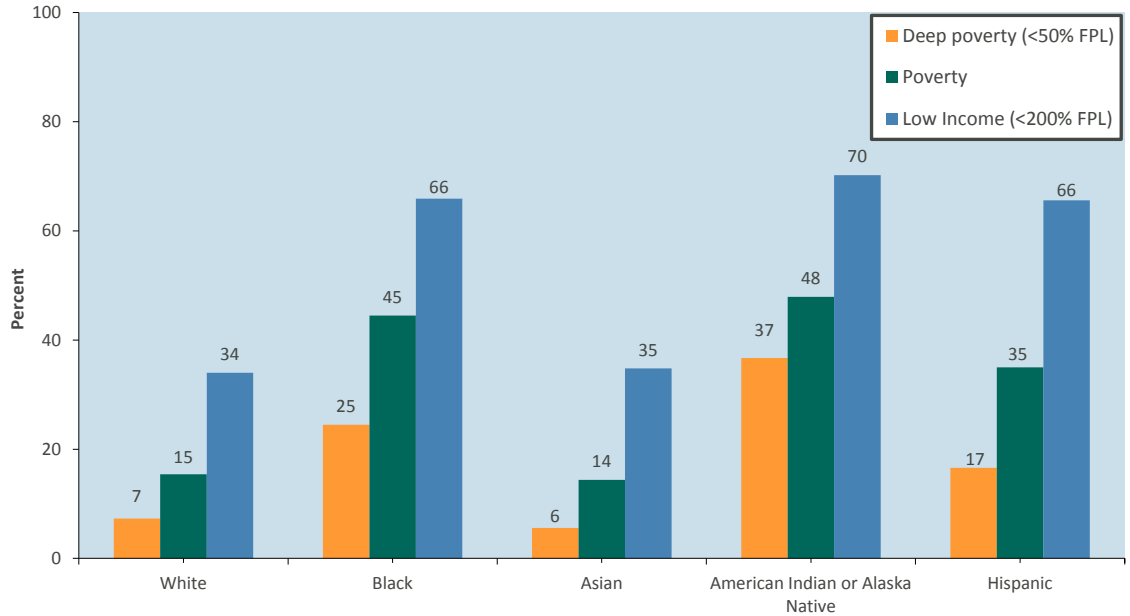
1 Evans, G. W. & Schamberg, M. A. (2009). Childhood poverty, chronic stress, and adult working memory. PNAS, 106(16), 6545-6549.
Melchior, M., Moffitt, T. E., Milne, B. J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantaged families suffer from poor health when they reach adulthood? A life-course study. American Journal of Epidemiology, 166(8), 3966-974.
Conroy, K., Sandel, M., & Zuckerman, B. (2010). Poverty grown up: How childhood socioeconomic status impacts adult health. Journal of Developmental & Behavioral Pediatrics, 31, 154-160.
Singh, G. K. & Siahpush, M. (2006). Widening socioeconomic inqualities in U.S. life expectancy, 1980-2000. International Journal of Epidemiology, 35, 969-979.
2 Frank, D. A., Casey, P. H., Black, M. M., Rose-Jacobs, R., Chilton, M., Cutts, D., March, E., Heeren, T., Coleman, S., Ettinger de Cuba, S., & Cook, J. T. (2010). Cumulative hardship and wellness of low-income, young children: Multisite surveillance study. Pediatrics, 125(5), ee1115-e1123.
3 For discussion of the limitations of the federal poverty measure, see Blank, R. M. & Greenberg, M. H. (2008). Improving the measurement of poverty (discussion paper 2008-17). The Brookings Institution. Available at: http://www.brookings.edu/research/papers/2008/12/poverty-measurement-blank.

Percentage of Children, Ages Birth through Two, Living in Deep Poverty, Poverty, and with Low Income: Selected Years, 2006-2012*



*Year reflects the year that the question was asked. Question was asked regarding the previous 12 months.
Source: CPS Annual Social and Economic Supplement, CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html. Data refer to children residing with and related to the householder.

Percentage of Children, Ages Birth through Two, Living in Deep Poverty, Poverty, and with Low Income, by Race and Hispanic Origin, 2012*



*Year reflects the year that the question was asked. Question was asked regarding the previous 12 months.
Source: CPS Annual Social and Economic Supplement, CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html. Data refer to children residing with and related to the householder.

old figure provides a better estimate for the number of individuals who struggle to meet basic needs; children living in households with incomes less than 200 percent of the official poverty level are considered "low-income." Individuals who live with incomes less than half of the poverty level are considered to be in "deep" poverty. Occasionally, we will refer to the "near-poor" in relation to those with incomes above, but less than twice, the poverty level.

Children are the age group most likely to live in poverty, and the youngest children are even more likely to be poor, in part because their parents are often younger adults at the outset of their earnings careers.

In 2012, nearly half of children in America younger than three were in low-income families; about one in four (25 percent) was living in poverty; and about one in eight (13 percent) was in deep poverty.

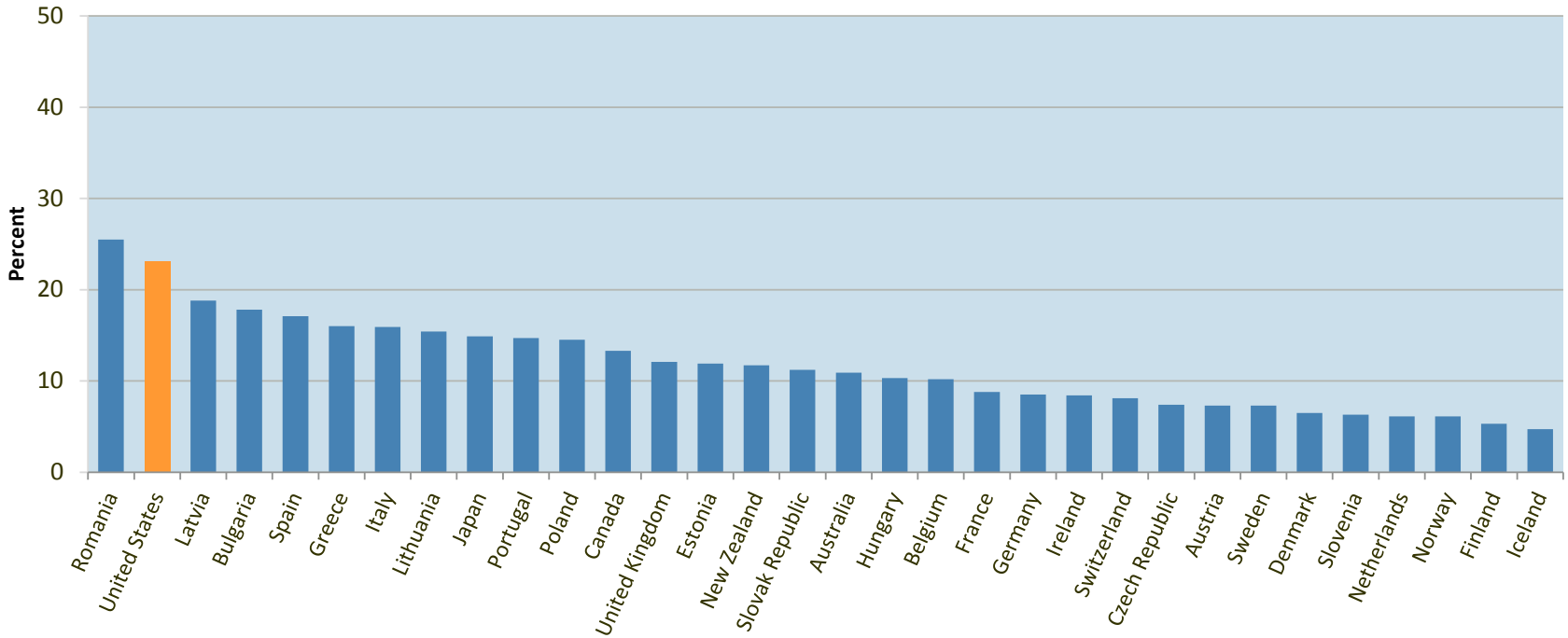
A recent authoritative analysis went a step further: it estimates that, as of mid-2011, 3.6 million U.S. children (ages birth through 17) were in extreme poverty—defined as "surviving on $2 or less in cash income per person per day in a given month."[4] This is the figure the World Bank uses in assessing global poverty. A simple extrapolation of this calculation to the population of infants and toddlers yields an estimate (conservative, because we know that the youngest children are the most likely to be poor) of more than half-a-million babies and toddlers on the edge of survival, in the wealthiest nation on earth.

There are stark differences in these figures by race and Hispanic origin:

- Nearly half of black and American Indian/Alaska Native children younger than three are poor (45 and 48 percent, respectively);
- Among the youngest Latinos, more than one in three (35 percent) is living in poverty;
- Two-thirds of black and Latinos are in low-income families, and seven in ten American Indian/Alaska Native infants and toddlers are;
- Among whites and Asians, more than a third are in low-income families; and
- One in four black infants and toddlers lives in deep poverty, as do more than one in three American Indian/Alaska Natives.

4 Shaefer, H. L. & Edin, K. (2013). Rising extreme poverty in the United States and the response of federal means-tested transfer programs. National Poverty Center Working Paper. Retrieved from www.npc.umich.edu/publications/working_papers.

Percentage of Children Who are Living in Relative Poverty* in 32 Developed Countries: 2009**



*Relative poverty is defined as living in a household where disposable income, adjusted for family size and composition, is less than half (50%) of the national median income.

**Data for the United States are from 2007 and data for New Zealand and Japan are from 2011.

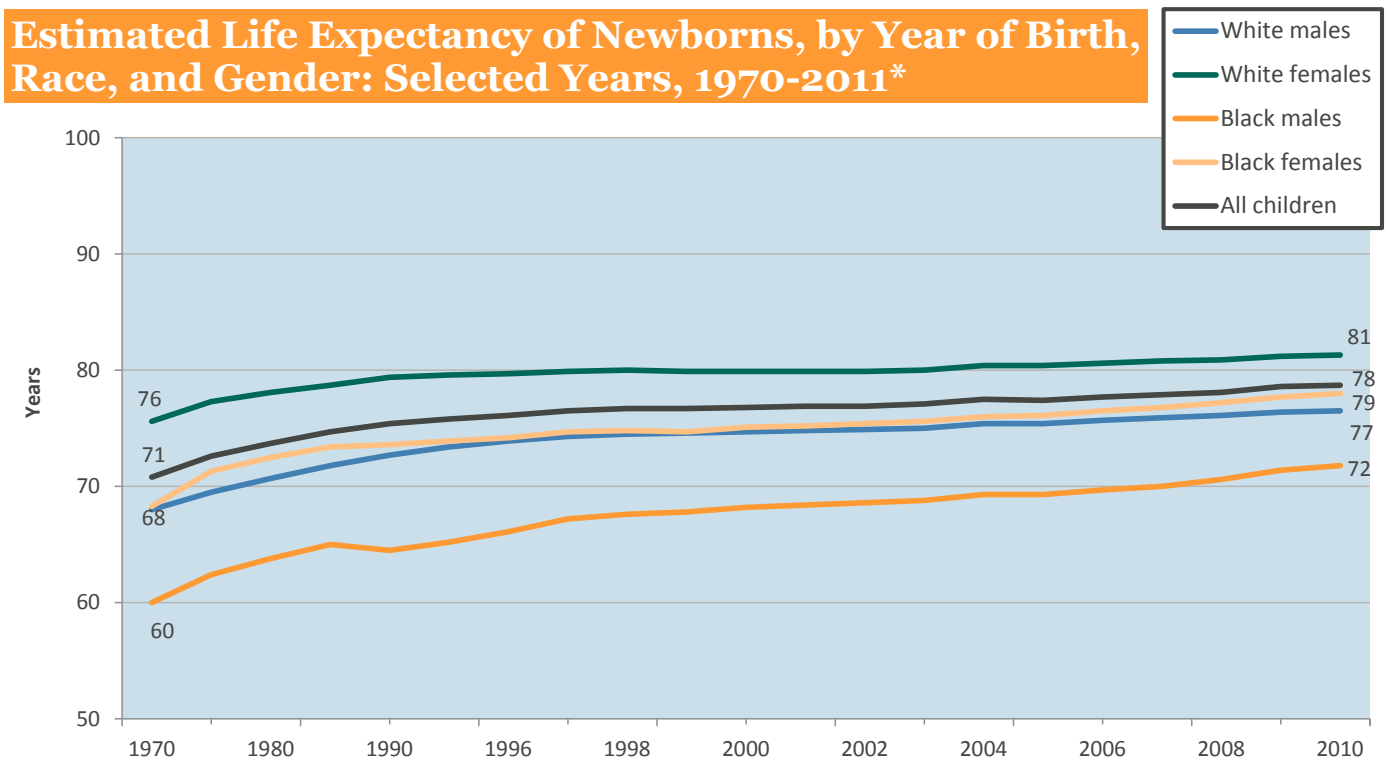
Source: UNICEF Innocenti Research Center. (2012). Measuring child poverty: New league tables of child poverty in the world's rich countries (report cared 10). Available at: http://www.unicef-irc.org/publications/pdf/rc10_eng.pdf

Child Health and Development:

Well-Being Status, Risk Factors, and Protective Factors

life expectancy

Estimated Life Expectancy of Newborns, by Year of Birth, Race, and Gender: Selected Years, 1970-2011*



*2011 data are preliminary.

Sources: Data for 1930-1999: Arias E. (2003) United States life tables, 2000. *National Vital Statistics Reports 51*(3). Hyattsville, Maryland: National Cente for Health Statistics. Tables 10 and 12. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_03.pdf Data for 2000-2009: Kochanek, K. D., Xu, J., Murphy, S. L., Miniño, A. M., Kung, H.(2012). Deaths: Final data for 2009, *National Vital Statistics Reports 60*(3). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf. Data for 2010-2011: Hoyert, D. L., Xu, J. (2012). Deaths: Preliminary data for 2011. *National Vital Statistics Reports 61* (6). Hyattsville, MD: National Center for Health Statistics. Available at: www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

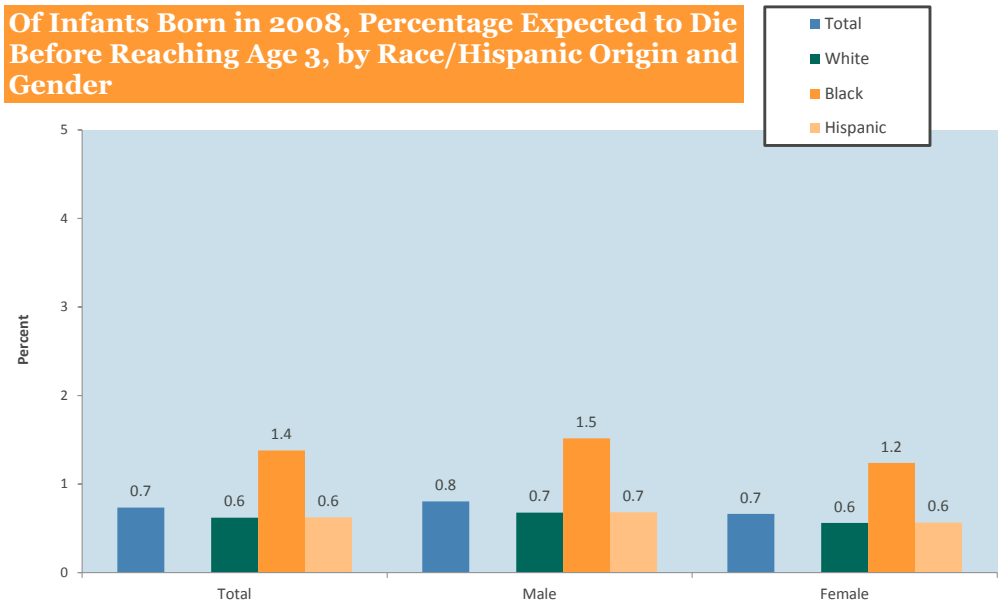
Life expectancy at birth is considered one of the fundamental indicators of a society's ability to provide for the health of its members. Overall, mortality rates for infants and for children older than age one fell considerably during the 20th century, due in large part to advances in medical technology, improved socioeconomic conditions, and progress in water and food safety, and sanitation practices.[1]

Despite this progress, **children in the United States have a shorter life expectancy than those in 25 other developed countries.** Additionally, there are large differences in life expectancy by gender, race, education, and income—further evidence of room for improvement.[2]

Female babies are expected to live about five years longer than male babies. White infants are expected to survive, on average, three years beyond their black counterparts. Nearly five years separates the life expectancy of babies born in the highest and lowest socio-economic groups. **If we look just at survival until the third birthday, white infants are twice as likely as black infants are to reach that milestone.**

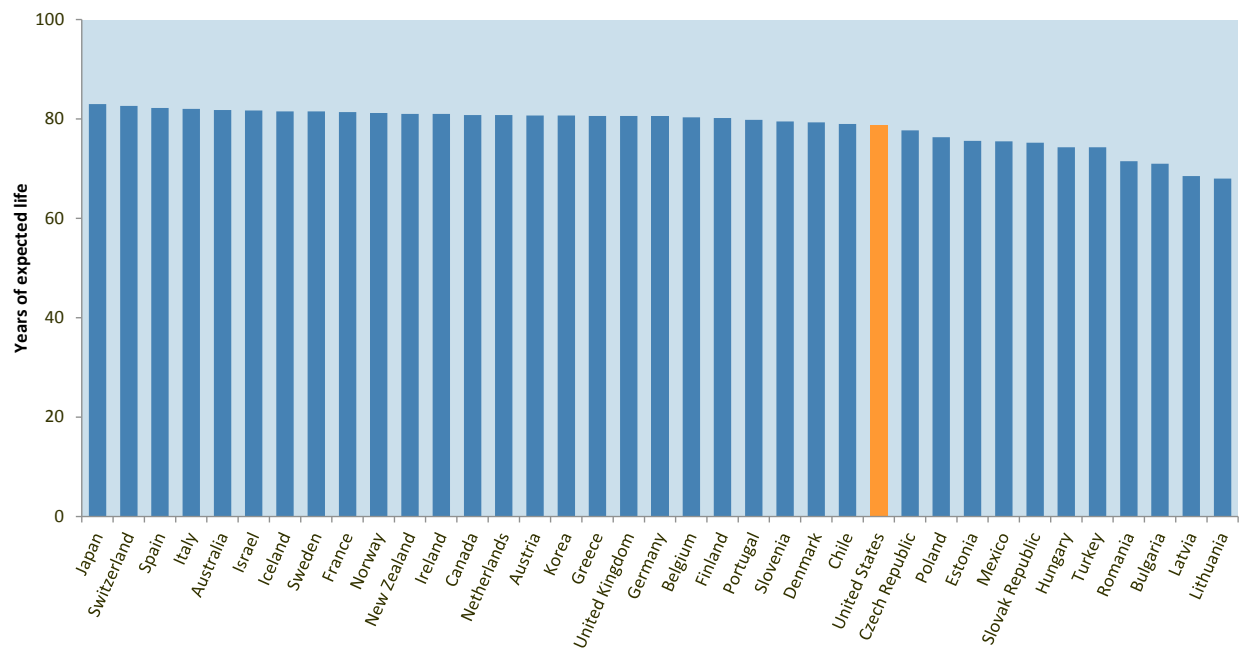
1 Child Trends DataBank. (2012). Life expectancy. Retrieved from http://www.childtrends.org/?indicators=life-expectancy
2 Ibid.

Of Infants Born in 2008, Percentage Expected to Die Before Reaching Age 3, by Race/Hispanic Origin and Gender



Source: Derived from Arias, E. (2012). United States life tables, 2008 *National Vital Statistics Reports, 61*(3). Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_03.pdf

Life Expectancy at Birth, in Years, 37 Developed Countries: 2010*



* Data refer to 2007 for non-OECD EU countries, 2008 for Canada, and 2009 for Italy.
Source: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

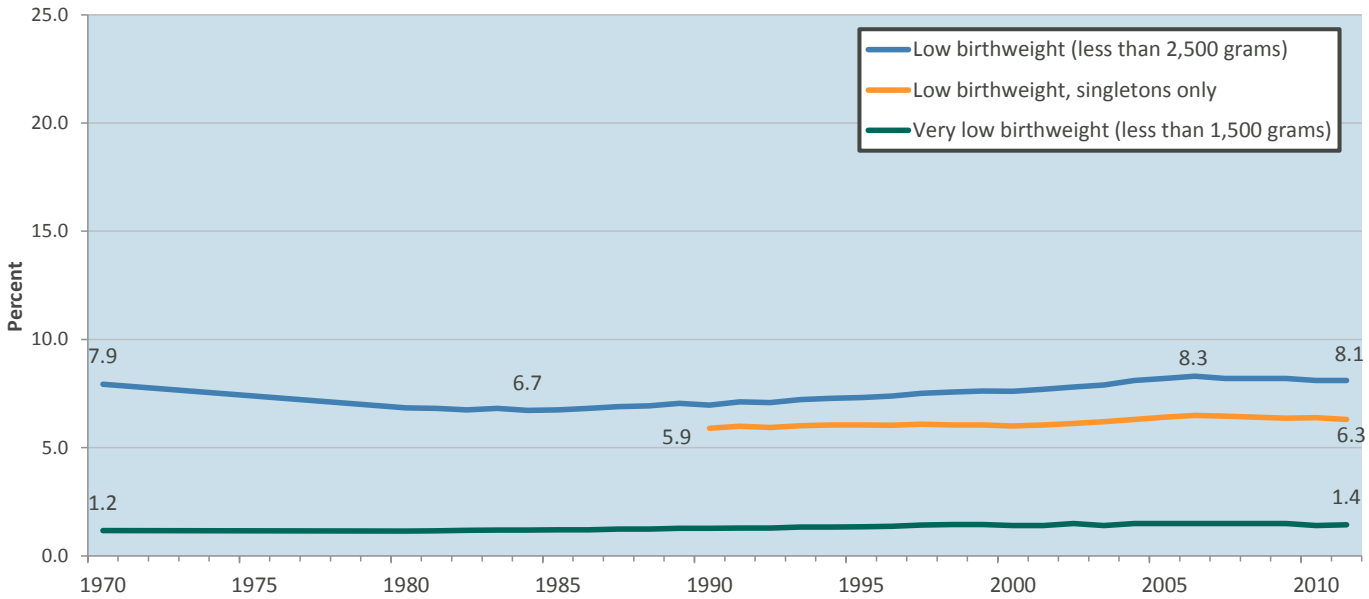
low birthweight

Low birthweight (defined as less than 5.5 pounds) is an indicator strongly associated with poor developmental outcomes in infancy, and even into adult life. Low weight is often associated with babies delivered pre-term, but can occur also with full-term births. According to research, a number of factors appear to contribute to the likelihood of low weight at birth, including mother's smoking during pregnancy; mother's low weight gain during pregnancy, or low pre-pregnancy weight; and mother's stress during pregnancy.[1]

The U.S. rate of low birthweight—currently around eight percent overall—is high by the standards of other highly developed nations. For instance, South Korea, New Zealand, Norway, and Sweden all have lower rates.[2]

Black infants are more likely than babies of other races to have low birthweight. In 2011, 13.3 percent of black infants had low birthweight, compared with 8.5 percent of Asian and Pacific Islander, 7.5 percent of American Indian and Alaska Native, 7.1 percent of white, and 7.0 percent of Hispanic infants. Black infants are also more than twice as likely as other infants to have very low birthweight (3.0 percent in 2011, compared with 1.1 to 1.3 percent among those of other major race groups).

Percentage of Infants Born at a Low or Very Low Birthweight, 1970-2011

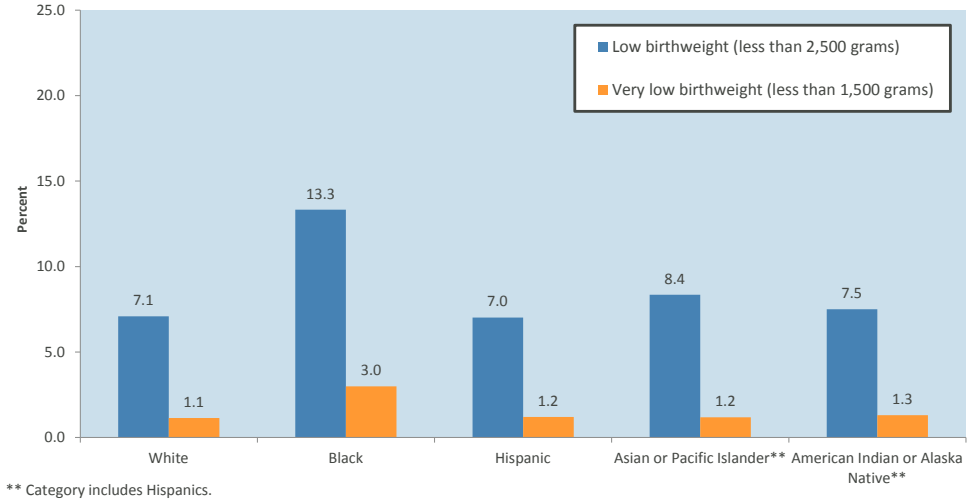


Sources: Data for 1970-2001: National Center for Health Statistics. (2003). *Health United States, 2003 with Chartbook on Trends in the Health of Americans*. National Center for Health Statistics. Table 12. Available at http://www.cdc.gov/nchs/data/hus/hus03.pdf. Data for 2002-2010 and plurality data 1990-2010: Centers National Center for Health Statistics, National Vital Statistics System. *VitalStats*. Length of Pregnancy (Gestation) and Birthweight. Accessed 9/13/2012. Available at http://205.207.175.93/VitalStats/ReportFolders/ReportFolders.aspx. Data for 2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf

1 Child Trends DataBank. (2012). Low and very low birthweight infants. Retrieved from http://www.childtrends.org/?indicators=low-and-very-low-birthweight-infants

2 UNICEF. (2008). The State of the World's Children 2008. Retrieved from http://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2008.pdf

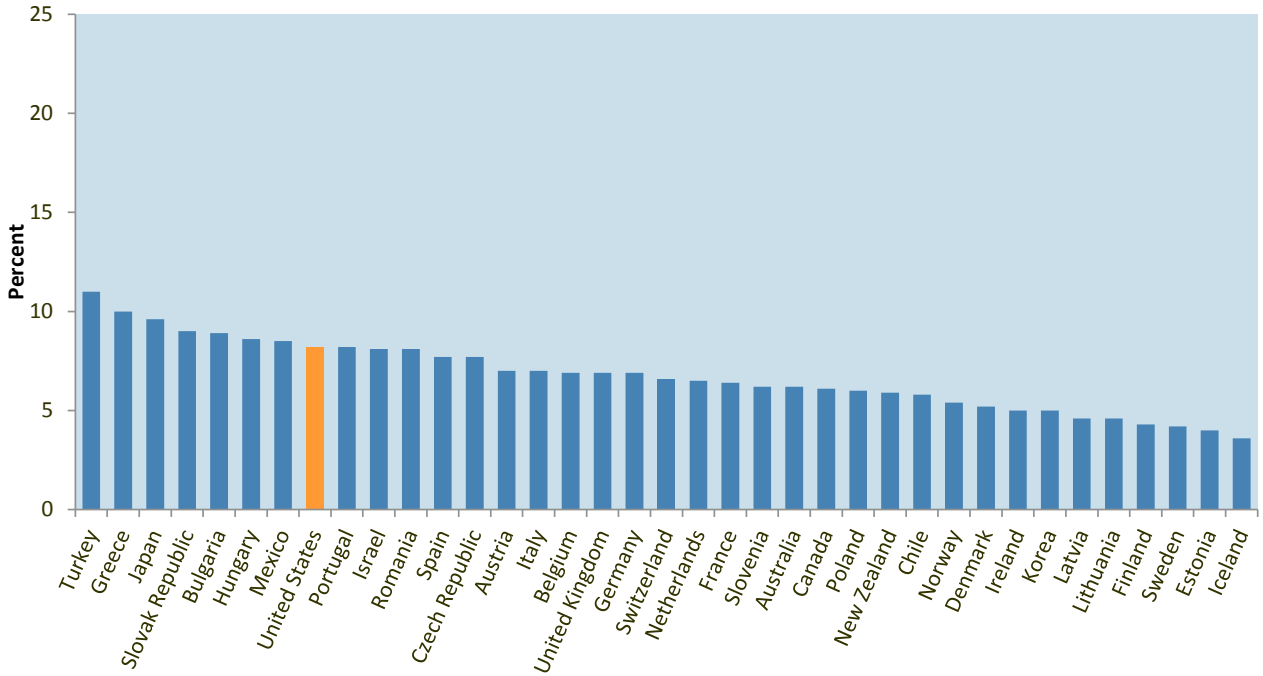
Percentage of Infants Born at a Low Birthweight, by Race and Hispanic Origin, 2011



** Category includes Hispanics.

Source: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf

Proportion of Infants with Low Birthweight in 37 Developed Countries: 2010*

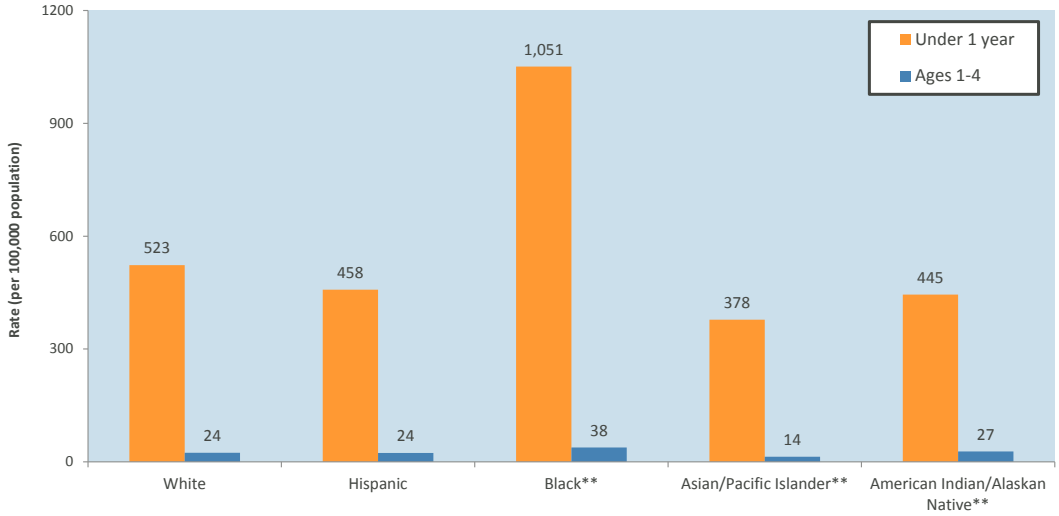


*Data refer to 2009 for Australia, Canada, Portugal, Italy; 2008 for Belgium and Turkey; 2006 for Bulgaria, Latvia, Lithuania, and Romania.

Source: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

deaths among infants and toddlers

Death Rates for Children Ages Birth through Four, by Race/Hispanic Origin, 2011*



*2011 Data are preliminary.
**Totals include Hispanics of the specified race.
Sources: Data for 2011: Hoyert, D.L., Xu, J. (2012) Deaths: Preliminary data for 2011. *National Vital Statistics Reports, 61*(6). Hyattsville, MD: National Center for Health Statistics. Table 1. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.

Most would expect the United States to have one of the lowest rates of infant mortality in the world. In fact, the U.S. ranks 26th among developed countries within the Organization for Economic Cooperation and Development.[1] Our performance on this indicator partly reflects technological advances that have enabled the short-term survival of many marginally viable babies, but also greatly unequal mortality associated with race.[2]

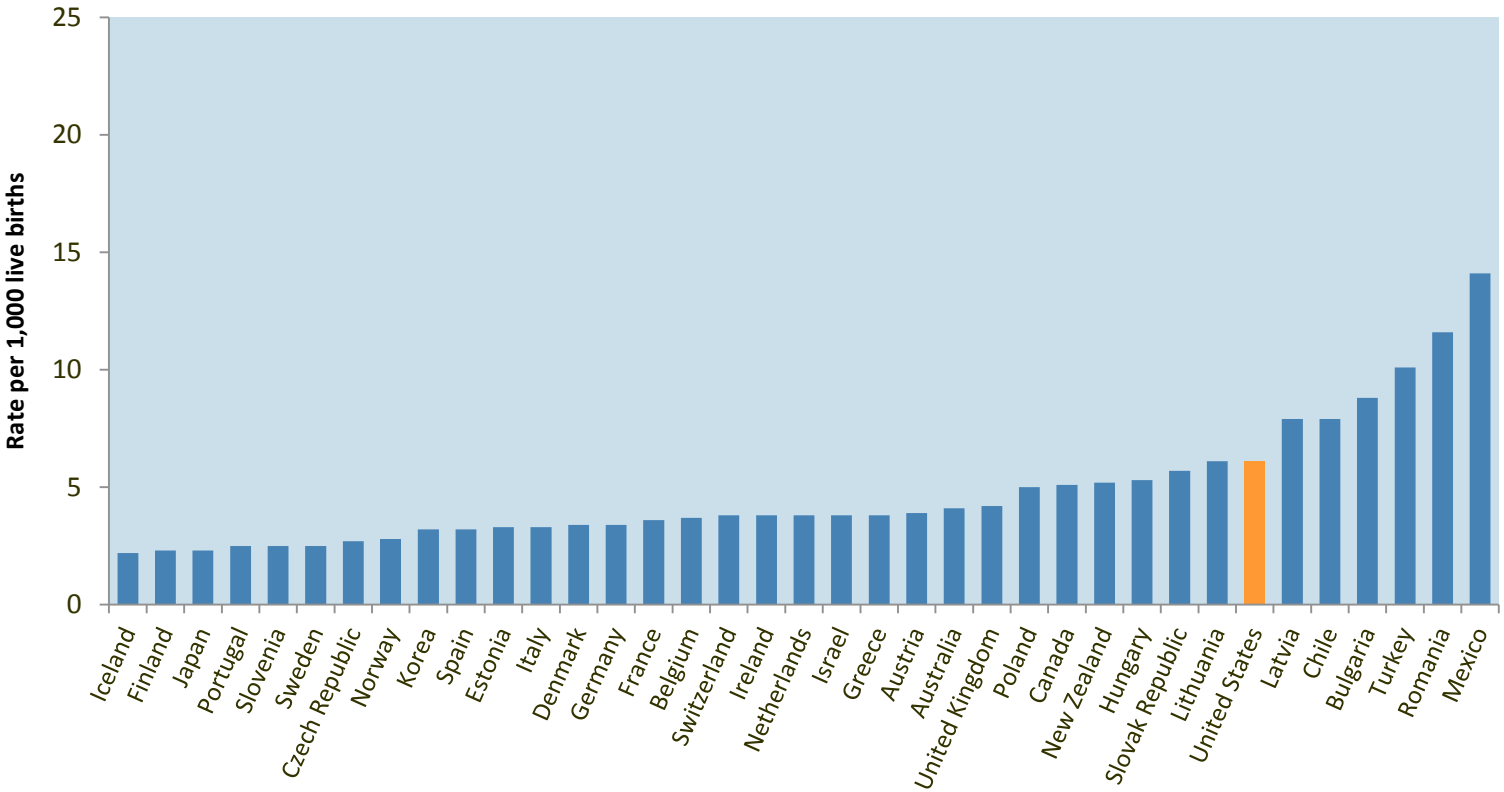
Children are much more likely to die during the first year of life than they are at older ages. For example, in 2010 (the most recent year for which we have these data) the death rate for children under age one was nearly 13 times higher than the death rate of children ages 15 to 19, the group with the next highest rate (623 and 49 per 100,000, respectively).[3]

A high rate of death can reflect underlying problems, such as poor access to prenatal care, violent neighborhoods, or inadequate child supervision. It can also point to inequities: for example, in access to health care or safe places to play, or exposure to environmental toxins. Among infants, the leading causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birthweight, and sudden infant death syndrome (SIDS).[4]

Black infants and toddlers have the highest, and Asian/Pacific Islanders the lowest, rates of death, with American Indian, white, and Latino infants and toddlers with roughly similar rates. When it comes to infant mortality, about half of the difference between rates for blacks and whites can be attributed to causes related to the higher rates of preterm births among black women. In contrast, among American Indian/Alaska Native infants, SIDS and unintentional injuries account for the majority of the mortality gap with white infants.[5]

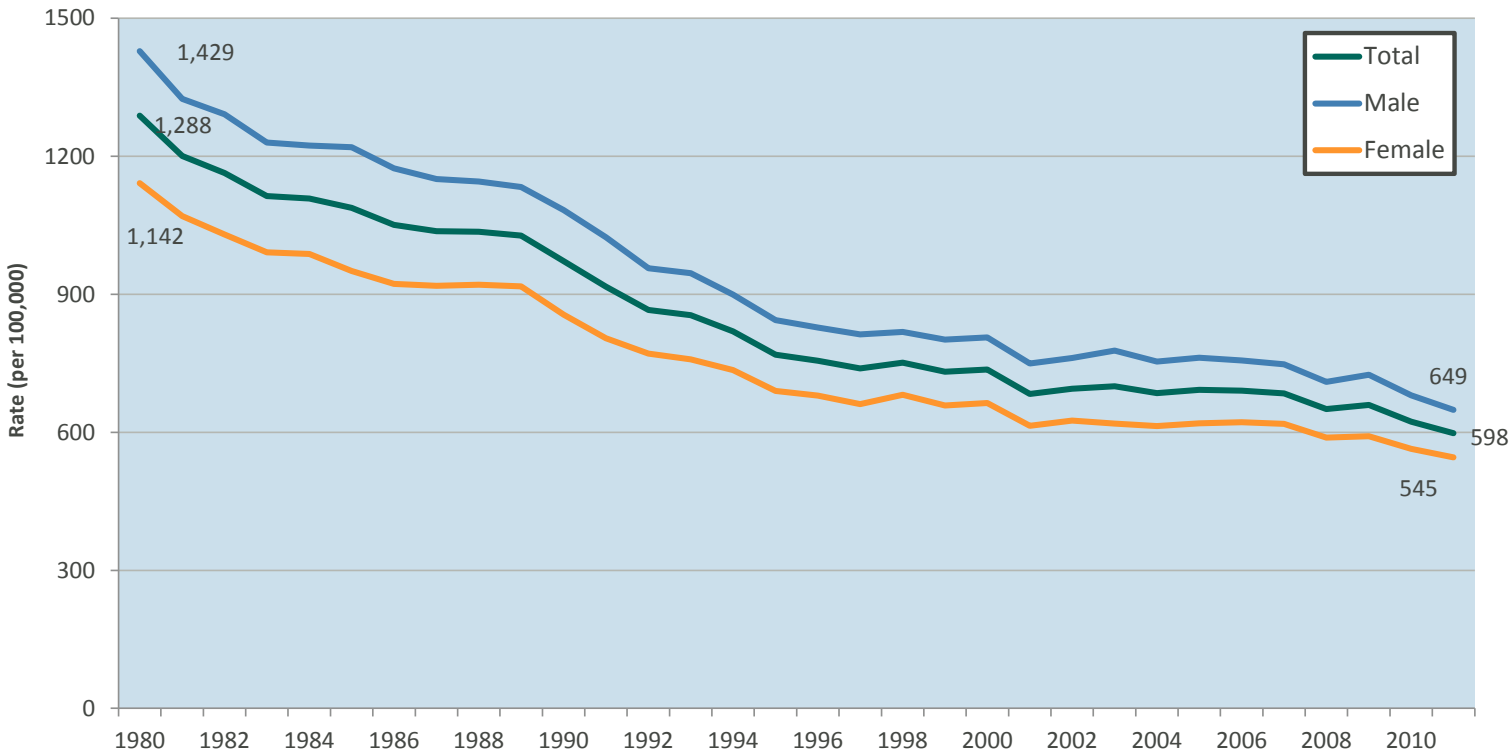
1 UNICEF. (2013). Child well-being in rich countries: A comparative overview. Innocenti Report Card 11. Retrieved from http://www.unicef-irc.org/publications/pdf/rc11_eng.pdf
2 MacDorman, M. F. & Mathews, T. J. (2011). Understanding racial and ethnic disparities in U.S. infant mortality rates. NCHS Data Brief, no. 74. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db74.pdf
3 Child Trends DataBank. (2012). Infant, child, and teen mortality. Retrieved from http://www.childtrends.org/?indicators=infant-child-and-teen-mortality
4 Ibid.
5 MacDorman, M. F. and Mathews, T. J. (2011). Understanding racial and ethnic disparities in U.S. infant mortality rates. NCHS Data Brief, No. 74. http://www.cdc.gov/nchs/data/databriefs/db74.pdf

Infant Mortality Rate (Deaths of Children Under Age One Per 1,000 Live Births) in 37 Developed Countries: 2010*



*Data refer to 2009 for Chile and New Zealand; 2008 for Belgium, Bulgaria, Canada, Ireland, Italy, Latvia, Lithuania, and Romania
Source: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

Death Rates for Infants (deaths per 100,000), by Gender, 1980-2011*



*2011 data are preliminary.

Sources: Data for 1980-2010 Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2009 on CDC WONDER Online Database. Available at: http://wonder.cdc.gov/ucd-icd10.html. Populatation data for denominators for infant death rates for 1980-1998: Intercensal population estimates, Census Bureau. Available at: http://www.census.gov/popest/data/intercensal/index.html. Data for 2011: Hoyert, D.L., Xu, J. (2012) Deaths: Preliminary data for 2011. National Vital Statistics Reports, 61(6). Hyattsville, MD: National Center for Health Statistics. Table 1. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.

child maltreatment

The youngest children—infants and toddlers—are the age group most likely to suffer abuse and neglect. Children one year and younger account for one in five incidents of maltreatment, and, together with children ages two to five, comprise nearly half of all cases. In 2011, about 85,000 infants, and 145,000 toddlers, were reported as substantiated victims of maltreatment.[1]

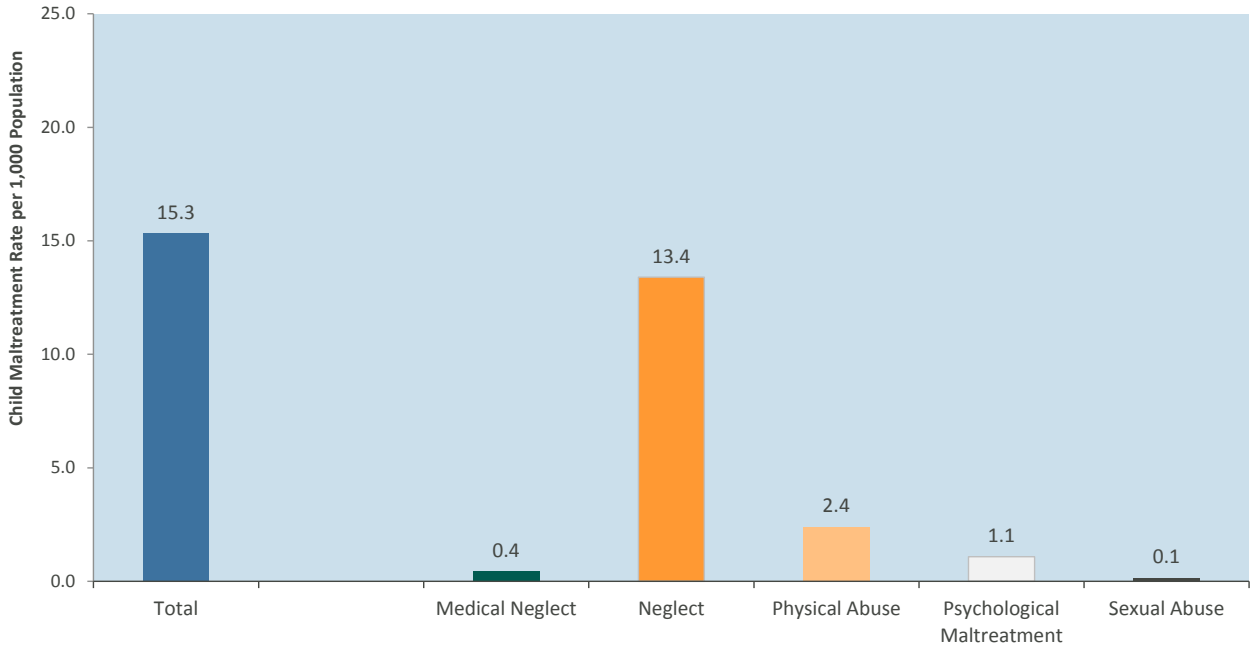
By far, the most prevalent form of maltreatment is neglect—"the absence of sufficient attention, responsiveness, and protection that are appropriate to the ages and needs of a child."[2] Unresponsive care can range from occasional inattention, to chronic under-stimulation, to failure to provide for a child's basic needs. In its more serious forms, neglect disrupts the normal development of the child's brain, and greatly increases the risk for emotional, behavioral, and cognitive problems in later life.[3]

Child maltreatment is influenced by a number of factors, including poor knowledge of child development, substance abuse, other forms of domestic violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse and, especially, neglect are more common in poor and extremely poor families than in families with higher incomes.[4]

Black, American Indian or Alaskan Native, and multiple-race children have higher rates of

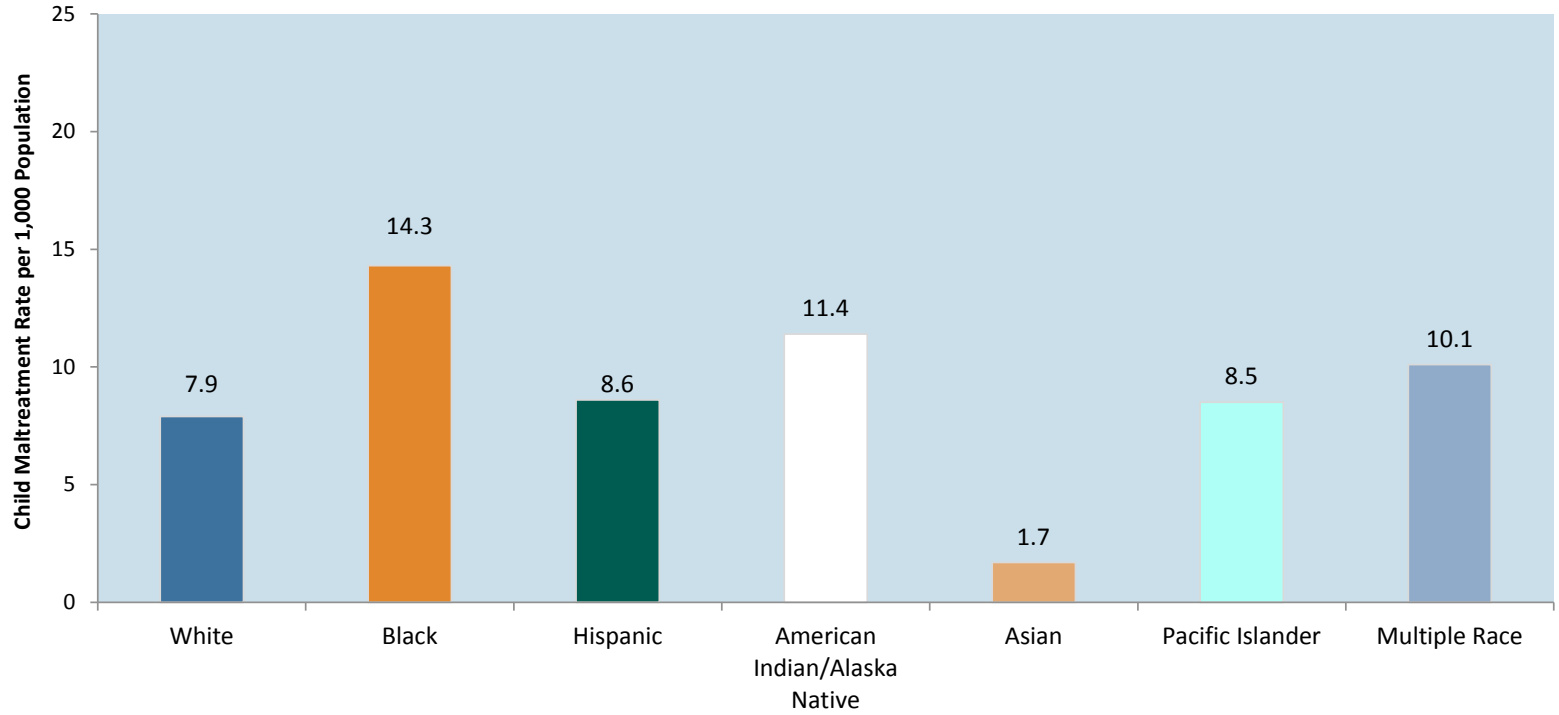
1 Child Trends DataBank. (2013). Child maltreatment. Retrieved from http://www.childtrends.org/?indicators=child-maltreatment
2 National Center on the Developing Child. (2012). The science of neglect: The persistent absence of responsive care disrupts the developing brain. Working Paper 12. http://www.developingchild.harvard.edu
3 Ibid.
4 Child Trends DataBank, op. cit.

Child Maltreatment Rate (Unique Substantiated Victims per 1,000 Population), Ages Birth Through Two, by Type of Maltreatment, 2011



[1]Because some victims have suffered multiple types of maltreatment, the rates by type add up to more than the total rate.
Source: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Child Maltreatment 2011(Washington, DC: U.S. Government Printing Office, 2012). Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

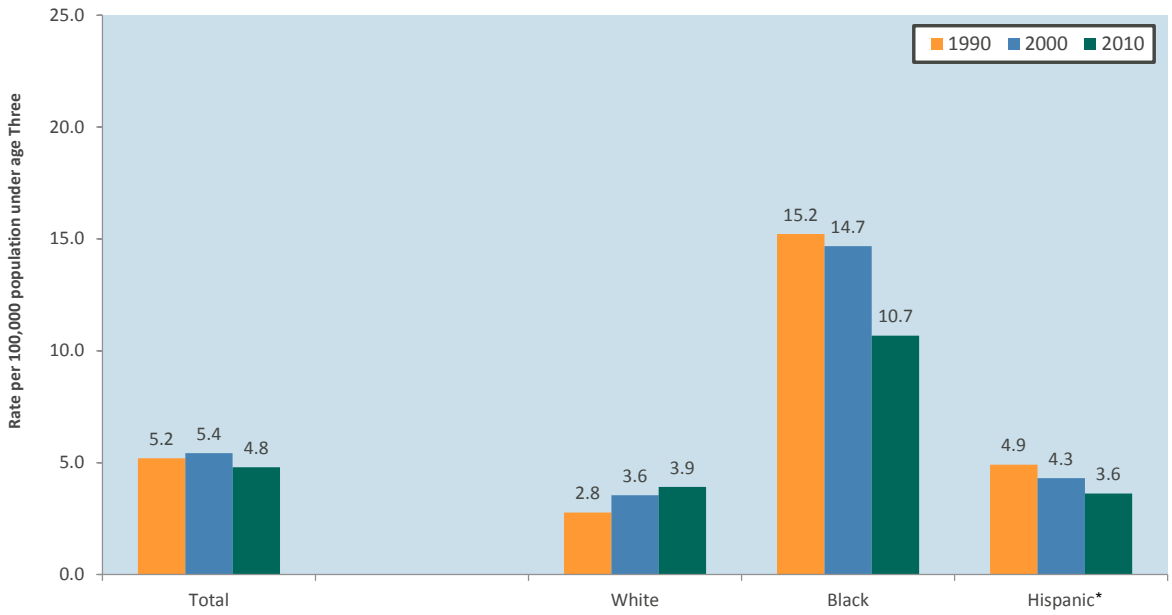
Maltreatment Rate (Unique Substantiated Victims per 1,000 Population), Ages Birth through 17, by Race[1]/Hispanic Origin, 2011



Source: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Child Maltreatment 2011(Washington, DC: U.S. Government Printing Office, 2012). Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

reported child maltreatment than do other children. Rates of abuse and neglect have fallen in recent years, though less rapidly in the case of infants and toddlers than for older children. Between 2006 and 2011, maltreatment rates for infants declined by 13 percent, and, for toddlers, by 15 percent.

Infant and Toddler Homicide, Total, and by Race/Hispanic Origin, 1990, 2000 and 2010



*Infants and toddlers of Hispanic origin may be of any race.
Source: WISQARS on-line data retrieval system. Available at http://www.cdc.gov/injury/wisqars/index.html

Homicide accounts for one in five injury-related deaths among infants in the United States. **Homicide risk is greater in the first year of life than in any other year of childhood before age 17.** Infants are most likely to be killed by their mother during the first week of life, but thereafter are more likely to be killed by a male (usually their father or stepfather). The risk of infant homicide is highest on the day of birth, and half of all infant homicides occur by the fourth month of life.[1]

Key risk factors associated with infant homicides include the circumstances surrounding the birth of the child. Among homicides occurring on the first day of life, 95 percent of the victims were not born in a hospital. Other important maternal risk factors include a second or subsequent infant born to an unmarried teenage mother; no prenatal care, or care only after the sixth month of pregnancy; a history of maternal mental illness; a mother with 12 or fewer years of education; and premature birth (gestation of less than 28 weeks). Studies suggest that male caretakers (fathers or mothers' intimate partners), often acting impulsively, are the perpetrators of the majority of infant homicides.[2]

About eight in 100,000 U.S. infants, and about three in 100,000 toddlers were victims of homicide in 2010. In most years, males have been more likely than females to be killed during infancy and toddlerhood. In 2010, for example, the infant homicide rate for boys was 8.8 per 100,000 children under age one, and 6.9 for girls. This gap has generally widened since 1970. Black infants and toddlers are substantially more at risk for homicide than are those with another race/ethnicity. In 2010, the homicide rate for black infants was 14.1 per 100,000, while Hispanic and white infants had rates of 6.8 and 7.1 per 100,000, respectively. However, the rate for black infants has decreased greatly since 1990, when it was at 24.5 per 100,000.

1 Child Trends DataBank. (2012). Infant homicide. Retrieved from http://www.childtrends.org/?indicators=infant-homicide
2 Ibid.

lead poisoning

Public awareness of the dangers to young children posed by environmental exposure to lead has contributed to marked declines in blood lead levels among tested children. Nevertheless, there are also disturbing facts: first, it is becoming clear that there is no safe level of lead exposure, so that even minute amounts may pose risks, particularly for infant development; second, **lead exposure increasingly affects disproportionately the most disadvantaged children—those who live in older, poorer urban areas.**[1]

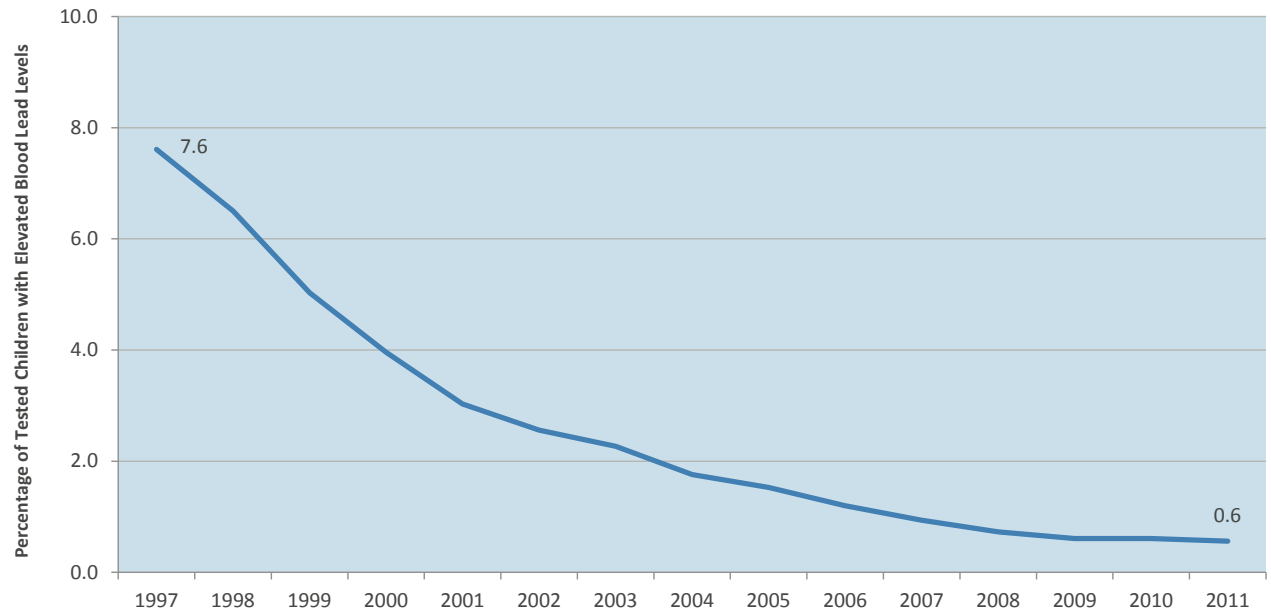
Particularly in children, high blood lead levels (BLLs) can lead to severe neurological problems such as seizures, comas, and death. Lead exposure can also cause learning disabilities, lowered intelligence or behavioral problems.[2]

The percentage of children under the age of six who were tested by their physician and had elevated blood levels has fallen sharply in the past 14 years. In 1997, 7.6 percent of children tested had elevated blood levels; in 2011, the proportion was 0.6 percent.

Mean BLLs remain higher for children in low-income families, black children, and children who live in older housing. In-utero exposure to lead is a significant problem among some new immigrants to the U.S.[3]

1 Child Trends DataBank. (2013). Lead poisoning. Retrieved from http://www.childtrends.org/?indicators=lead-poisoning
2 Ibid.
3 Ibid.

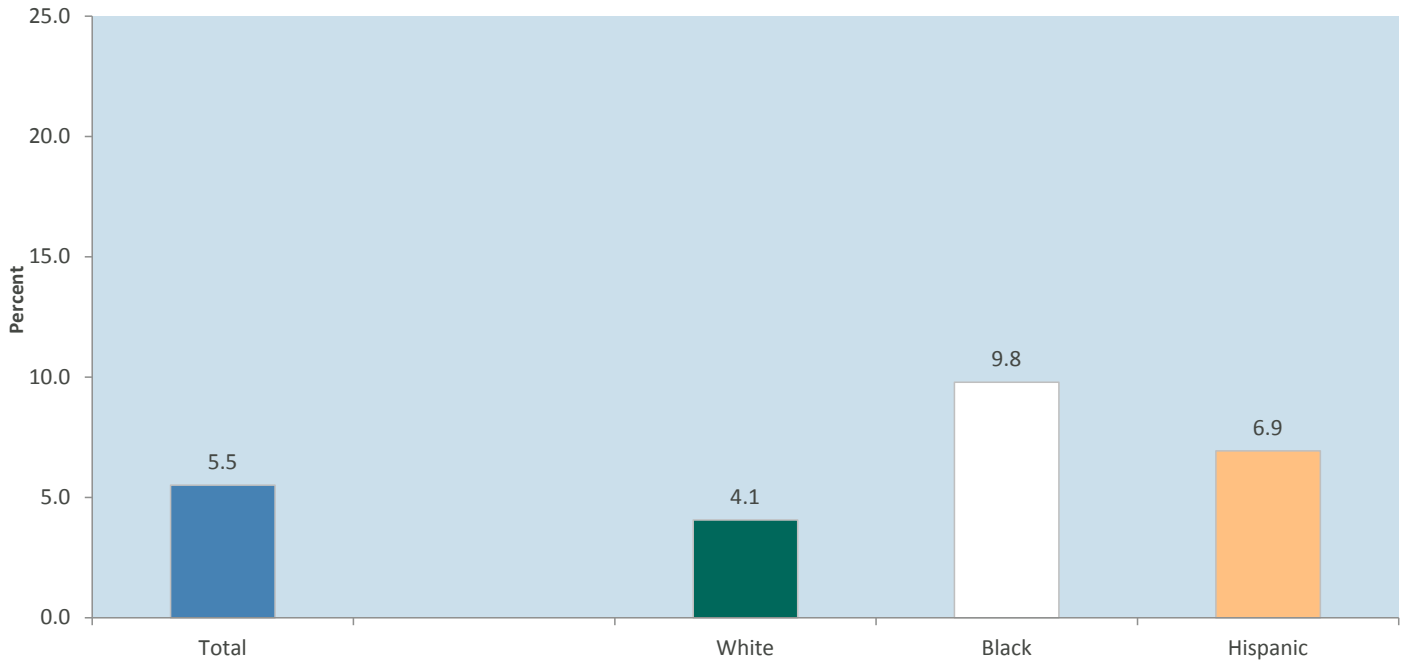
Elevated Blood Lead Levels* for Children Younger than Six Years, 1997-2011



*Elevated blood lead levels are defined as greater than or equal to 10 micrograms per deciliter (µg/dL) .
Source: Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Environmental Health. (2013). CDC's national surveillance data (1997-2011): Tested and confirmed elevated blood lead levels by state, year and blood lead level group for children <72 months. Available at: http://www.cdc.gov/nceh/lead/data/national.htm

asthma

Percentage of Children Ages Birth Through Two Currently with Asthma, Total and by Race /Hispanic Origin, 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health

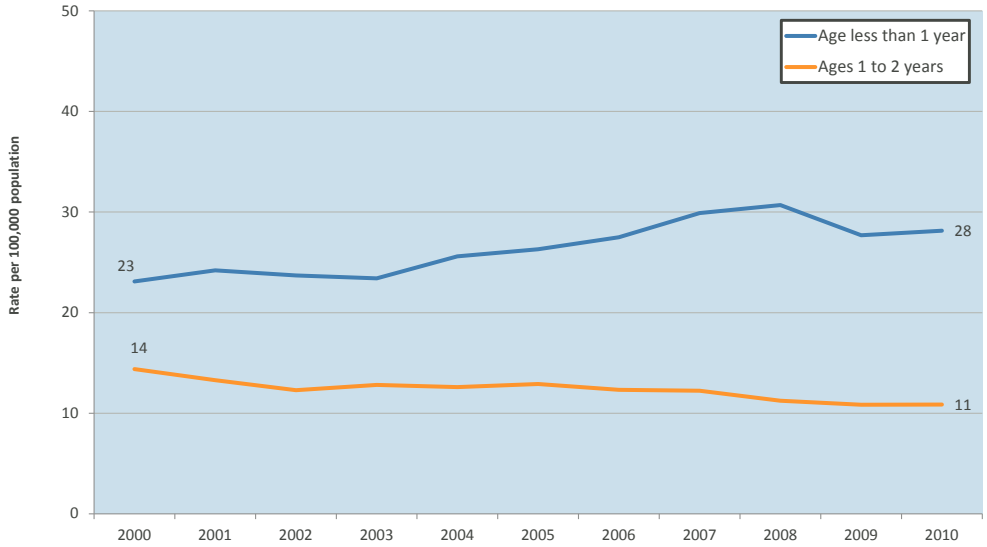
Asthma is the most prevalent chronic condition of childhood in the U.S. Research implicates multiple underlying causes for asthma; however, it is clear that a number of environmental triggers can set off an asthma attack. Many of these are associated with poor housing and with exposure to pollutants that are disproportionately found in poor neighborhoods.[1]

Among children younger than three, about one in 18 have current asthma—a proportion that has changed little over the past ten years. Rates among young black children are more than twice as high as among white children, while rates for Latinos fall in between. **Infants and toddlers living in poverty are three times more likely to have asthma as are those with family incomes at least double the poverty level.** Boys are more likely than girls to have asthma.

1 Child Trends DataBank. (2013). Asthma. Retrieved from http://www.childtrends.org/?indicators=asthma

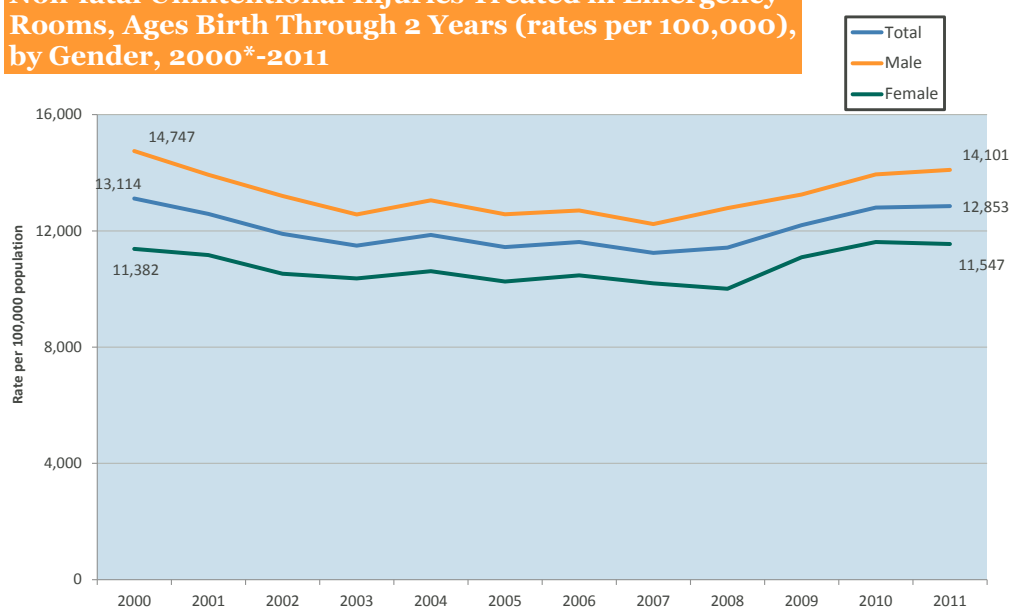
unintentional injuries

Fatal Unintentional Injuries (rates per 100,000), Infants and Toddlers, by Age, Selected Years, 2000-2010



Source: National Center for Injury Protection and Control. (2012). WISQARS online, fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/fatal.html

Non-fatal Unintentional Injuries Treated in Emergency Rooms, Ages Birth Through 2 Years (rates per 100,000), by Gender, 2000*-2011



Note: Data for 2000 may be affected by seasonality.
Source: National Center for Injury Protection and Control. (2012). WISQARS online, non-fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/nonfatal.html.

Infants and toddlers are particularly prone to certain types of injuries, and are more likely to die from injuries than are older children. For infants, injuries are the fourth leading cause of death;[1] for toddler deaths, they lead all causes. Non-fatal injuries are much more common than fatal ones. Falls lead all other causes of non-fatal injuries in infants and toddlers, accounting for close to half of all these injuries in both groups.[2]

Fatal injury numbers among the youngest children are generally too small to produce interpretable sub-group trends. However, consistently since 2000, American Indian/Alaska Native and black children appear to be at highest risk among major racial/ethnic groups.

For non-fatal injuries, data are also not sufficient to support much sub-group analysis.

1 Suffocation is the cause in 82 percent of infant deaths.
2 Child Trends DataBank. (2012). Unintentional injuries. Retrieved from http://www.childtrends.org/?indicators=unintentional-injuries

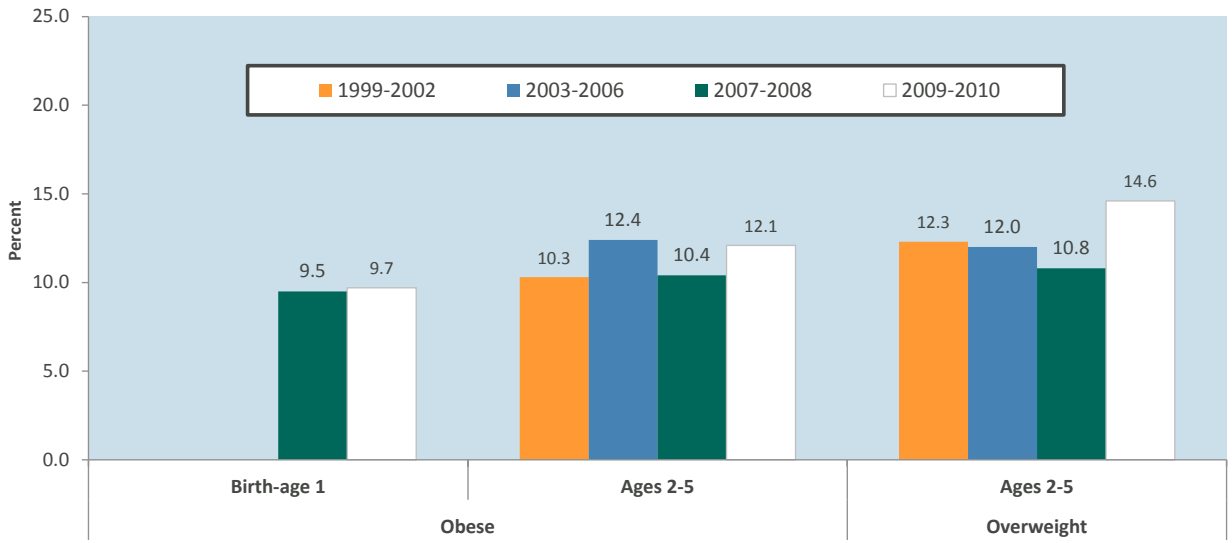
overweight

The widespread problem of overweight in our society extends to the youngest children. Children who are overweight or obese are at increased risk for health and socio-emotional problems, and overweight in the preschool years is highly predictive of being overweight later in childhood. Overweight children are more likely than their peers to develop cardiovascular disease, type-2 diabetes, liver disease, sleep apnea, high cholesterol, and asthma. **There is increasing evidence that the problem of overweight in our population may begin in the earliest years of life.**[1] While there is a paucity of nationally representative data on the weight status of infants and toddlers, the best available data (from 2009-10) show that, among children ages two to five, more than one in four is overweight, and one in eight is obese.

Economic disadvantage appears to be associated with greater risk for being overweight. Within a predominantly low-income sample of two- to five-year-olds, data show that, by race/ethnicity, American Indian/Alaska Native children have the highest rates of overweight and obesity (41 and 21 percent, respectively). Latino children have the next-highest rates, followed by white children; black and Asian/Pacific Islander children have the lowest rates. There is a similar pattern when it comes to obesity, with the exception that white and black rates are close to the same, with Asian/Pacific Islander children lower than either. Overall, rates of obesity and overweight in this low-income sample are higher than those for all children in this age group.

1 Child Trends DataBank. (2012). Overweight children and youth. Retrieved from http://www.childtrends.org/?indicators=overweight-children-and-youth

Percentage of Children Under Age Six Who are Overweight or Obese:* Selected Years, 1999-2010

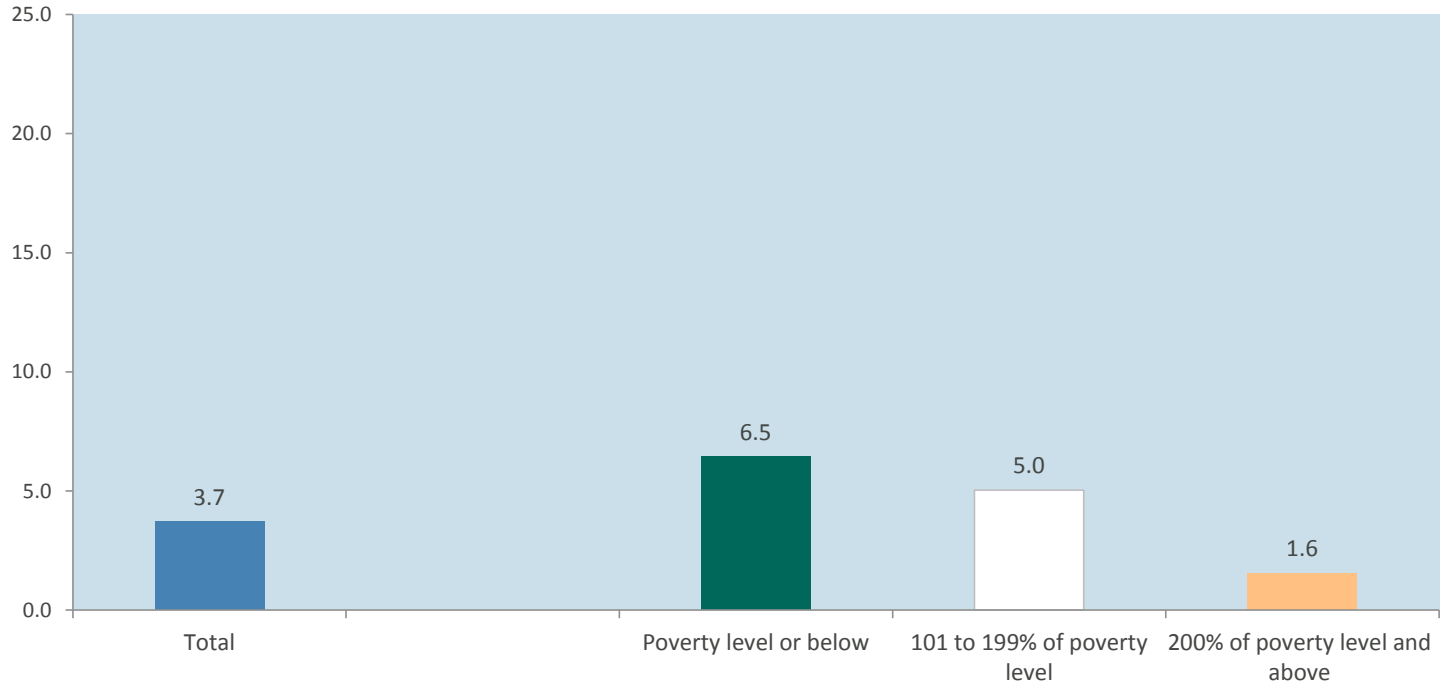


*Based on 2000 CDC growth chart percentiles for children 2 years of age and older; overweight is defined as BMI-for-age >= 85th to < 95th percentile, and obesity is defined as >= 95th percentile.

Sources: Data for 1999-2002 from Hedley, Allison, Ogden, Cynthia, Johnson, Clifford, Carroll, Margaret, Curtin, Lester and Katherine Flegal. "Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2002," JAMA, 291 (23): 2847-2850. Data for 2003-2006: Ogden, Cynthia, Carroll, and Flegal, Katherine. "High Body Mass Index for Age Among US Children and Adolescents, 2003-2006." JAMA, 299 (20): 2401-2405. Data for 2007-2008: Ogden C.L., Carroll, M.D., Curtin, L.R., Lamb, M. M., Flegal, K. M. (2010). Prevalence of high body mass index in US children and adolescents, 2007-2008, JAMA 303 (3). pp 242-249. Available at: http://jama.jamanetwork.com/article.aspx?articleid=185233. Data for 2009-2010: Ogden C.L., Carroll, M.D., Kit, B.K., Flegal, K.M., (2012). Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010, JAMA 307 (5). pp 483-490. Available at: http://jama.jamanetwork.com/article.aspx?volume=307&issue=5&page=483.

oral health

Percentage of Children, Ages One through Two Years, Who had an Oral Health Problem in the Past 12 Months, by Poverty Level, 2011/12

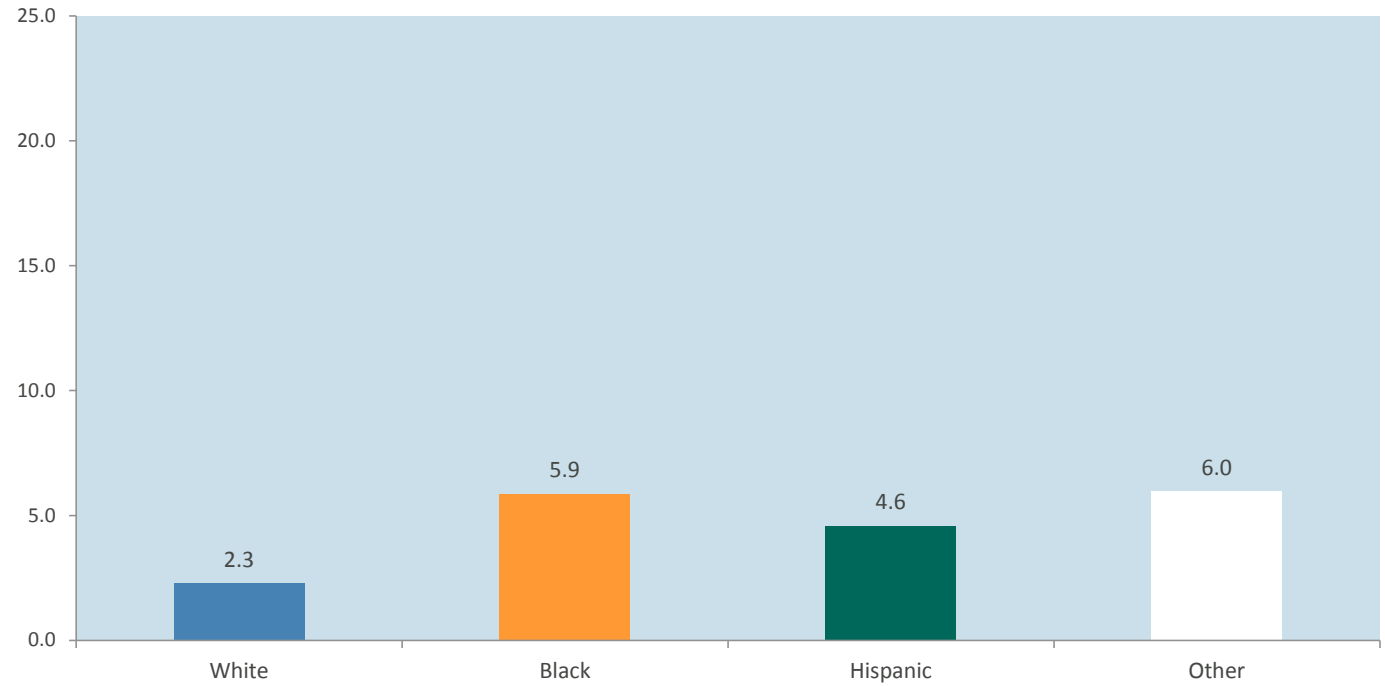


Note: Oral health problems include toothaches, decayed teeth, or unfilled cavities
Source: Child Trends' analysis of the National Survey of Children's Health.

Oral health (which includes dental health) is a dimension of care and well-being that is sometimes overlooked. However, dental caries (tooth decay) can be considered to be a chronic disease of childhood, with prevalence rates higher than those for asthma or allergies.[1] Untreated oral diseases can lead to problems in eating, speaking, and sleeping. Poor oral health among children has been tied to poor performance in school and poor social relationships. For example, children with chronic dental pain may have difficulty concentrating, poor self-image, and problems completing schoolwork. Children with early childhood dental problems also often weigh less.[2]

1 Ramos-Gomez,F., Crystal, Y. O., Ng, M. W., Tinanoff, N., & Featherstone, J. D. (2010). Caries risk assessment, prevention, and management in pediatric care. General Dentistry, November/December, 2010, 505-517.
2 Child Trends DataBank. (2012). Unmet dental needs. Retrieved from http://www.childtrends.org/?indicators=unmet-dental-needs

Percentage of Children, Ages One through Two Years, Who had an Oral Health Problem in the Past 12 Months, by Race/Hispanic Origin, 2011/12



Note: Oral health problems include toothaches, decayed teeth, or unfilled cavities
Source: Child Trends' analysis of the National Survey of Children's Health.

The American Academy of Pediatric Dentistry recommends that all children visit the dentist within six months of the eruption of their first primary tooth, or no later than their first birthday.[3]

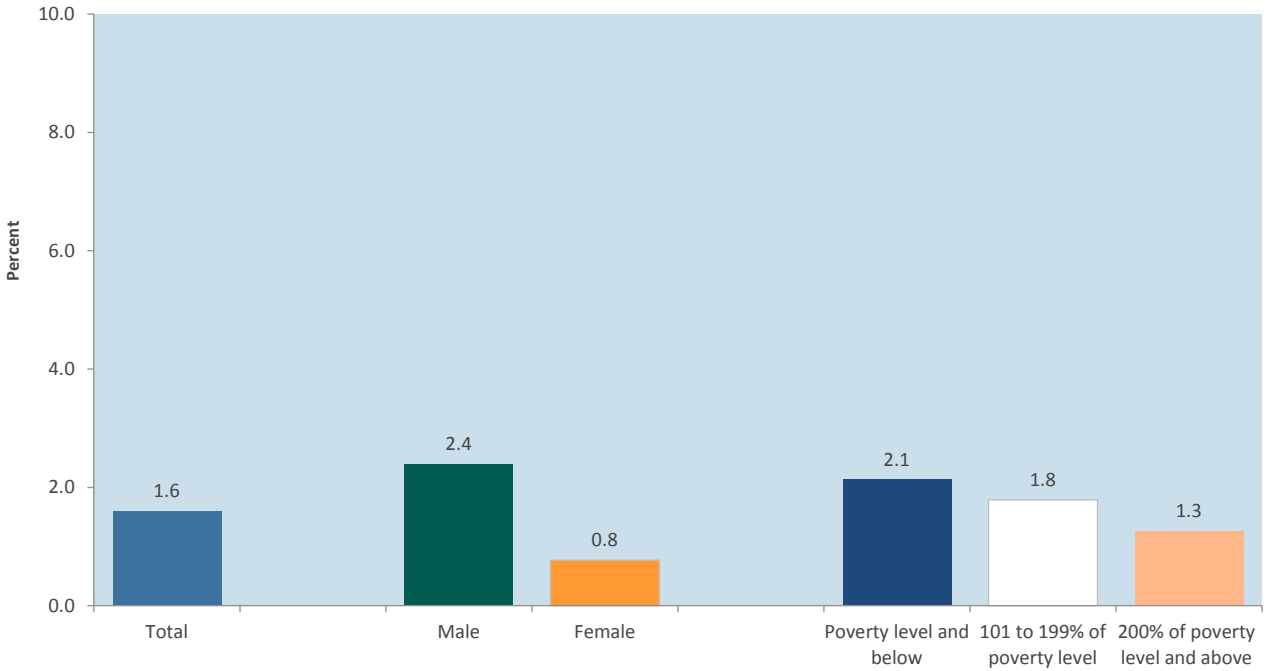
According to 2011/12 data from a nationally representative survey, nearly nine in ten (85 percent) of infants and toddlers have teeth that are in "excellent" or "very good" condition, as reported by their parents. A notably lower percentage of Latino children (73 percent) had teeth in "excellent" or "very good" condition, and this indicator also shows a strong relationship with family income. Children whose parents are foreign-born are also less likely to have healthy teeth.

Four percent of infants and toddlers had one or more oral health problems within the past year. Black children are more than twice as likely as white children to have had problems.

3 Ibid.

autism spectrum disorders

Percentage of Children Ages Two Through Five Who Have Been Diagnosed with Autism or Autism Spectrum Disorder, by Total, Sex, and Poverty Level: 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health.

The identification of autism spectrum disorders (ASD) in young children has risen in recent years. Although most children with ASD are not identified before age four, symptoms usually are evident between the ages of one and three.[1] Children with ASD exhibit a wide range of characteristics, but have in common problems with social and communication skills. Other features typical of children with ASD are unusual patterns of learning, paying attention, and reacting to sensory stimuli.[2]

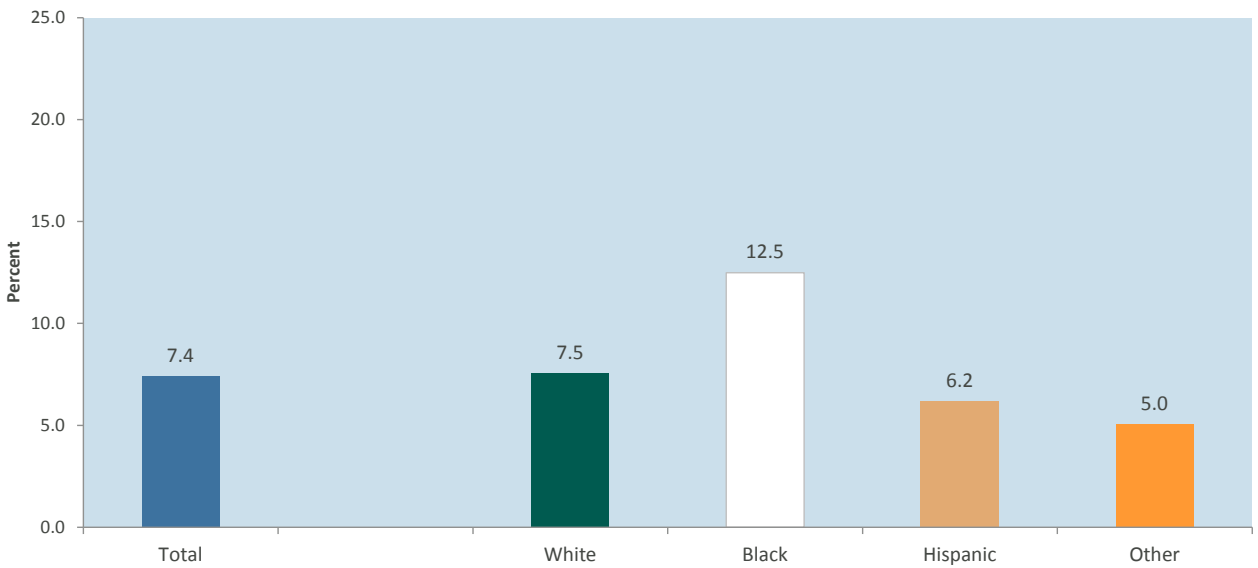
In 2011/12, 1.6 percent of U.S. children ages two through five had ever been diagnosed with ASD. Boys are three times as likely as girls to have received the diagnosis: in 2011/12, the estimated prevalence among boys was 2.4 percent, compared with 0.8 percent among girls. Low-income children are more likely than those in higher-income families to have been diagnosed with ASD.

Early identification and intervention are important for children with ASD, so that they can gain access to programs and services that address the disabilities associated with this disorder. According to 2011/12 data, about one in four children ages two through 17 with ASD received the diagnosis before age three. Girls were more likely than boys, and black children more likely than white or Latino children, to receive early diagnosis.

1 Centers for Disease Control and Prevention. (2012). Prevalence of autism spectrum disorders—Autism and Developmental Disabilities Monitoring Network, 14 sites, United States, 2008. MMWR Surveillance Summaries, 61(3).
2 Child Trends DataBank. (2012). Autism spectrum disorders. Retrieved from http://www.childtrends.org/?indicators=autism-spectrum-disorders

special health care needs

Percentage of Children, Ages Birth through Two, with Special Health Care Needs, by Race/Hispanic Origin, 2011/2012



Note: Special health care needs include needing prescription medications, needing an elevated level of services, being limited in activities, needing specialized therapies, or having an emotional/developmental/behavioral problem, when the need is expected to persist for at least a year.

There is no consensus on how to define disabilities or "special health care needs" among children. Both terms encompass a broad range of chronic health conditions, from major physical or developmental disabilities to conditions that are often less limiting, such as autism spectrum disorder or asthma. In 2010/11, about one in 14 children younger than three was reported by their parents to have a special health care need. A significantly higher percentage of children in poverty had a special health care need than did children living in families with incomes at least twice the poverty level.[1]

The coordination of care, involving doctors, teachers, and community resources, can be challenging for parents of children with special health care needs. About two-thirds of infants and toddlers with special health care needs who received two or more services got help with coordination of care or services, according to their parents.

1 Child Trends DataBank. (2012). Children with special health care needs. Retrieved from http://www.childtrends.org/?indicators=children-with-special-health-care-needs

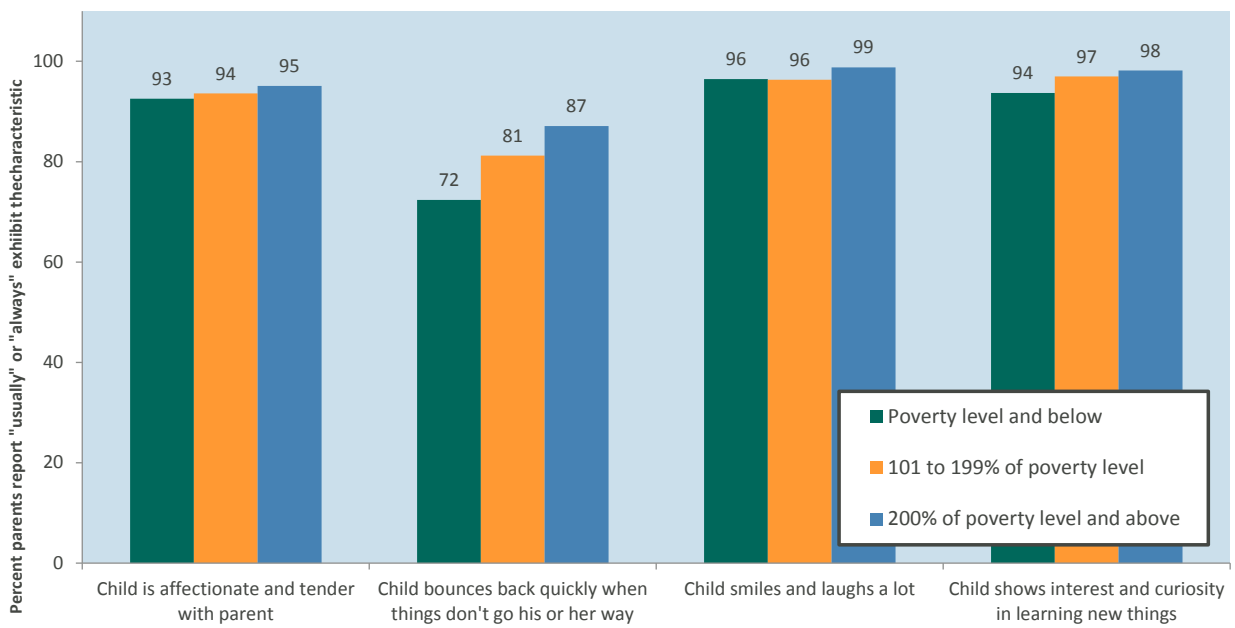
For many years, more attention was paid to study of the characteristics of a "normal" (or of an unwell) child than to those that exemplify a child who is thriving. However, developmental science has begun to identify a number of building blocks of the positive pole of well-being, sometimes referred to as "flourishing."[1]

Within the period of infancy and toddlerhood, important markers of flourishing include a healthy attachment relationship, curiosity and interest in learning, the ability to regain equilibrium after an upset, and expressions of joy or happiness.

A recent national survey collected responses from parents that allow us to describe the proportion of young children who are flourishing in these ways. A child whose parents say they "always" or "usually" in the past month "smile and laugh a lot," "bounce back quickly when things don't go their way," "show interest and curiosity in learning new things," and "is affectionate and tender with the parent" is considered to show characteristics of flourishing. There is no consensus as yet on whether any one of these is more important than the others, or whether there are meaningful differences between, say, a child who meets all four of these criteria and one who meets only three.

However, survey results show that more than eight in ten children six months through two years of age are exhibiting each these aspects of flourishing. Proportions range from 98 percent ("usually" or "always" smiles and laughs a lot), to 82 percent ("usually" or "always" bounces back quickly). On each of the four measures, significantly fewer children living in poverty, compared with those in families with incomes at least twice the poverty level, meet this level of frequency. Moreover, compared with their white counterparts, black children are less likely to have parents say they "usually" or "always" exhibit each of these characteristics, as are Latino children with regard to all but the "affectionate and tender" measure.

Percentage of Children, Six Months through Two Years, Exhibiting Selected "Flourishing" Characterisicstics, by Income Level: 2011/12



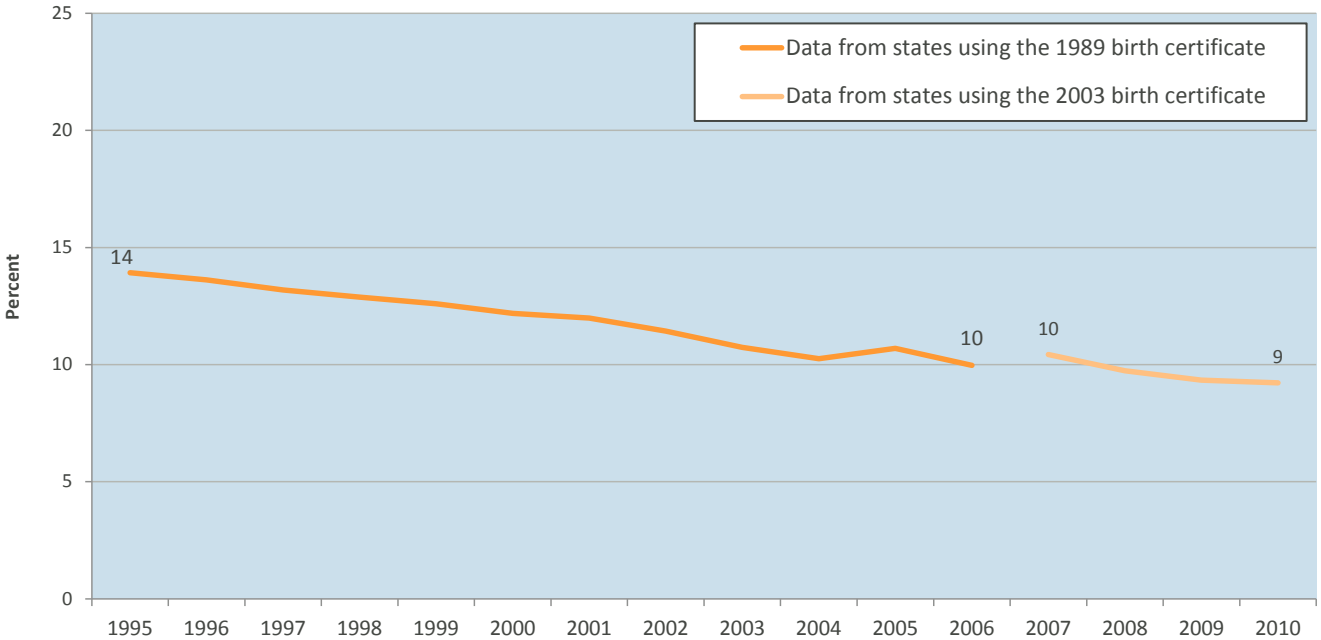
Source: Child Trends' analysis of the National Survey of Children's Health.

1 Moore, K. A. & Lippman, L. H. (Eds.) (2005). What do children need to flourish? Conceptualizing and measuring indicators of positive development. NY: Springer.

Risk Factors:

smoking during pregnancy

Percentage of Births Where Mothers Smoked During Pregnancy, 1995-2010

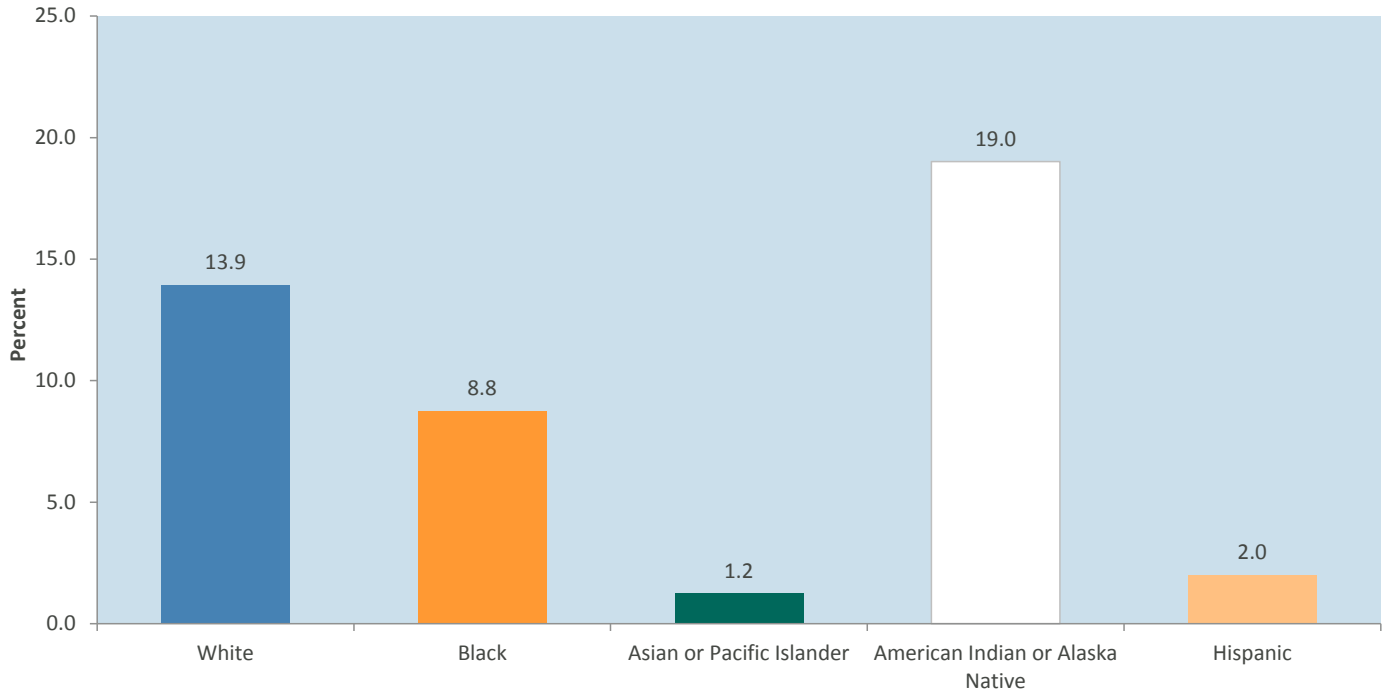


Note: The number of states using the 1989 and 2003 revisions of the standard birth certificate has varied over time. Differences are due to a change in question wording, from asking about tobacco use throughout the pregnancy to asking about use in individual trimesters and the three months prior to pregnancy.
Data Source: National Center for Health Statistics, CDC WONDER. Available at: http://wonder.cdc.gov/controller/datarequest/D27;jsessionid=8C8BFA903E0896C0902AD1BF22A6D3EE.

If a pregnant women smokes, or even if she is exposed to "second-hand" (environmental) cigarette smoke, the harmful effects of smoking extend to the developing infant in utero. Infants born to mothers who smoke are more likely to be born with low weight, to develop asthma, and to become overweight in early childhood. They are three times more likely than infants whose mothers do not smoke during pregnancy to die from Sudden Infant Death Syndrome (SIDS).[1]

1 Child Trends DataBank. (2012). Mothers who smoke while pregnant. Retrieved from http://www.childtrends.org/?indicators=mothers-who-smoke-while-pregnant

Percentage of Births Where Mothers Smoked During Pregnancy, by Race and Hispanic Origin, 2010*



*Data are based on the 34 States using the 2003 revision of the standard birth certificate, representing 76 percent of all births
Data Source: National Center for Health Statistics, CDC WONDER. Available at: http://wonder.cdc.gov/controller/datarequest/D27;jsessionid=8C8BFA903E0896C0902AD1BF22A6D3EE.

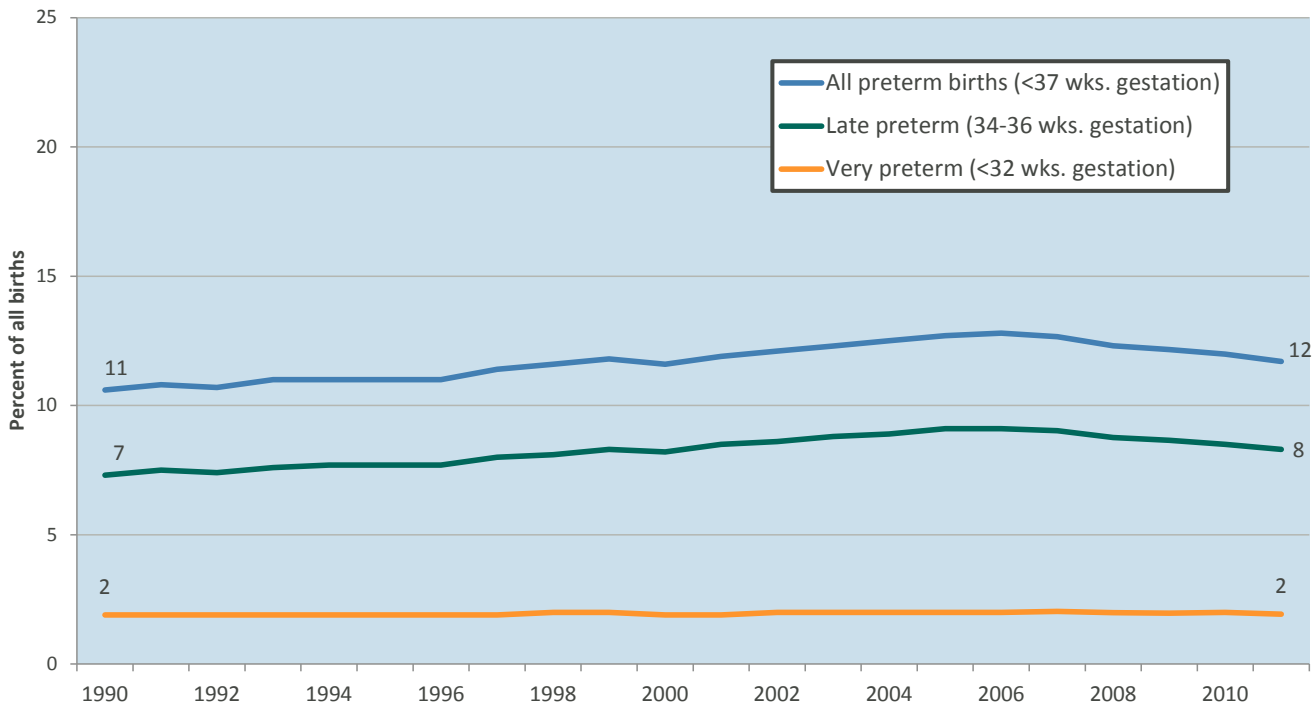
Smoking during pregnancy (like cigarette smoking generally) is a behavior disproportionately associated with race/ethnicity and socioeconomic status. American Indian/Alaska Native women have the highest rate among major race/ethnicity groups, at 19 percent. White women have the next highest risk, with 14 percent reporting smoking during pregnancy; black women are at nine percent. Pregnant Latina and Asian/Pacific Islander women have the lowest rates, at two and one percent, respectively.[2] Differences by mother's level of education are still more striking. **The highest rates of smoking during pregnancy are among women with no more than a high school diploma;** they are more than 15 times more likely to smoke than are pregnant women who have four years of college or more. Younger women are also more likely than older women to smoke while pregnant.

2 There can be substantial variation by sub-group within these broad categories. For example, rates among Puerto Rican women are much higher than rates among Latinas with origins in Central and South America.

Risk Factors:

preterm births

All Preterm and Late Preterm Births, as Percentages of All Births, 1990-2011

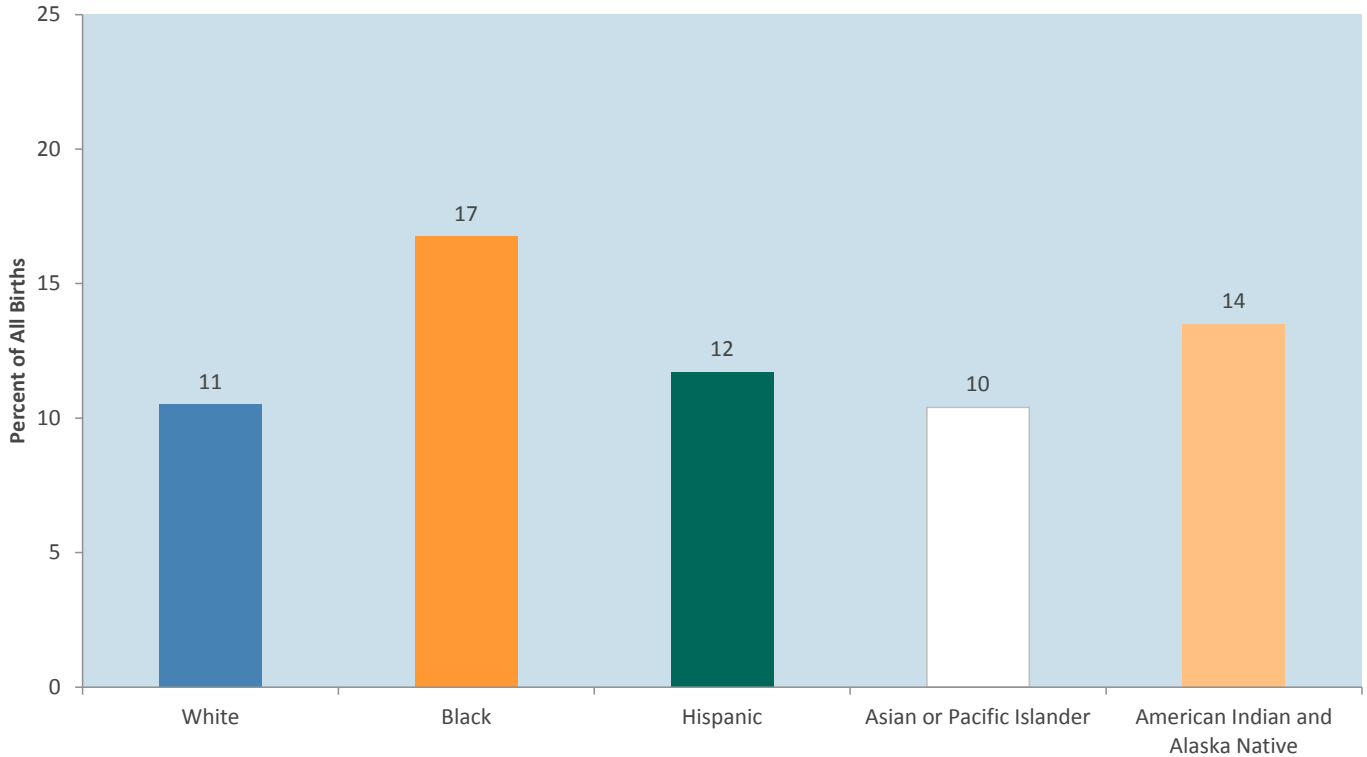


Note: Percentage calculations exclude records missing gestation period data.
Source: Data for 1990-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm . Data for 2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

Babies born preterm (before the 37th week of pregnancy) are at risk for a number of negative outcomes. Preterm birth is the leading cause of infant mortality. Infants born preterm have higher rates of health complications and lifelong disabilities, including mental retardation, learning and behavioral problems, cerebral palsy, lung problems, vision and hearing loss, diabetes, high blood pressure, and heart disease. Children born preterm may also have increasing difficulties with the more complex cognitive functioning called upon as they grow older, even before they enter school.[1]

1 Child Trends DataBank. (2013). Preterm births. Retrieved from http://www.childtrends.org/?indicators=preterm-births

Percentage of Births that are Preterm Births (Less Than 37 Weeks Gestation), by Race/Hispanic Origin,* 2011



*Hispanics can be of any race. Asian and Pacific Islanders, and American Indian and Alaska Natives, include Hispanics.
Note: Percentage calculations exclude records missing gestation period data.
Source: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

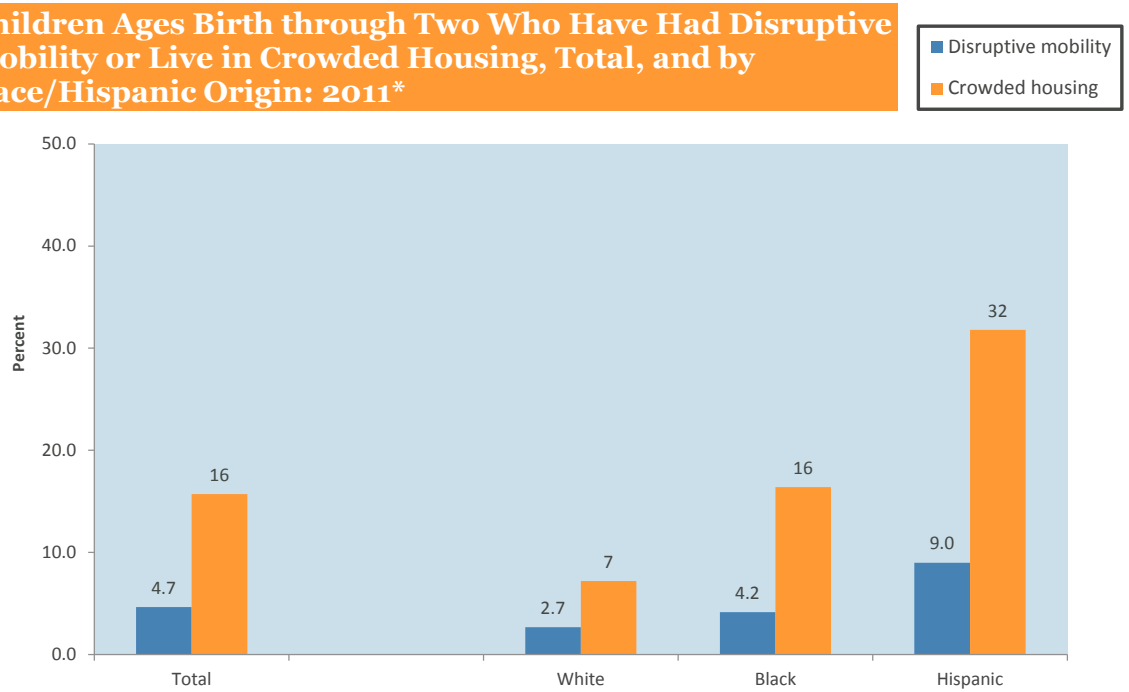
Currently, about one in eight U.S. babies is born preterm. However, among black infants, the figure is closer to one in six; for Latino babies, about one in nine, and for white infants, closer to one in ten. The causes of preterm birth are not all understood, but among the contributing factors are a multiple pregnancy (twins, triplets, etc.), mother's smoking or use of alcohol and other drugs during pregnancy, and high levels of maternal stress, including experiencing domestic violence. The Healthy People 2020 goal is 11.4 percent.[2]

2 Ibid.

Risk Factors:

housing insecurity

Children Ages Birth through Two Who Have Had Disruptive Mobility or Live in Crowded Housing, Total, and by Race/Hispanic Origin: 2011*



*Data for disruptive mobility are for 2011 and 2012.
Note: Disruptive mobility is defined as moving more than two times per year of life, while crowded housing is defined as having more than two household members per bedroom, or, if no bedrooms, more than one person per room.
Sources: Disruptive mobility: Child Trends' analysis of the National Survey of Children's Health. Crowded housing: Child Trends' analysis of American Community Survey data, Public Use Microdata Sample.

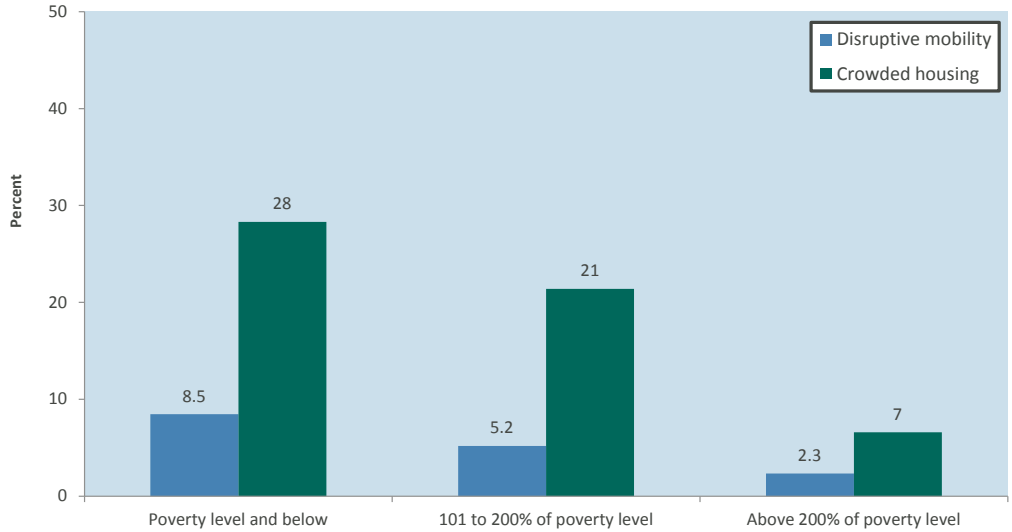
The quality of the physical environment, and in particular, of housing, has substantial effects on development—perhaps especially so for the youngest children, since they lack independent mobility. In addition, the stability of housing—as measured by the frequency of residential moves—plays a role in children's well-being.

Crowded living conditions impose burdens, both practical and emotional, on children and parents, negatively affecting child health and behavior, and parenting. In homes where families are crowded, parents are less responsive to infants and toddlers, and more likely to use punitive discipline.[1] Crowding has also been associated with children's health problems, including respiratory conditions, injuries, and infectious diseases, and with young children's food insecurity.[2]

Frequent moves can disrupt many aspects of families' lives, including their connections with social support networks, and formal services such as child care. High rates of housing mobility may also be indicative of economic insecurity and parents' tenuous hold on employment. Multiple childhood moves have also been associated with negative outcomes, particularly for older children, in the areas of health, behavior, and school performance.[3]

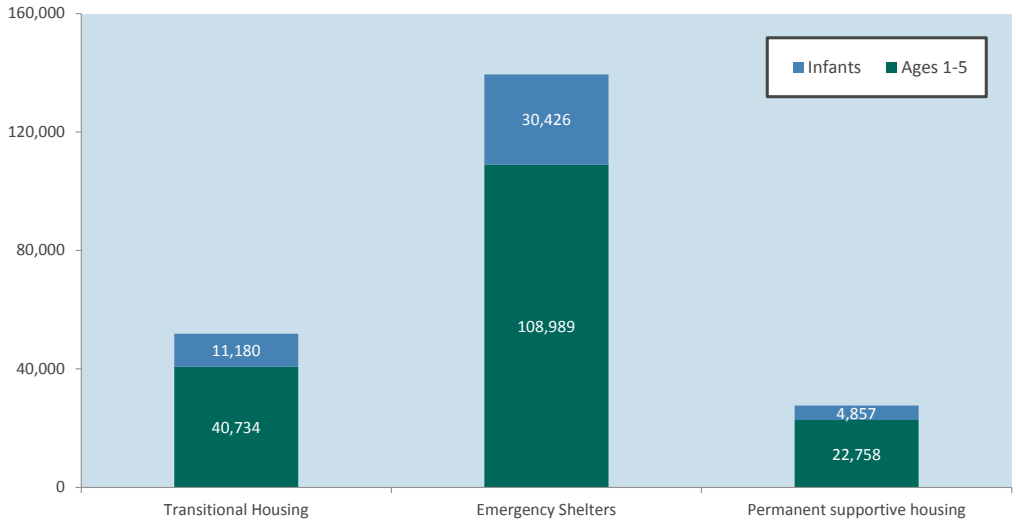
1 Evans, G. (2006). Child development and the physical environment. Annual Review of Psychology, 57, 423-451.
2 Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., Geppert, J., Ettinger de Cuba,S., Heeren, T., Coleman, S., Rose-Jacobs, R., & Frank, D. A. (2011). U.S. housing insecurity and the health of very young children. American Journal of Public Health, 101(8), 1508-1514.
3 Ibid.

Children Ages Birth through Two Who Have Had Disruptive Mobility or Live in Crowded Housing, by Poverty Level: 2011*



*Data for disruptive mobility are for 2011 and 2012.
Note: Disruptive mobility is defined as moving more than two times per year of life, while crowded living is defined as having more than two household members per bedroom, or, if no bedrooms, more than one person per room.
Sources: Disruptive mobility: Child Trends' analysis of the National Survey of Children's Health. Crowded living: Child Trends' analysis of American Community Survey, Public Use Microdata Sample.

Sheltered Homeless Children Younger than Six, by Age Group, 2010



Source: US Department of Housing and Urban Development, Office of Community Planning and Development. (2011) The 2010 Annual Homeless Assessment Report to Congress. Available at: http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf.

For this indicator, we define crowding as more than two people per bedroom. In 2011, about one in six infants and toddlers lived in crowded housing, but the proportion was more than one in four for those below the poverty level. By race/ethnicity, Pacific Islander infants and toddlers were three times as likely as their white peers to live in crowded conditions, and Latinos were not far behind. American Indian, Asian, and black young children were all more than twice as likely as whites to be in crowded housing.

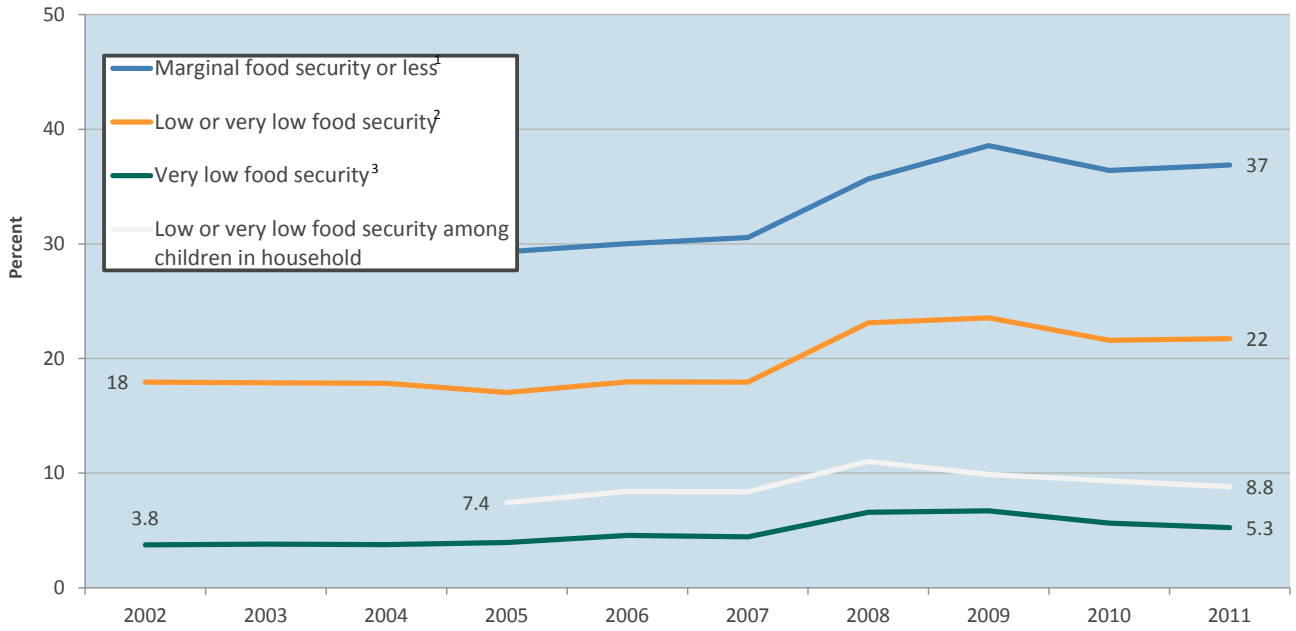
We define disruptive mobility as more than two moves per year of life. Among infants and toddlers in 2011/12, overall about one in 20 fell in that category. However, young children living with single mothers were more than twice as likely as those living with two parents to have experienced disruptive mobility; Latinos were three times more likely to have done so than were whites; and young children in poverty were three times more likely to have experienced disruptive mobility than were their counterparts in families with incomes at least twice the poverty level.

Finally, homelessness marks an extreme form of housing insecurity. **In 2010, there were nearly 40,000 infants in the U.S. who were among the "sheltered homeless."** An additional 143,000 one- to five-year-olds were in this group. More than 2,000 of these young children were not accompanied by an adult.

Risk Factors:

food insecurity

Percentage of Children (0-2) in Food-Insecure Households, Selected Years, 2002-2011



[1] Marginal food security is when the household reported one or two indications of food insecurity--typically concerns about food sufficiency or shortage of food in the house. There is little or no indication of changes in diets or food intake. Households that were less food secure were also included.
[2] Low food security is when the household reports of reduced quality, variety, or desirability of diet. There is little or no indication of reduced food intake. Households that were less food secure were also included.
[3] Very low food security is when the household reports there are reports of multiple indications of disrupted eating patterns and reduced food intake.
Source: Child Trends' analysis of the Current Population Survey: Food Security Supplement.

No parent wants to have their baby grow hungry. Indeed, parents will sacrifice their own nutritional needs before they let their children's go unmet. Inadequate food intake in children is associated with a number of serious health, behavior, and cognitive deficits. Children who are food-insecure are in poorer health than children who are in food-secure households. Higher rates of hospitalization, iron deficiency anemia, and chronic health conditions are reported among food-insecure children. Paradoxically, food insecurity is also with children's greater risk for being over-weight.[1]

Studies also report that food insecurity is associated with higher rates of behavioral problems in three-year-olds. Food insecurity, particularly when experienced in the earliest primary grades, also has significant detrimental effects on young children's interpersonal skills, self-control, and the group of competencies (including attentiveness, persistence, and flexibility) termed "approaches to learning." Recent research shows that

1 Child Trends DataBank. (2012). Food insecurity. Retrieved from http://www.childtrends.org/?indicators=food-insecurity

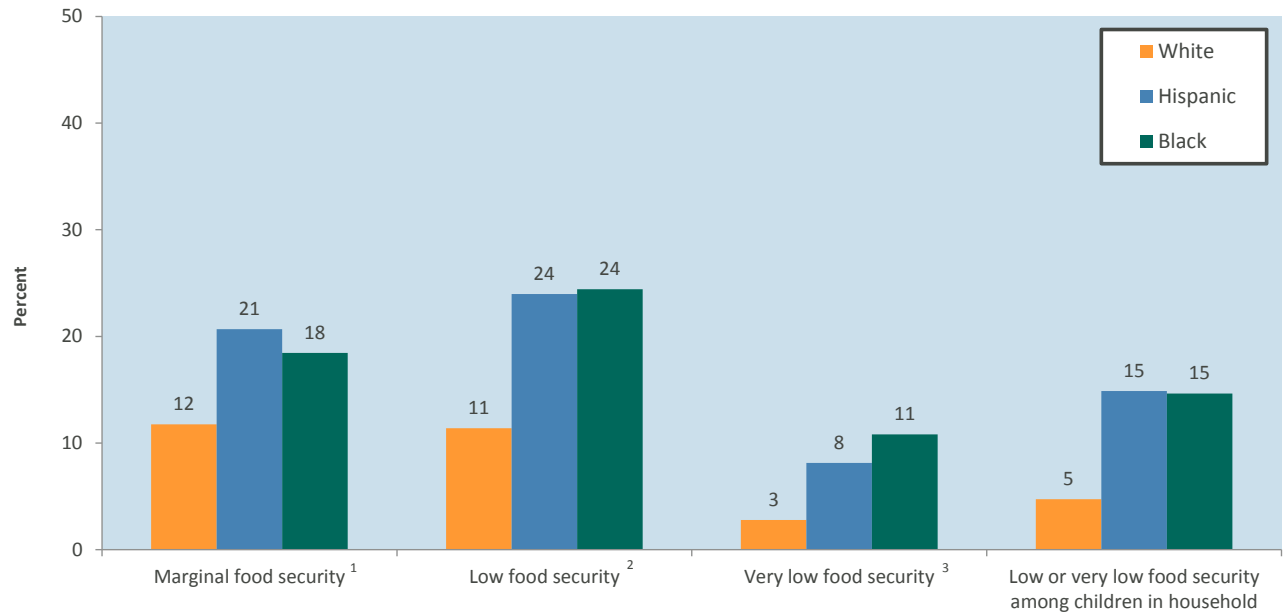
even "marginal" food insecurity can have negative effects on health.[2]

The measurement of food insecurity is somewhat complex, relying on a series of survey questions. All members of a household that is having difficulty obtaining enough healthy food are considered "food-insecure." However, because adults generally do all they can to see that children are the last to suffer food-related hardship, a more sensitive indicator of serious risk is the percentage of households reporting that children are going without sufficient healthy food.

Not surprisingly, the prevalence of food insecurity is closely tied to poverty, but also to race/ethnicity, parental education, and family structure. **While one in nine white and Asian infants and toddlers lives in a food-insecure household, among black and Latino households hunger is twice as common—closer to one in four children, and about one in five among American Indian/Alaska Native households.** Further along the risk spectrum, about one in seven Latino and black infants and toddlers lives in a household where there is food insecurity specifically among children—a percentage more than twice that found in white, Asian, and American Indian/Alaska Native households.

2 Cook, J. T., Black, M., Chilton, M., Cutts,D., Ettinger de Cuba, S., Heeren, T., Rose-Jacobs, R., Sandel, M., Casey, P. H., Coleman, S., Weiss, I, & Frank, D. A. (2013). Are food insecurity's health impacts underestimated in the U.S. population? Marginal food insecurity also predicts adverse health outcomes in young U.S. children and mothers. Advances in Nutrition, 4, 51-61.

Percentage of Children Ages Birth through Two in Food-Insecure Households, by Race/Hispanic Origin, 2011



[1] Marginal food security is when the household reported one or two indications of food insecurity--typically concerns about food sufficiency or shortage of food in the house. There is little or no indication of changes in diets or food intake.
[2] Low food security is when the household reports of reduced quality, variety, or desirability of diet. There is little or no indication of reduced food intake.
[3] Very low food security is when the household reports multiple indications of disrupted eating patterns and reduced food intake.
Source: Child Trends' analysis of the Current Population Survey: Food Security Supplement.

Risk Factors:

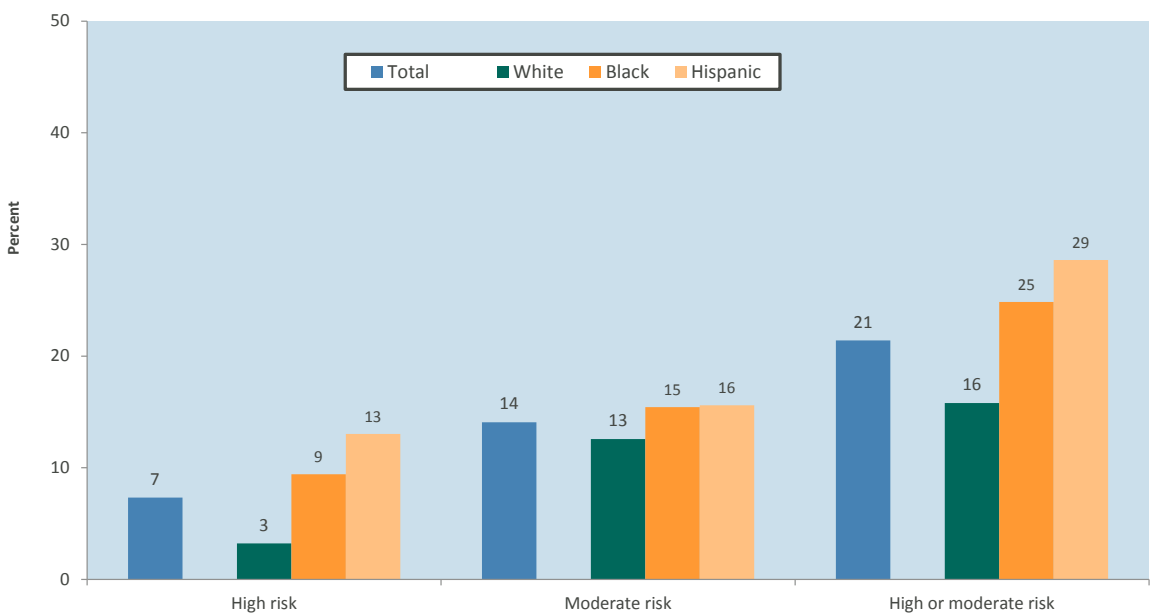
parental concerns about development

Developmental delays among young children can signal the presence of serious physical or psycho-social problems. Screenings can help identify children who are not meeting expected milestones of development.[1] **Because development during infancy and toddlerhood is rapid and cumulative, the success of early intervention depends on early identification.** Delayed development (sometimes termed "failure to thrive") can also indicate the presence of serious neglect or maltreatment.

In 2011/12, more than one in five children (21 percent) between the ages of four months and two years had parents who indicated their concern about one or more items that are considered predictive of developmental delays. For children in this age group, these items include receptive and expressive language, socio-emotional development, and fine- and gross-motor development. Research indicates that when parents express one or more concerns, their child's risk for disabilities is eight times as great as for those whose parents have no concerns; when parents express two or more concerns, the risk is twenty times as high.[2]

Disparities in the prevalence of parental concerns about development are evident by family income, by parental education level, and by race/Hispanic origin. Children in families living below the poverty level are more than 50 percent more likely to trigger parental concerns than are children in families with incomes at least twice the poverty level. Black and Latino children are more likely than white children to have parents who have concerns about their development. Young children whose parents have less than a high school education are more than three times as likely to be at moderate risk (two or more parental concerns) for developmental delays, and those whose parents have only a high school education more than twice as likely, compared with the group whose parents have more than a high school education.

Percentage of Children Ages 4 Months through Two Years With Developmental Risk,* Total and by Race/Hispanic Origin: 2011/12

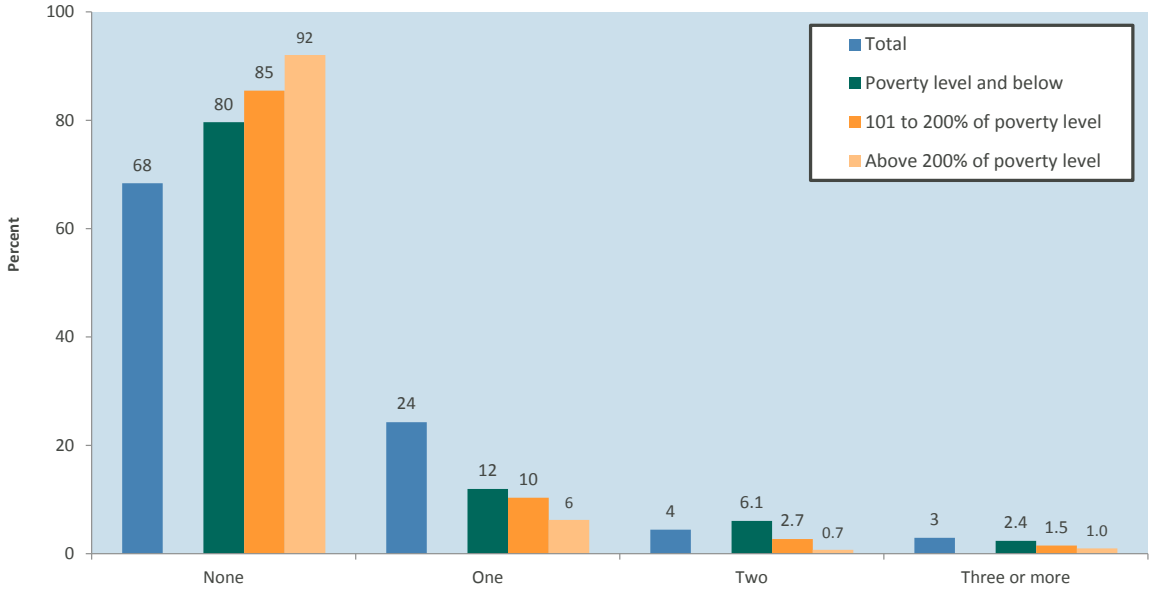


*Risk assessment is based on one or more age-specific parental concerns that are predictive of delay.
Source: Child Trends' analysis of the National Survey of Children's Health.

1 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272-280.
2 Ibid.

Risk Factors: adverse experiences

Percentage of Children Ages Birth through Two, by Number of Adverse Experiences,* Total, and by Poverty Level: 2011/12



*Adverse experiences include: frequent socioeconomic hardship (total only), parental divorce or separation, parental death, parental incarceration, witnessing domestic violence, witnessing violence in the neighborhood, living with someone who is mentally ill or suicidal, living with someone who has problems with substance abuse, and racial or ethnic descrimination.
Source: Child Trends' analysis of National Survey of Children's Health.

Evidence is mounting that highlights the importance of cumulative stress in affecting a number of health and other life-course outcomes. While a degree of stress is unavoidable, when stress reaches "toxic" levels it interferes with the normal development of the body's neurological, endocrine, and immune systems, leading to increased susceptibility to disease. **Infants and toddlers, because their brains are developing rapidly, may be especially vulnerable, and damage may be long-lasting.**[1]

Research has focused on specific life-events in childhood that may be traumatic, depending in part on whether there are supportive caretakers who can "buffer" the level of stress. Recently, this list has been adapted for use in a nationally representative survey of U.S. parents. Survey items asked parents to indicate whether their child had ever experienced one or more of the following: economic hardship, divorce/separation of parent, death of a parent, a parent who served time in jail, witness to domestic violence, victim of or witness to neighborhood violence, lived with someone who was mentally ill or suicidal, lived with someone with an alcohol/drug problem, or was treated or judged unfairly due to race/ethnicity.

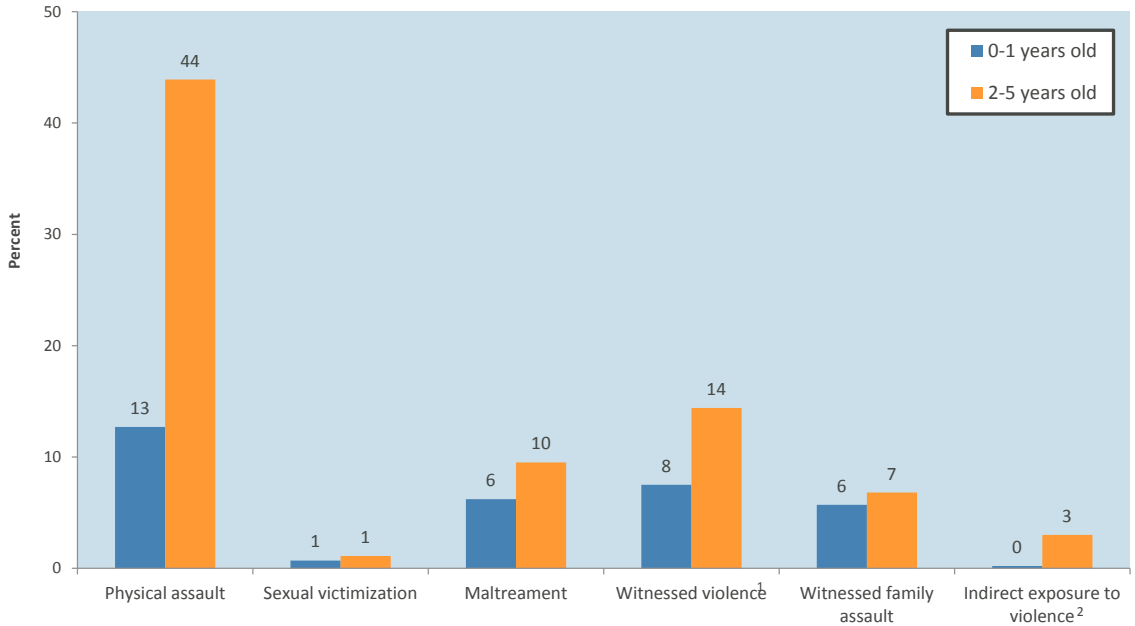
Most U.S. infants and toddlers have experienced none of these adverse events. However, nearly one in four has experienced at least one; the most prevalent is the experience, very or somewhat often, of economic hardship. **About one in 14 has had two or more adverse experiences, which is significant because research shows that cumulative stressful experiences are particularly likely to be harmful.** The prevalence of two or more adverse experiences (excluding economic hardship) is more than four times as high among infants and toddlers living in poverty as it is among those in families with incomes at least twice the poverty level. Boys are less likely than girls to have had no adverse experiences, and are more likely to have a single such experience; boys and girls are equally likely to have had two or more. Children with special health care needs are more than twice as likely as those without such needs to have had two, and more than three times as likely to have had three or more, adverse experiences.

1 Shonkoff, J. P., Garner, A. S., and the Committee on Psychosocial Aspects of Child and Family Health.. (2012). The lifelong effects of early childhood adversity and toxic stress. American Academy of Pediatrics Technical Report. Retrieved from http://pediatrics.aappublications.org/content/129/1/e232.full.pdf

Risk Factors:

exposure to violence

Children Ages Birth through Five Exposed to Violence in the Past Year: Percentages by Child's Age, 2011



[1] Includes witnessing family assault, assault in the community, shooting, or war.
[2] Includes hearing about or seeing violence; excludes witnessing violence, household theft, and school threat of bomb or attack.
Source: Finkelhor, D., Turner, H., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. Published online before print. Available at: http://archpedi.jamanetwork.com/article.aspx?articleid=1686983.

The youngest children are disproportionately exposed to potentially traumatic experiences, many of which involve violence. In fact, the first year of life is the single most dangerous period of childhood when it comes to the risk of death from abuse or neglect. Younger children are also more likely than older children to be present in homes where there is domestic violence. Although some children are more resilient than others, the effects of trauma experienced in the earliest years can be evident at later ages.

Children are more likely to be exposed to violence and crime than adults are. An experience of violence can lead to lasting physical, mental, and emotional harm, whether the child is a direct victim or a witness. Children who are exposed to violence are more likely to suffer from attachment problems, regressive behavior, anxiety, and depression, and to have aggression and conduct problems. Other health-related problems, as well as academic and cognitive problems, delinquency, and involvement in the child welfare and juvenile justice systems, are also associated with experiences of violence. Even community violence that children do not directly witness has been shown to affect negatively their ability to pay attention, and their cognitive performance.[1]

One in eight infants, and nearly half of two- to five-year-olds, were victims of physical assault within the past year, according to a 2011 nationally representative survey. One in 13 infants (7.5 percent), and one in seven two- to five-year-olds (14.4 percent), witnessed violence.

1 Child Trends DataBank. (2013).. Children's exposure to violence. Retrieved from http://www.childtrends.org/?indicators=childrens-exposure-to-violence

Protective Factors: immunizations

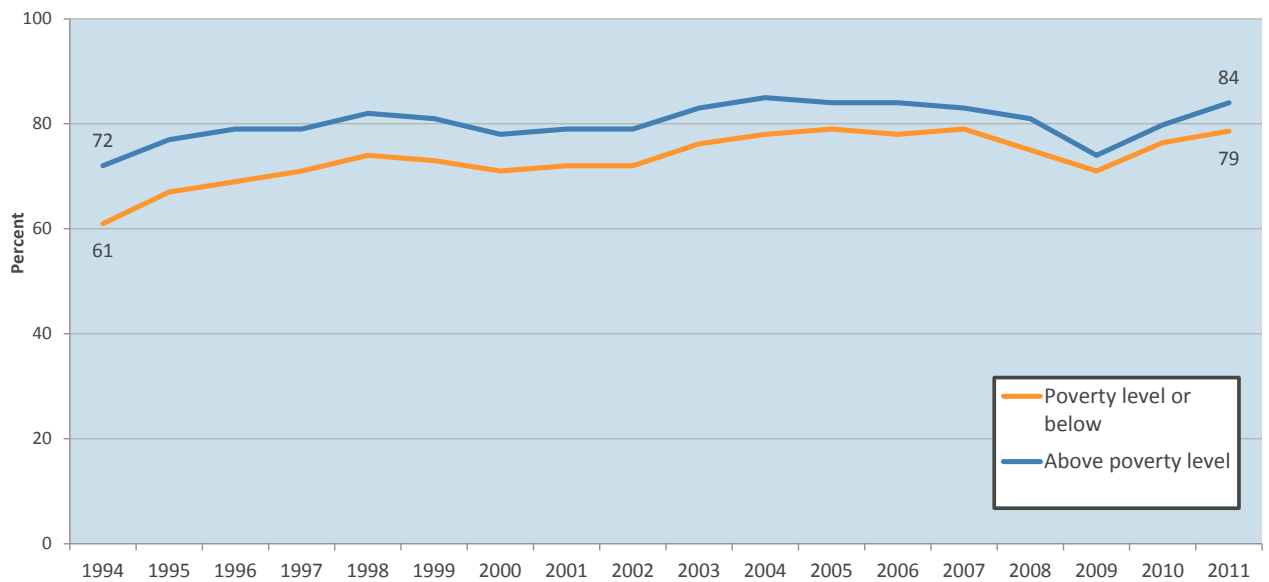
Immunizations are a highly cost-effective preventive strategy to protect against many illnesses that can be life-threatening to infants and toddlers. Vaccines are given early in life because many of the diseases they prevent are more common, and more deadly, among infants and small children. Additionally, childhood immunization is an important step in maintaining high vaccination levels within the population, which prevent outbreaks of such diseases.[1] The U.S. Centers for Disease Control and Prevention issues specific recommendations for vaccines children should receive before they reach three years of age.

These include four doses of the diphtheria, tetanus, and pertussis (DTP) vaccine, three or more doses of polio vaccine, one or more doses of the measles-mumps-rubella (MMR) vaccine, three or more doses of the Haemophilus influenzae type b (Hib) vaccine, the hepatitis B vaccine, and the varicella (chickenpox) vaccine. The DTP, polio, MMR, and Hib vaccines are collectively referred to as the combination or 4:3:1:3 series.

Progress toward full immunization of this age group has stalled in recent years, with about one in five infants and toddlers lacking one or more of the recommended vaccines. Young children in poor families are less likely than those in families living above the poverty level to receive all recommended immunizations.

1 Child Trends DataBank. (2012). Immunization. Retrieved from http://www.childtrends.org/?indicators=immunization

Percentage of Children, Ages 19-35 Months, Receiving the 4:3:1:3 Combined Vaccination Series, by Poverty Status, 1994-2011



Sources: Data for 1994 from: Eberhardt MS, Ingram DD, Makuc DM, et al. Health, United States, 2001, with Urban and Rural Healthbook.Hyattsville, Maryland: National Center for Health Statistics. 2001: Table 73. Data for 1995-2001 from: National Center for Health Statistics. (2003). Health United States, 2003 With Chartbook on Trends in the Health of American. National Center for Health Statistics.Table 71. Data for 2002 from: National Immunization Program (2003). Immunization Coverage in the U.S. Results from National Immunization Survey. Centers for Disease Control and Prevention. Data for 2003: National Immunization Program (2004). Immunization Coverage in the U.S.:Results from National Immunization Survey. Centers for Disease Control and Prevention. Available online at: http://www.cdc.gov/nip/coverage/default.htm#. Data for 2004-2011: Centers for Disease Control and Prevention, National Immunization Program ,NIS data, tables, Jan-Dec . /www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

Protective Factors: breastfeeding

Breastfeeding supports infants' immunologic, nutritional, physical, and cognitive development. Research shows that breastfeeding is associated with a number of benefits to children, including reduced rates of infectious diseases, sudden infant death syndrome, type 1 and type 2 diabetes, lymphoma, leukemia, Hodgkin's disease, overweight and obesity. Children who are breastfed during early infancy are less likely to suffer from diarrhea, ear infections, lower respiratory infections, urinary tract infections, and bacterial meningitis. Breast milk may also help protect against allergies and digestive disorders.[1]

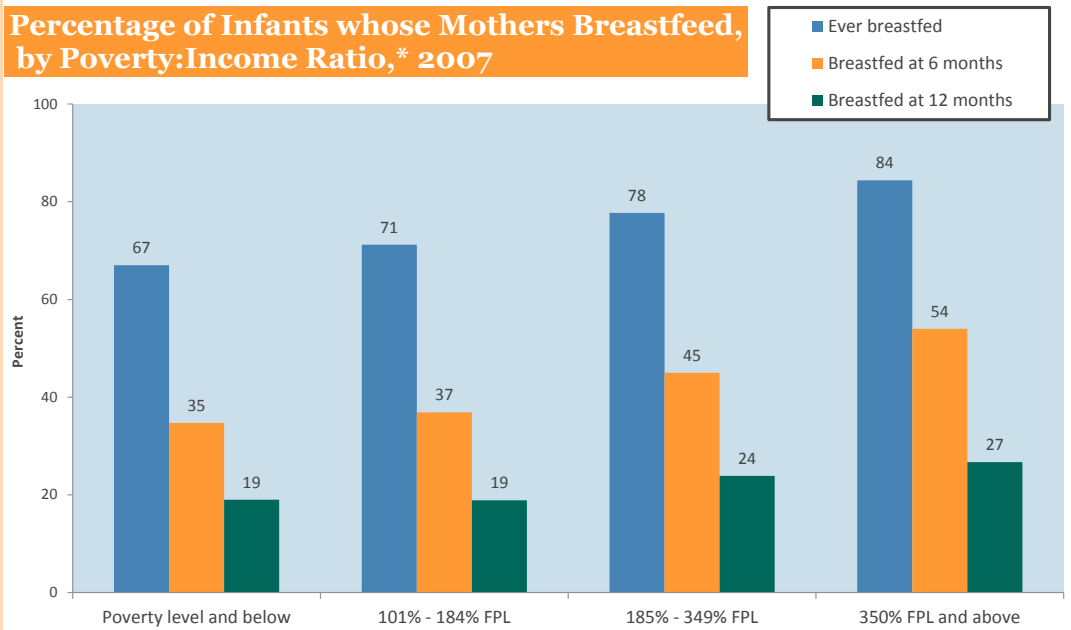
In addition to benefitting infants, breastfeeding is also associated with positive outcomes for mothers. Studies demonstrate a number of maternal health benefits, including earlier return to pre-pregnancy weight, reduced rates of breast and ovarian cancers, and decreased risk of hip fractures and osteoporosis later in the mother's life. Breastfeeding mothers also report higher rates of mother-infant attachment and bonding, feelings of maternal empowerment, and confidence.[2]

For infants born in 2009 (preliminary data), 77 percent of mothers reported ever breastfeeding, 47 percent reported still breastfeeding at six months, and 26 percent reported breastfeeding at 12 months.

Infants born in 2007 (the latest data available with these breakouts) to black mothers were less likely to be ever breastfed than infants born to white, Hispanic, Asian/Pacific Islander, or American Indian and Alaska Native mothers. While Hispanic mothers are more likely than white or American Indian and Alaska Native mothers to ever breastfeed, the likelihood that they will be breastfeeding at six or twelve months is similar in each of these groups. Asian and Pacific Islander mothers are more likely to breastfeed than any group other than Hispanic mothers, according to each of the three measures, particularly at six and twelve months.

Data collected from a low-income sample show significantly lower rates of breastfeeding, as well as differences by mothers' educational attainment and marital status. College graduates, and married mothers, respectively, were more likely to breastfeed than their less educated or unmarried counterparts.[3]

Percentage of Infants whose Mothers Breastfeed, by Poverty:Income Ratio,* 2007



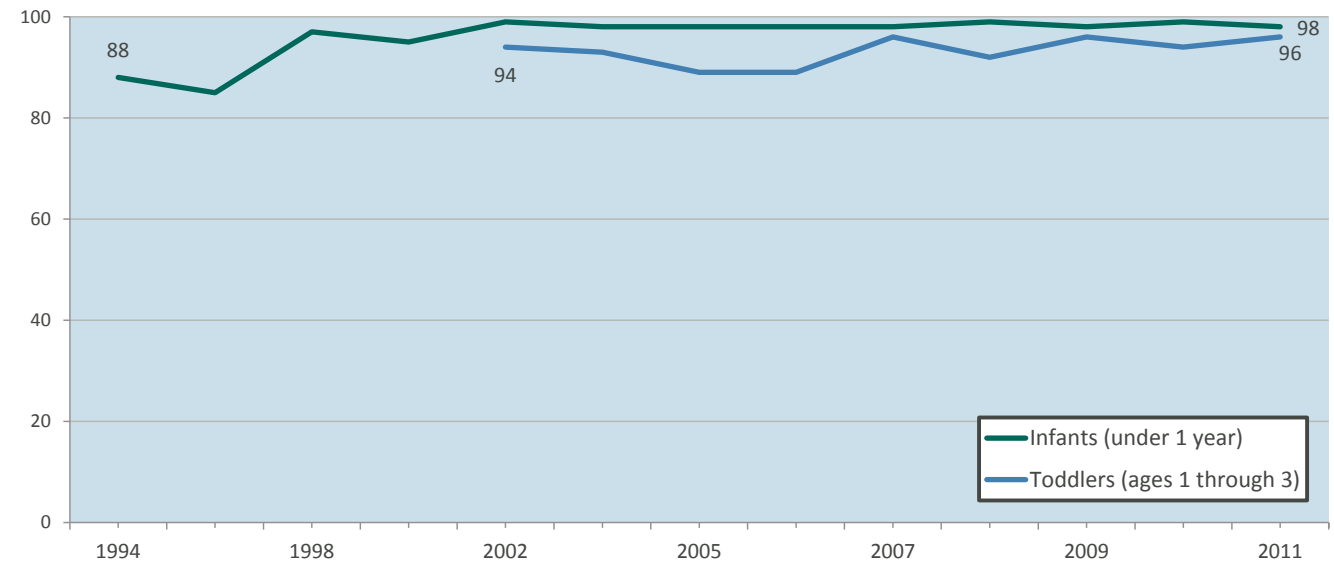
*The poverty income ratio equals the ratio of the self-reported family income to the federal poverty threshold value, taking into account the number of people in in the household.
Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2000–2009, CDC National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

1 Child Trends DataBank. (2012). Breastfeeding. Retrieved from http://childtrendsdatabank.org/alphalist?q=node/82
2 Ibid.
3 Centers for Disease Control and Prevention. 2011 Pregnancy Nutrition Surveillance. Retrieved from http://www.cdc.gov/pedNSS/pnss_tables/pdf/national_table12.pdf

Protective Factors:

car seat restraints

Percentage of Children, Ages Birth through Three, Using Seat Belts or Other Car Seat Restraints: Selected Years, 1994-2011

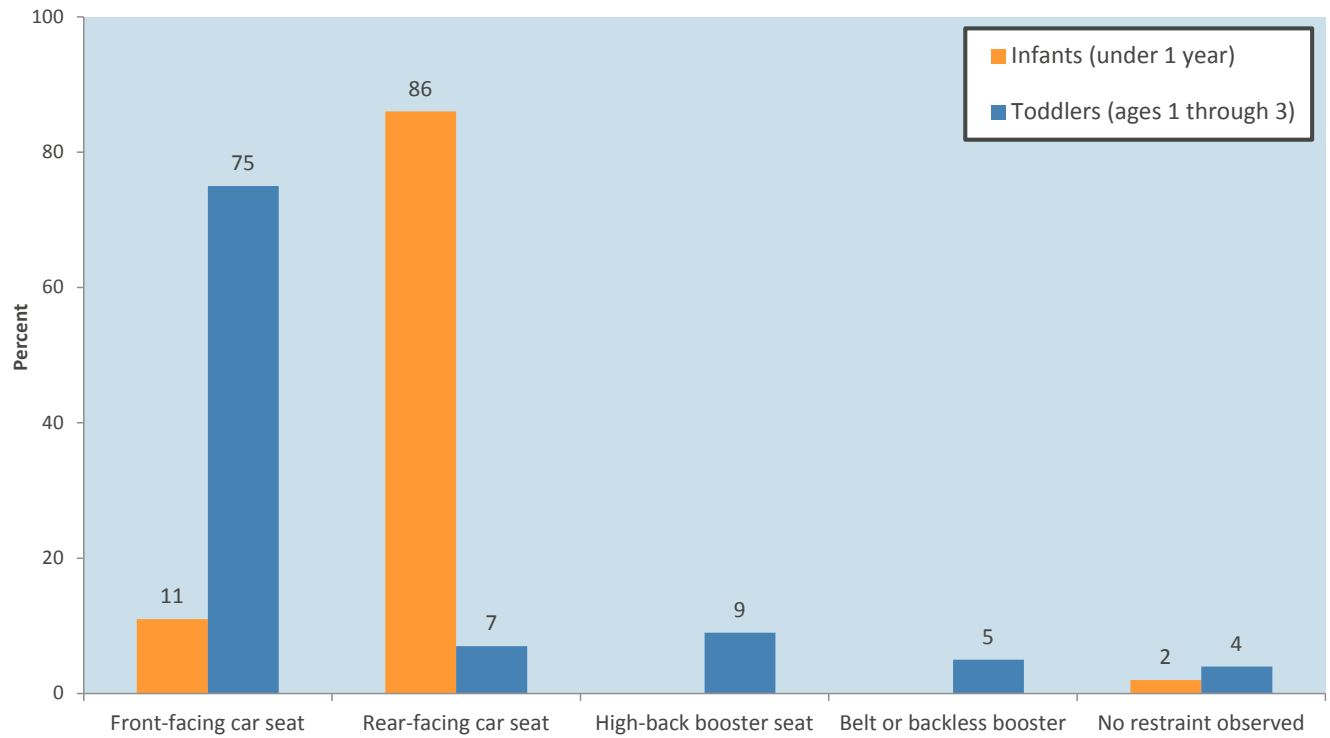


Sources: Data for 1994-2000: Bondy, N. & Glassbrenner, D. (2001). National Occupant Protection Use Survey: 2000 Controlled Intersection Study. DOT HS 809 318. U.S. Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/809318.pdf. Data for 2002-2009: National Highway Traffic Safety Administration. (2010). Occupant restraint use in 2009: Results from the National Occupant Protection Use Survey, Controlled Intersection Study. DOT HS 811 414. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/811414.pdf. Data for 2010 -2011: Pickrell, T. M., & Ye, T. J. (2013). Occupant Restraint Use in 2011: Results from the National Occupant Protection Use Survey Controlled Intersection Study. (Report No. DOT HS 811 697). Washington, DC: National Highway Traffic Safety Administration. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/811697.pdf.

Starting in toddlerhood, deaths from motor vehicle crashes account for nearly a third of all injury-related deaths.[1] Child safety seats reduce the risk of fatal injury by 71 percent. According to the latest recommendations by the National Highway Traffic Safety Administration, all children through age 12 should ride in the back seat of a vehicle. Young children up to three years of age should be in a rear-facing safety seat, until their height or weight reaches limits set by the seat's manufacturer. In 2011, 14 percent of infants under a year old were not in rear-facing car seats, 18 percent of toddlers ages one to three were not in a car seat (rear- or forward-facing).[2]

1 Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System. Fatal injury data. Retrieved from http://www.cdc.gov/injury/wisqars/
2 Child Trends DataBank. (2013). Seat belt use. Retrieved from http://www.childtrends.org/?indicators=seat-belt-use

Percentage of Children, Ages Birth through Three, Using Seat Belts or Other Car Seat Restraints, 2011



Pickrell, T. M., & Ye, T. J. (2013). The 2011 National Survey of the Use of BoosterSeats. (Report No. DOT HS 811 718). Washington, DC: National Highway Traffic Safety Administration. http://www-nrd.nhtsa.dot.gov/Pubs/811718.pdf

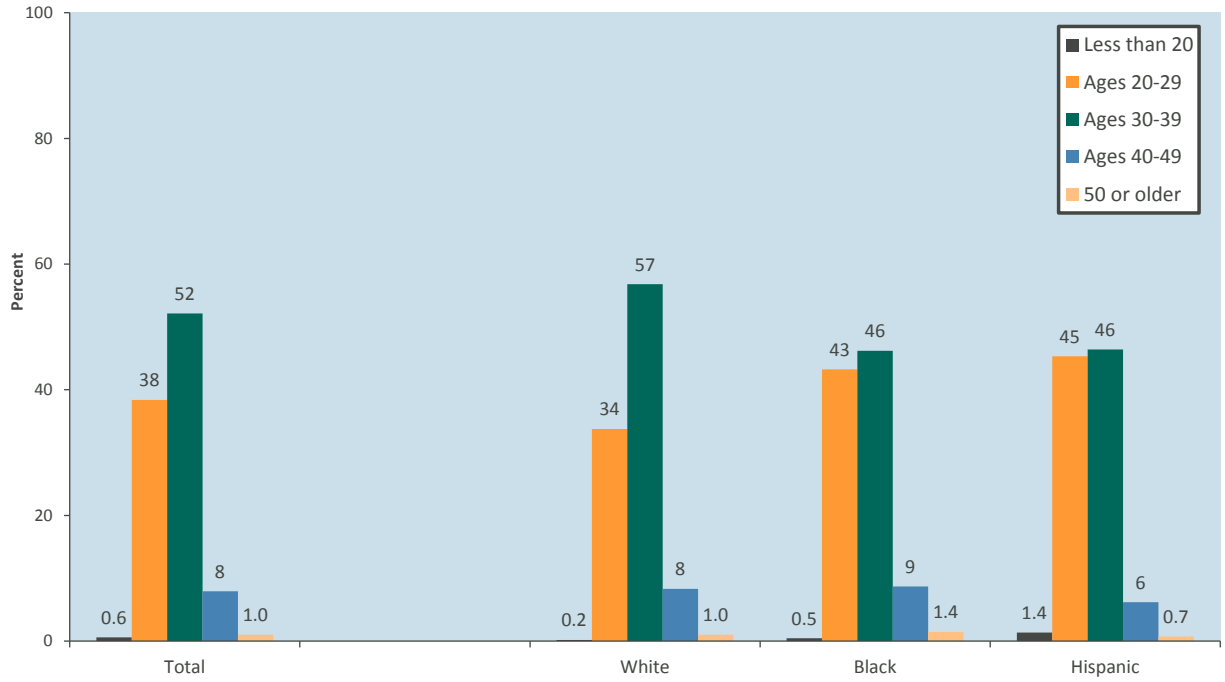
Among infants and toddlers, relatively high rates of use of safety seats are observed—99 and 96 percent, respectively. However, many are riding in seats that are improperly positioned: for instance, one in seven infants, and three-quarters of toddlers, are in front- rather than rear-facing seats. About one in six toddlers are using booster seats rather than the recommended safety seats. Young children are more likely to be using safety belts or other restraints if riding with a driver who is wearing safety belts.

Data are not available that would permit analysis of differences in the use of car safety seats by particular sub-groups of children or families.

Parental Well-Being

parents' age

Population of Children Ages Birth through Two , Percentages by Mother's Age and Child's Race/Hispanic Origin: 2012



Source: Child Trends' calculations using U.S. Census Bureau March Current Population Survey

Men and women are starting families, and are continuing to have children, at increasingly older ages. Advancing age is associated with declining fertility and increased risk of genetic mutations in sperm and egg cells. Use of fertility-enhancing treatments is increasing, particularly among older women. These developments may raise health risks for parents and/or their infants. The proportion of all U.S. births that were to women ages 30 and older doubled between 1980 and 2004, tripled for women 35 and older, and quadrupled for women 40 and older.[1]

Research has shown that increasing mothers' age, and, to a lesser extent, increasing age among fathers, is linked with a greater risk for pregnancy complications and other negative outcomes, including infant mortality and autism spectrum disorders.[2]

The implications, for infants and toddlers, of "mid-life" parenting are not well studied. Intuitively, older parents may have, on average, the advantages of greater economic resources, more stability in life circumstances, and the wisdom stemming from higher educational attainment as well as life experience, compared with younger parents. On the other hand, older parents may more challenged by the physical demands of caring for young children.

As of 2012, six in ten infants and toddlers have a parent who is 30 or older. Nearly one in eleven lives with a mother who is 40 or older, and one in five with a father of that age. Older mothers (30-plus) are a larger share among young white children than they are among their black or Latino peers, whereas mothers of Latino infants and toddlers are more likely than those in other groups to be younger than 30. More than one in four young black children, and nearly one in five Latinos, lives with a father who is 40 or older—proportions greater than those found for their white counterparts.

1 Luke, B. & Brown, M. B. (2007). Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age. Human Reproduction, 22(5), 1264-1272.
2 Croen,L. A., Najjar, D. V., Fireman, B., & Grether, J. K. (2007). Maternal and paternal age and risk of autism spectrum disorders. Archives of Pediatric & Adolescent Medicine, 161, 334-340.

parents' education

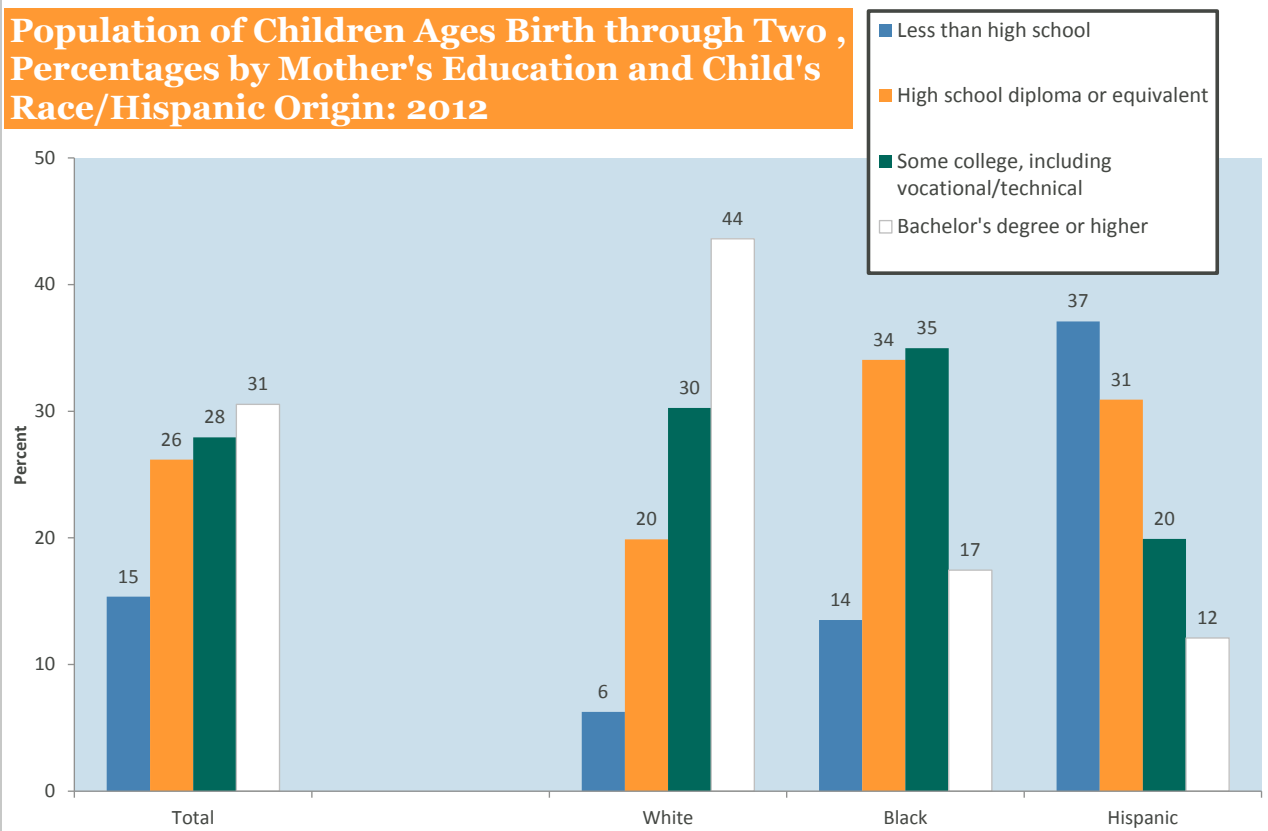
The education level of parents is one of the most powerful predictors of child well-being, beginning in the prenatal period. Higher levels of education are associated with greater financial, material, and social resources, but also with better parental health, and with parenting that is more sensitive to children's developmental needs.[1]

Higher levels of parental educational attainment are strongly associated with positive outcomes for children in many areas, including incidence of low birthweight, school readiness, and educational achievement.[2]

As a group, today's parents are more educated than they were in the past. About one in three parents of children younger than three (31 percent of mothers, 32 percent of fathers) has a bachelor's degree or higher, and nearly two-thirds (59 percent of mothers, 58 percent of fathers) have at least some years of college or other post-secondary training. However, about one in eight (15 percent each) has less than a high school education.

Moreover, in spite of the substantial gains most groups have made over the past few decades, parental education levels vary greatly by race and Hispanic origin. Among the mothers and fathers of Latino infants and toddlers, the proportion with less than a high school education is five times as great as it is among their white counterparts; and, at the other end of the education spectrum, the proportion of their parents with at least a bachelor's degree is about one-third as high as it is for whites. Among black infants and toddlers, twice as many as their white peers have mothers who did not finish high school, and the proportion with a father or mother who has completed college is about one-third what it is for white infants and toddlers.

Population of Children Ages Birth through Two , Percentages by Mother's Education and Child's Race/Hispanic Origin: 2012

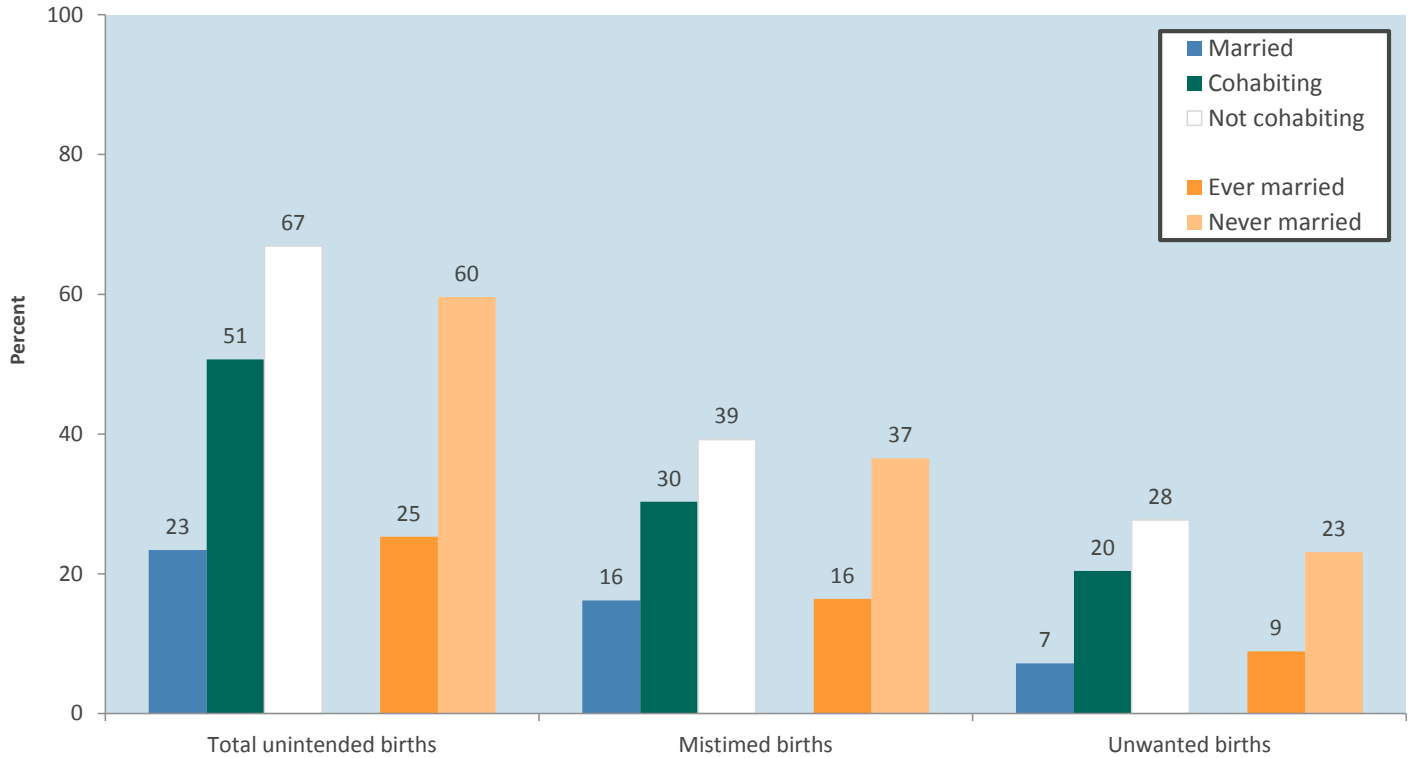


Source: Child Trends' calculations using U.S. Census Bureau March Current Population Survey, 2012, public use data.

1 Child Trends DataBank. (2012). Parental education. Retrieved from http://www.childtrends.org/?indicators=parental-education
2 Ibid.

unintended births

Unintended Births as a Percentage of All Births,[1] by Marital and Cohabiting Status of Mother at Time of Birth, 2006-2010



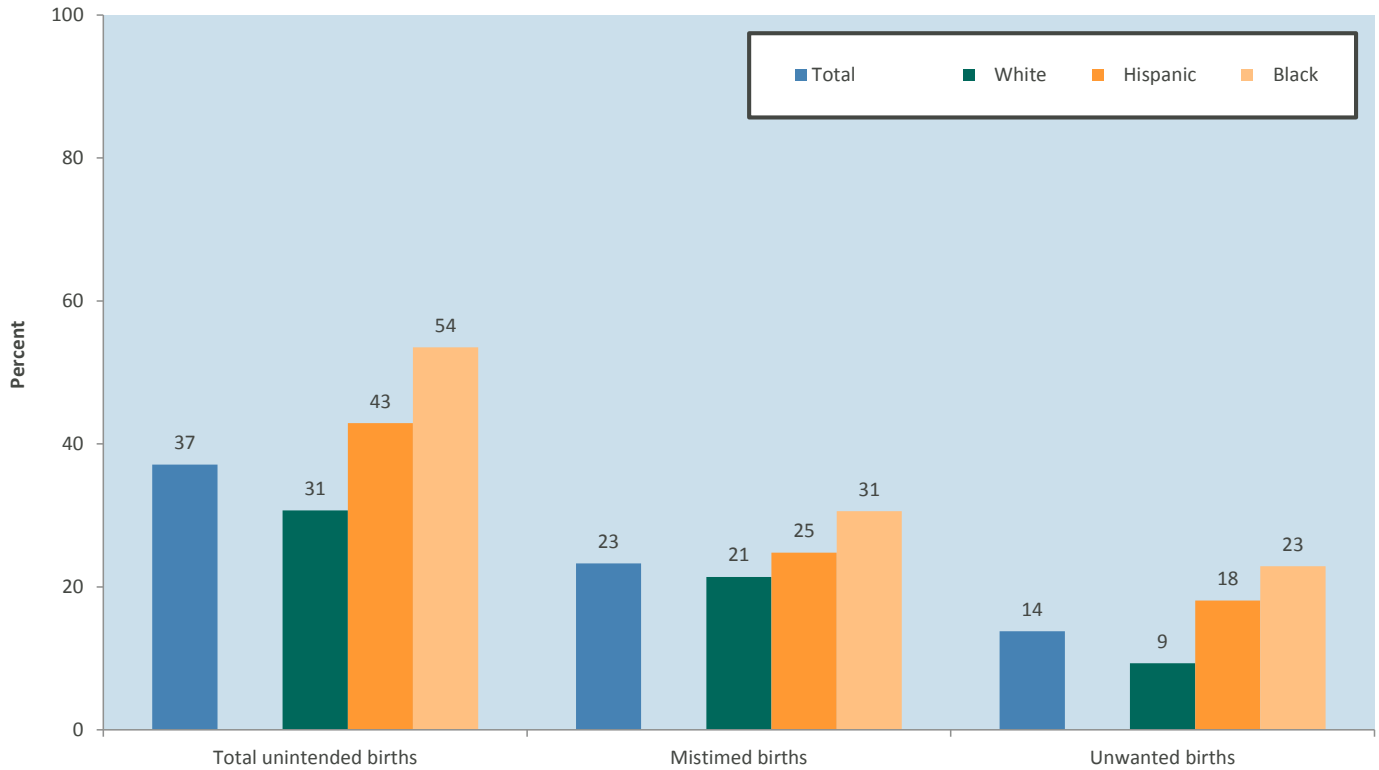
[1] Includes any births to mothers in the 5 years before the interview

Sources: Mosher W.D., Jones J., Abma J.C. (2012). Intended and unintended births in the United States: 1982–2010. *National health statistics reports; no 55*. Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf.

A welcomed pregnancy and birth are associated with more positive outcomes for both mother and child than when these are unwanted. Evidence from research is mixed, but unintended childbearing has been linked with a number of adverse prenatal and perinatal outcomes, including inadequate or delayed initiation of prenatal care, prematurity, and absence of breastfeeding.[1]

1 Child Trends DataBank. (2013). Unintended births. Retrieved from http://www.childtrends.org/?indicators=unintended-births

Unintended Births as a Percentage of All Births,[1] by Race/Hispanic Origin of Mother, 2006-2010



[1] Includes any births to mothers in the 5 years before the interview

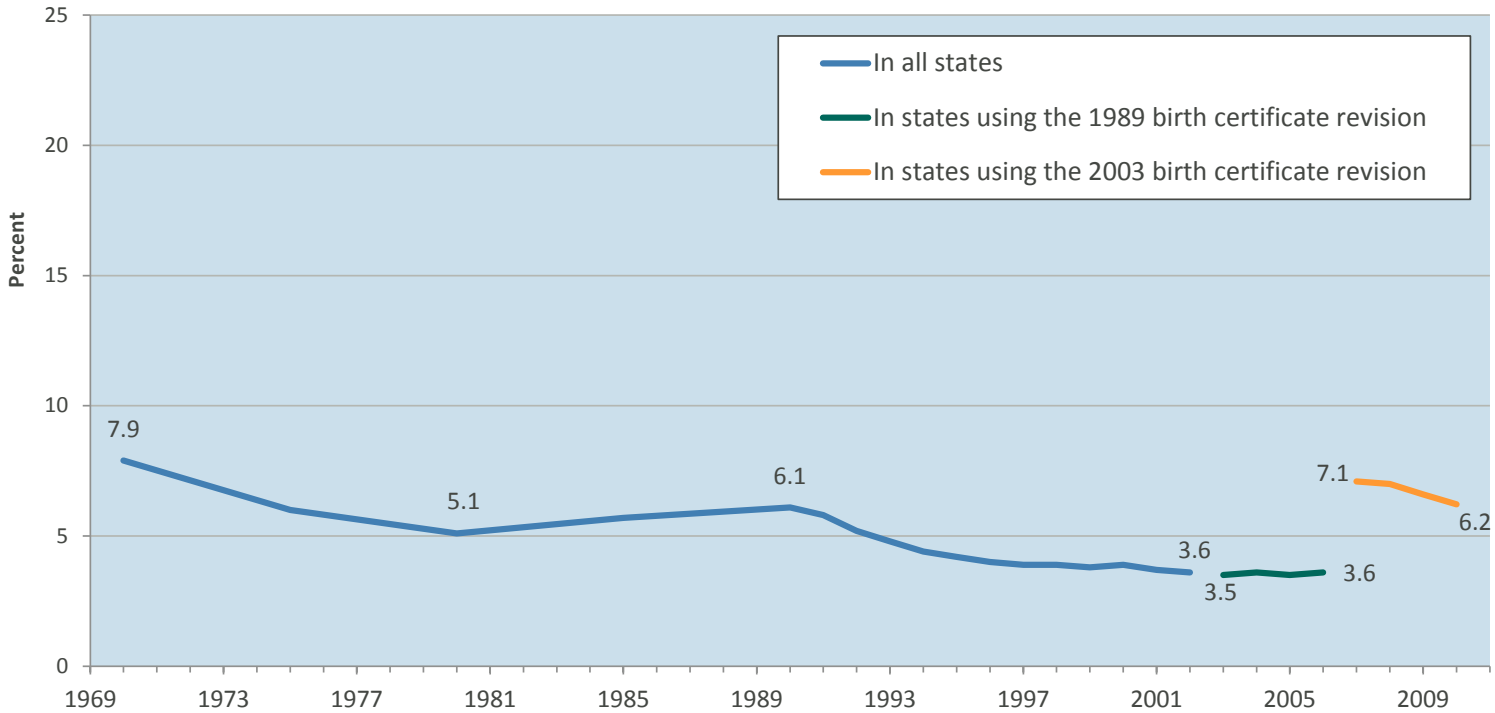
Sources: Mosher W.D., Jones J., Abma J.C. (2012). Intended and unintended births in the United States: 1982–2010. *National health statistics reports; no 55*. Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf.

Additionally, results from some studies show that children born as a result of unintended pregnancies, particularly when the birth is unwanted, have poorer physical and mental health, have mother-child relationships that are less close, and do less well in school, compared with children from pregnancies that were intended. From the perspective of first-time fathers, mistimed or unwanted pregnancies may also be associated with increased likelihood of depression among fathers, poorer co-parenting, and higher parental conflict.[2]

About one in seven births is unwanted, and about one in four is "mis-timed." Both unwanted and mistimed births are more prevalent among younger (particularly teen) mothers, mothers with fewer years of education, mothers who are black or Latina, and among those who are not married (including women who are cohabiting).

2 Ibid.

Percentage of Births to Mothers Receiving Late* or No Prenatal Care, Selected Years, 1970-2010**

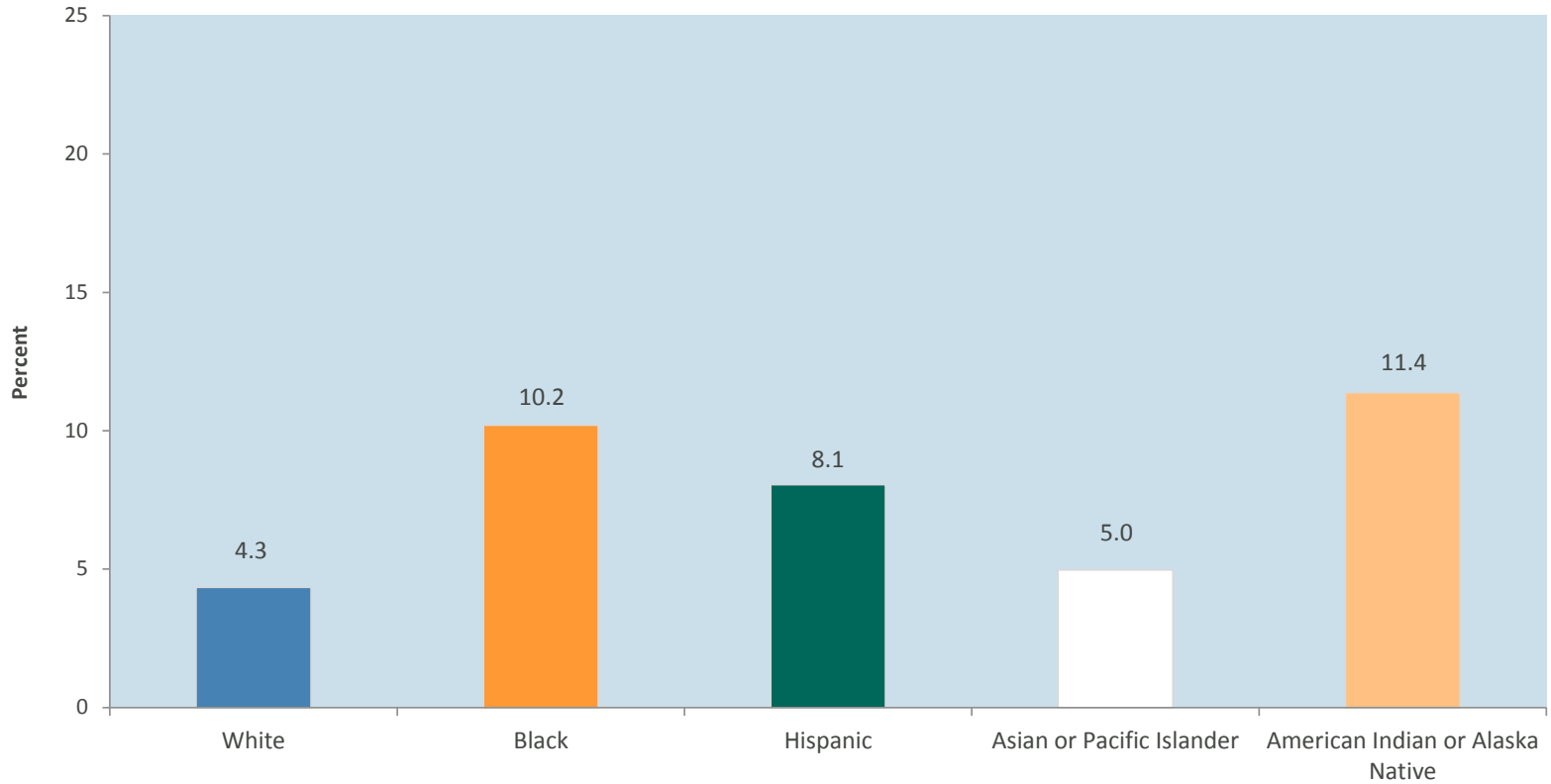


* Late care means that the mother received care only in the third trimester.
**Data for 2003 -2006 include only those jurisdictions using the 1989 revision of the birth certificate. Data for 2007 forward include only those jurisdictions using the 2003 revision of the birth certificate. The number of states included has varied over time.
Sources: Data for 1970-1994: Eberhart, M. S., Ingram, D. D., Makuc, D. M., et al. (2001). Urban and rural health chartbook: Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. Table 6. Available at: http://www.cdc.gov/nchs/hus/previous.htm. Data for 1995-2010: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

The shared well-being of mother and child begins with prenatal care. Pregnant women who receive no prenatal care, or whose care begins only in the last trimester of pregnancy, are more likely to have babies with health problems. Mothers who do not receive prenatal care are three times more likely to give birth to a low-weight baby, and their baby is five times more likely to die. However, in addition to the initiation of care, its frequency and timing are important, especially in order to respond effectively to specific maternal risk factors.[1]

1 Child Trends DataBank. (2012). Late or no prenatal care. Retrieved from http://www.childtrends.org/?indicators=late-or-no-prenatal-care

Percentage of Mothers Receiving Late* or No Prenatal Care, by Race and Hispanic Origin: 2010**



*Late care means that the mother received care only in the third trimester

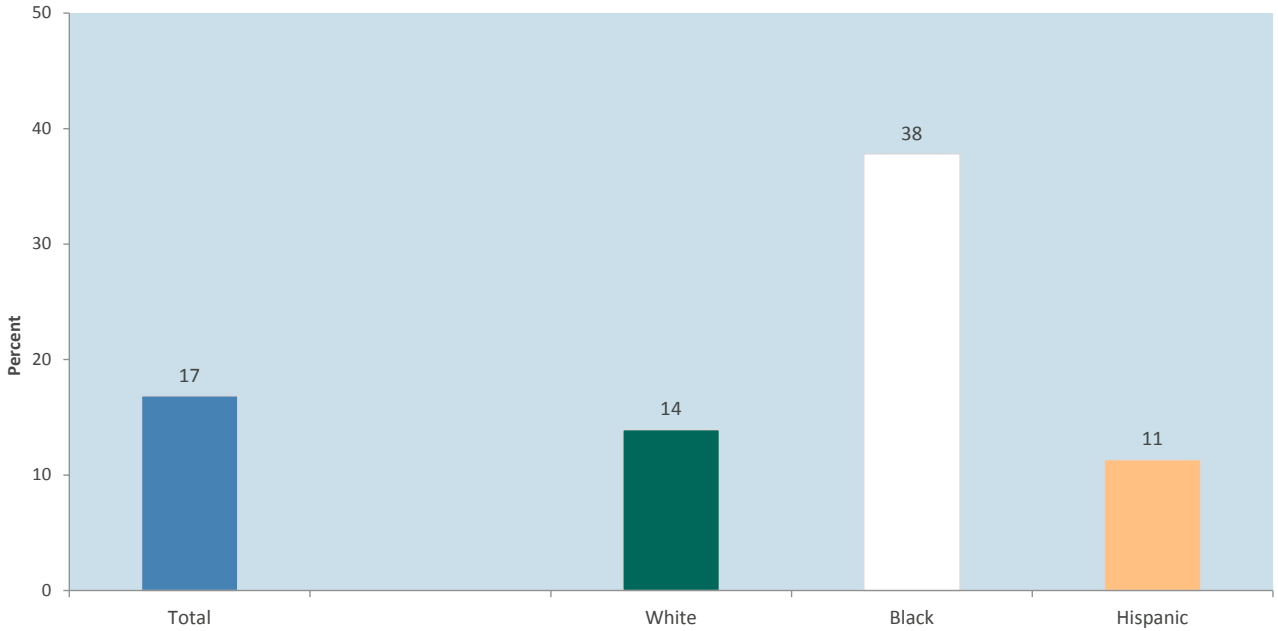
**Data exclude those jurisdictions using the 1989 revision of the birth certificate (16 states and DC, representing 24 percent of births) .

Source: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

About one in 17 (six percent) pregnant women receives late or no prenatal care; there are, however, notable disparities in these data by race/ Hispanic origin and by mother's age. **Black women are more than twice as likely as white women, and Latinas nearly twice as likely, to receive late or no prenatal care.** Rates for American Indian women are nearly three times as high as those for white women. Pregnant teens are more than twice as likely as women 25 and older to miss early prenatal care.

maternal mortality

Maternal Mortality Rate* (per 100,000 Live Births), 2010



*The maternal mortality rate indicates the likelihood of a pregnant woman dying of maternal causes. The number of live births used in the denominator is an approximation of the population of pregnant women who are at risk of a maternal death. "Maternal deaths" are defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." Included in these deaths are ICD–10 codes A34, O00-O95, and O98-O99.

Source: Child Trends' analysis of data from CDC WONDER, available at: http://wonder.cdc.gov/

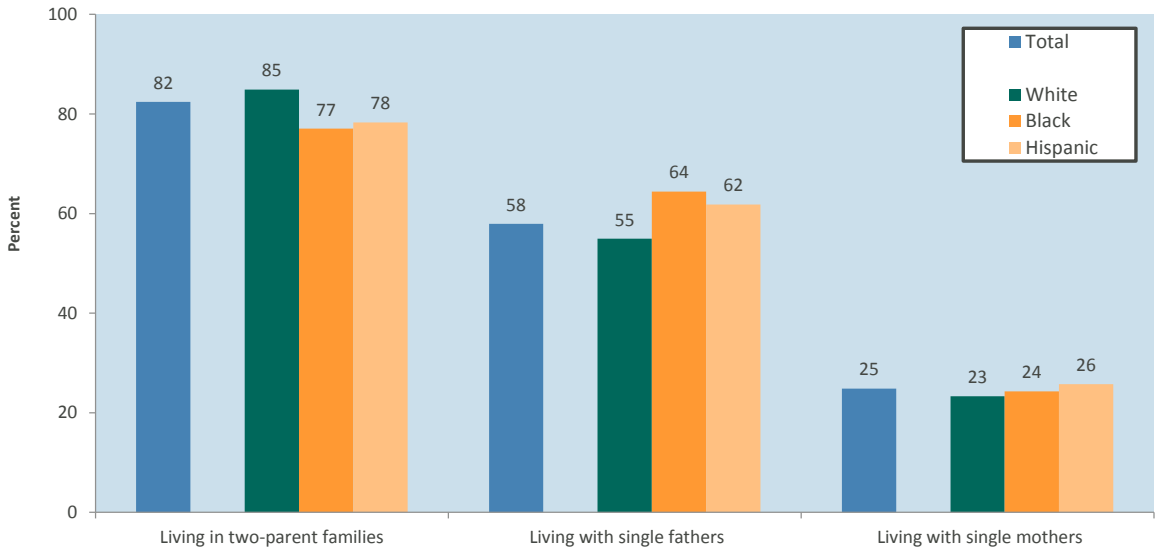
Maternal mortality—women's deaths associated with pregnancy and birth—is a long-standing measure of health system adequacy. Not well known is that **U.S. maternal mortality rates are comparatively high:** 42 developed countries, including Bulgaria, Spain, and Lithuania, have rates lower than ours.[1] **Moreover, U.S. rates have more than doubled since 1987.**[2]

Explanations for this unenviable record refer to a growing number of women entering pregnancy with chronic health conditions, such as hypertension, diabetes, and heart disease, as well as more complete reporting.[3] However, marked disparities, particularly by age group, and by race, are additional drivers of the overall high rate. Women ages 35 and older have rates of maternal mortality that are four times that of women in their early twenties, and more than twice that of women ages 25-34. Maternal mortality among black women is two-and-a-half times the rate for white women.[4] **According to the Centers for Disease Control and Prevention, about half of maternal deaths in the U.S. are preventable.**[5]

1 World Health Organization. (2012). Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and the World Bank estimates. Retrieved from http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf
2 Amnesty International. (2010). Deadly delivery: The maternal health care crisis in the USA. Retrieved from http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf
3 Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. Retrieved from http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html
4 U.S. Department of Health and Human Services. (2013). Healthy People 2020. Objective MICH-5. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
5 Bacak, S. J., Berg, C. J., Desmarais, J., Hutchins, E., & Locke, E. (Eds.) (2006). State mortality review: Accomplishments of Nine States. Centers for Disease Control and Prevention. Retrieved from http://www.cdph.ca.gov/data/statistics/Documents/MO-CDC-ReportAccomplishments9States.pdf

secure parental employment

Percentage of Children, Ages Birth through Two, Who have a Parent with Secure Employment,* by Family Type and Race/Hispanic Origin: 2012



*Secure employment is defined as having worked full time for 50 to 52 weeks in the past year.
Source: Child Trends' analysis of Current Population Survey, March Supplement.

For nearly all families with young children, parental employment is a necessity for meeting basic needs. For low-income families, it is not a guarantee of escape from poverty, but employment is associated with higher family income and greater access to private health insurance. In some cases, long hours of employment among mothers with very young children have been associated with modestly negative child outcomes.[1] Mothers' employment rate in the U.S. (about 55 percent) is near the mean for the group of developed nations. In Sweden and the Netherlands, more than 70 percent of mothers of infants and toddlers are working, whereas in Turkey and Japan (for instance), rates are below 20 percent.

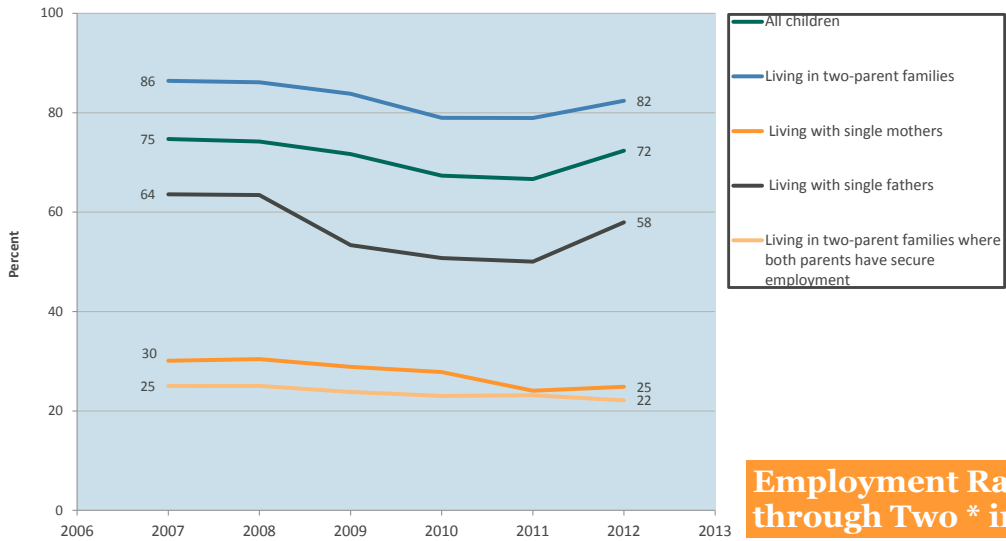
More recently, research links parental (particularly fathers') permanent job loss to increased likelihood of parental divorce, family relocation, and children's repeating a grade; and to decreased earnings when children enter the labor force. Thus, the "scarring" effects of parental unemployment may be multigenerational.[2]

As of 2012, about seven in ten (72 percent) infants and toddlers lived with at least one parent who is employed full-time, year-round. This is up from 2010's figure of 67 percent, a recent low reflecting the impact of the Great Recession. Not surprisingly, a much lower percentage of young children living in poverty have secure parental employment than do children in more well-off families. Among children in two-parent families, less than half (45 percent) of those in poverty have secure parental employment, compared with nearly nine in ten (89 percent) children not living in poverty. Among children living with single mothers, those in poverty are more than four times more likely to lack secure parental employment as their counterparts not living in poverty.

Overall, white infants and toddlers are most likely, and black infants and toddlers least likely, to have secure employment, with Latinos falling in-between.

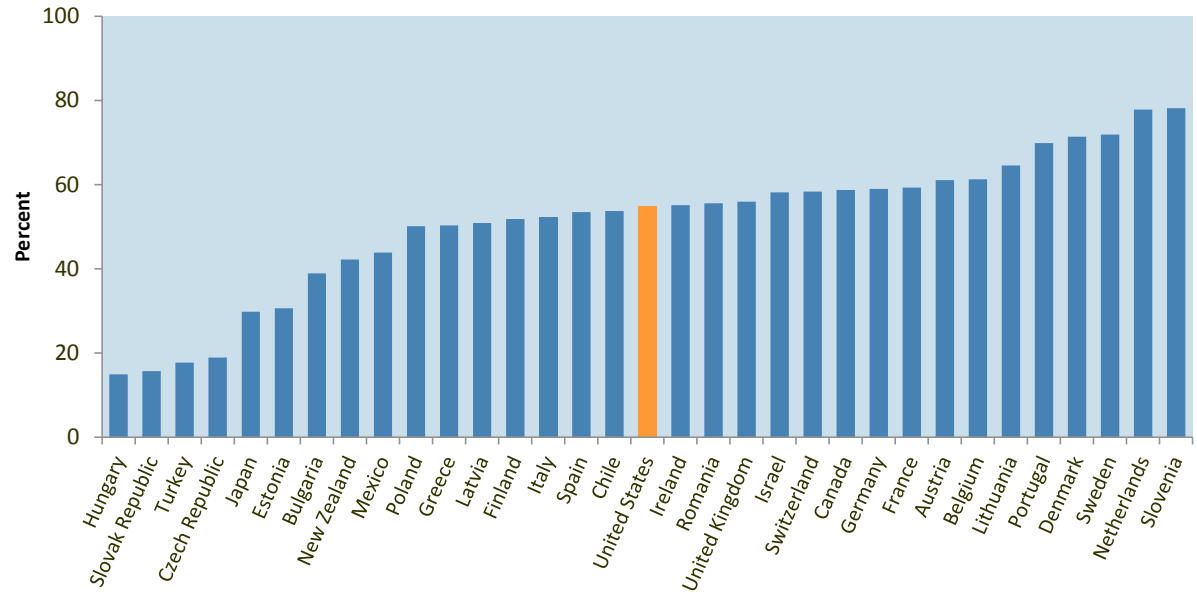
1 Child Trends DataBank.(2012). Secure parental employment.Retrieved from http://www.childtrends.org/?indicators=secure-parental-employment
2 Ibid.

Percentage of Children, Ages Birth through Two, Who have a Parent with Secure Employment,* by Family Type: 2007-2012



*Secure employment is defined as having worked full time for 50 to 52 weeks in the past year.
Source: Child Trends' analysis of Current Population Survey, March Supplement.

Employment Rate Among Mothers with a Child Ages Birth through Two * in 33 Developed Countries: 2009**



*Data for Israel refer to mother with a youngest child younger than 2
**Data refer to 2010 for Chile; 2007 for Sweden; 2006 for Switzerland; 2005 for Japan; 2001 for Canada; 1999 for Denmark.
Sources: Data for the United States: Bureau of Labor Statistics. (2010). Employment characteristics of families - 2009 (USDL-10-0721). Author. Table 6. Available at: http://www.bls.gov/news.release/archives/famee_05272010.pdf. All other data: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

g depression

Depression is a disorder that negatively affects a wide swath of life's activities; in parents of young children, it can be detrimental to the ongoing, responsive interplay (verbal, social, physical) so critical for healthy development of infants and toddlers. Parental depression may also interfere with the ability to provide for basic household needs.[1]

Not surprisingly, therefore, depression in parents is associated with poor health and developmental outcomes for children of all ages, including prenatally. Maternal depression has been linked to delays in cognitive and motor development among children 28 to 50 months old. Children of depressed mothers are more likely than other children to have behavior problems, academic difficulties, and health problems (including psychiatric illness).[2]

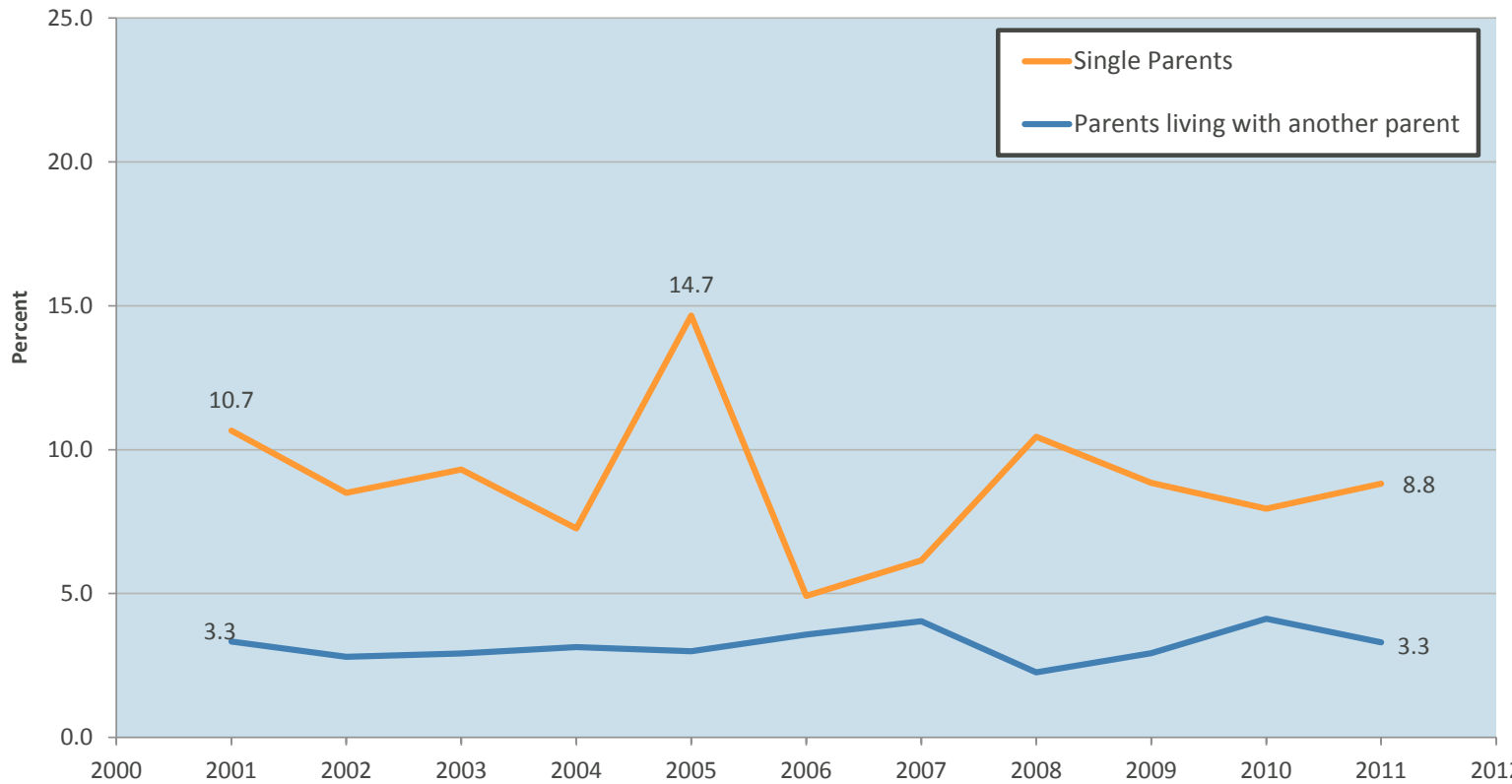
Depressed mothers are more likely than non-depressed mothers to have poor parenting skills and to have negative interactions with their children. Mothers who are depressed are less likely to use appropriate practices (such as using car seats, smoke alarms and covering electrical outlets) to prevent injury and harm among their children, and more likely to use corporal punishment. Maternal depression is a significant risk factor for child abuse and neglect. Low-income mothers who are depressed may also be less likely than their non-depressed peers to access public assistance. The two factors most strongly associated with maternal depression, in turn, are intimate-partner violence, and mothers' health.[3]

Postpartum depression is a particularly common occurrence that may be aggravated by hormonal changes and sleep deficits.[4] Data collected from recent mothers in a 22-state area showed that, in 2006-08, about one in seven reported symptoms of postpartum depression in the two-to-nine months following their child's birth. **The prevalence of postpartum depression was especially high (more than one in five) among mothers with less than 12 years' education, and among American Indian/Alaska Native, black, and multiple-race mothers.**[5]

Although mothers' depression has been the subject of more studies, research shows that fathers' depression also has harmful effects on parenting.[6]

1 Child Trends DataBank. (2012). Parental depression. Retrieved from http://www.childtrends.org/?indicators=parental-depression
2 Ibid.
3 Ibid.
4 The Mayo Clinic. (2012). Postpartum depression. Retrieved from http://www.mayoclinic.com/health/postpartum-depression/DS00546
5 U.S. Department of Health and Human Services. Health Resources and Services Administration. (2011). Women's health USA: 2011. Rockville, MD: Author.
6 Child Trends DataBank, op. cit.

Parents Of Children Ages Birth Through Two Who Reported Two or More Depressive Symptoms[1] During the Past 30 Days, 2001-2011

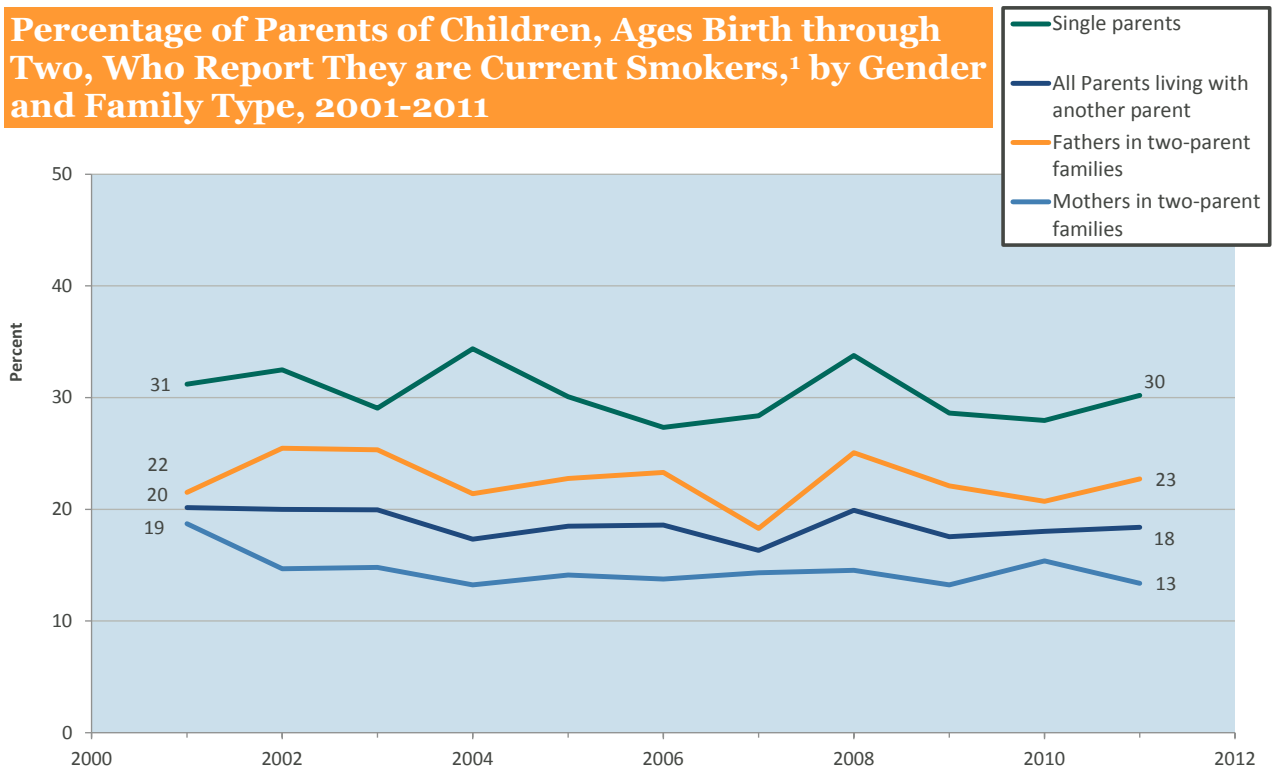


[1] Depressive symptoms include the following: felt sad, hopeless, worthless, restless, or that everything was an effort all of the time or most of the time during the past 30 days.
Source: Original analysis by Child Trends of National Health Interview Survey data.

The prevalence of depressive symptoms among parents of infants and toddlers is disproportionately high among single parents, and (within two-parent families) among parents with incomes below the poverty level: among both these groups, it approaches one in ten.

smoking

Percentage of Parents of Children, Ages Birth through Two, Who Report They are Current Smokers,[1] by Gender and Family Type, 2001-2011



[1] Current smokers are defined as those who have ever smoked 100 cigarettes and currently smoke every day or some days.
Source: Original analysis by Child Trends of National Health Interview Survey data

Parents who smoke put their young children's health at risk. The effects of second-hand smoke are particularly harmful for young children and children with asthma. Second-hand smoke is responsible for between 150,000 and 300,000 lower respiratory tract infections among young children under 18 months of age each year. Of course, smoking also damages the health of parents.[1]

Among parents of infants and toddlers, the rate of current smoking is particularly high among white single parents: nearly half (49 percent) are smokers, which is three times the prevalence among black single parents, and four times that among single Latino parents. Within two-parent families, men are much more likely than women to smoke (23 and 13 percent, respectively), and parents with below-poverty incomes are twice as likely to smoke as those with above-poverty incomes (15 and 32 percent, respectively). Latinos in two-parent families are considerably less likely to be smokers than their white or black counterparts. **In two-parent families, smoking is twice as common in poor families as it is in those who are not poor.**

1 Child Trends DataBank. (2012). Parental smoking. Retrieved from http://www.childtrends.org/?indicators=parental-smoking

heavy drinking

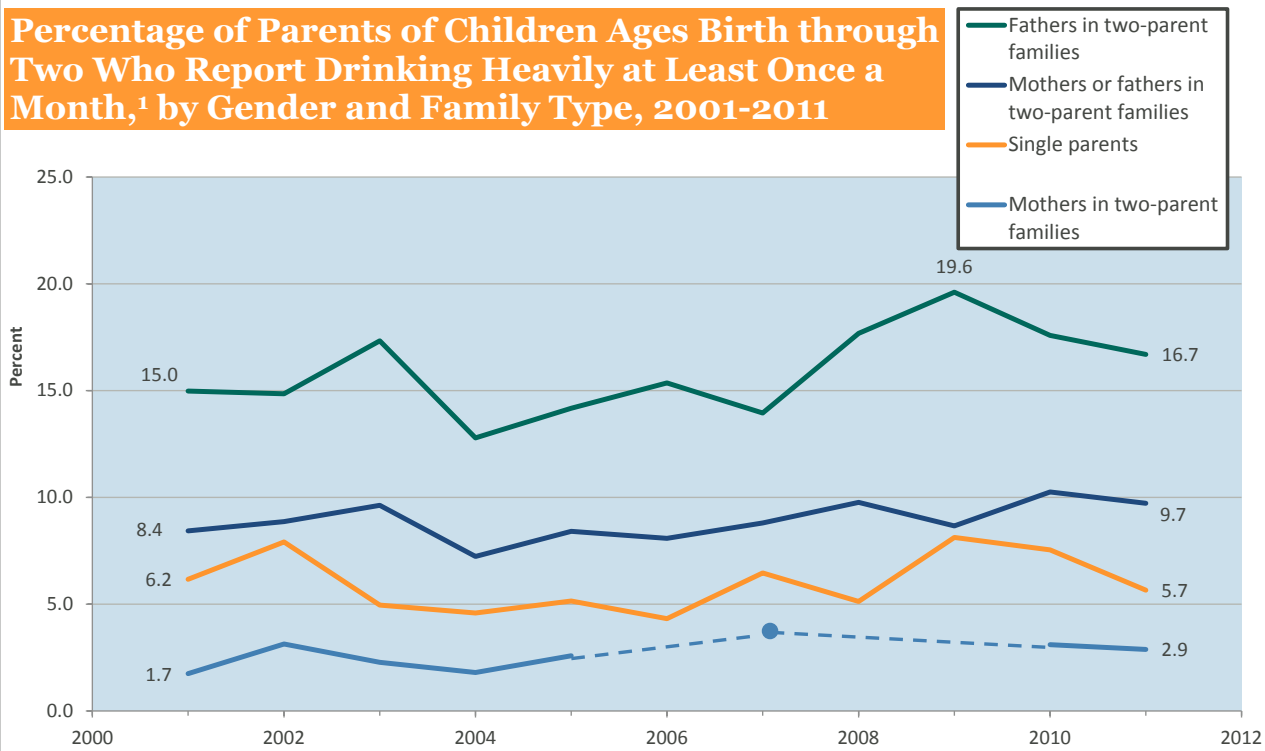
Alcohol use can impair judgment, endanger the health and safety of oneself and others, and lead to dependence that can jeopardize relationships with family, peers, and employers.[1] Thus, there are special concerns about heavy alcohol use by parents of young children.

According to the U.S. Surgeon General, women who are pregnant or may become pregnant should abstain from alcohol, because studies show it can have detrimental effects on an unborn fetus, even in the earliest time after conception, when a woman may not know that she is pregnant. The consequences for children who have been exposed to alcohol before birth may last throughout their lifetimes, and include mental retardation, learning disabilities, conduct disorder, and other serious health problems.
One of the most serious outcomes of maternal prenatal alcohol use are fetal alcohol spectrum disorders (FASD), which involve problems with the brain, growth retardation, and facial malformations.[2]

Parents who drink alcohol to excess may be more likely to be abusive to children, due to lowered inhibitions, sharpened aggressive feelings, and diminished brain functioning. Children whose parents have alcohol problems are also at greater risk for depression, anxiety disorders, and problems with cognitive and verbal skills.[3]

Among parents of infants and toddlers, the highest rates of "heavy" drinking are reported by fathers in two-parent families (about one in six in this group), and the lowest rates by mothers in two-parent families. About one in 18 single parents reports drinking heavily in the past month. The overall prevalence of reported heavy drinking by parents is too low to support examining the data by other demographic variables.

Percentage of Parents of Children Ages Birth through Two Who Report Drinking Heavily at Least Once a Month,[1] by Gender and Family Type, 2001-2011

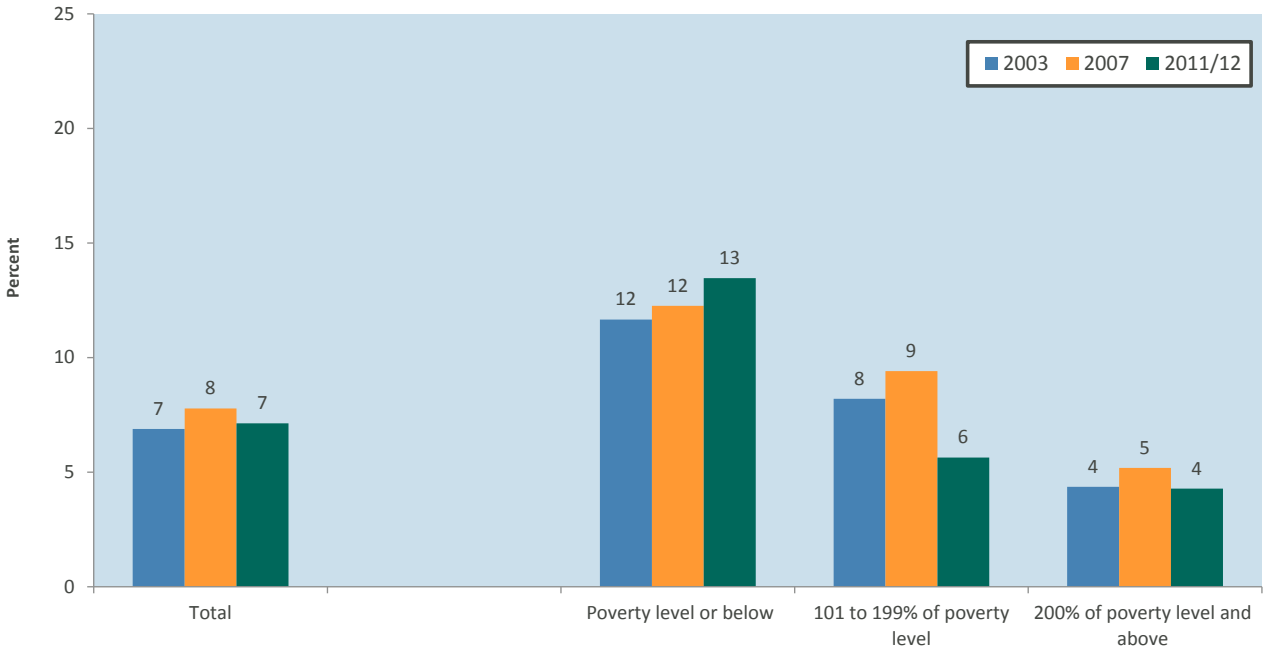


[1] Heavy drinking is defined as drinking five or more alcoholic drinks on one occasion
Source: Original analysis by Child Trends of National Health Interview Survey data

1 Child Trends DataBank. (2012). Heavy drinking among parents. Retrieved from http://www.childtrends.org/?indicators=heavy-drinking-among-parents
2 Ibid.
3 Ibid.

parental stress

Percentage of Children Ages Birth through Two Whose Parents Report Frequent Stress from Parenting,* Total and by Family Income Level:** 2003, 2007, and 2011/12



*Children qualify as having stressed parents if their parents responded "Usually" or "Always" to one or more of the following statements about their feelings during the past 30 days: "child was much harder to care for than other children"; "often bothered a lot by their child's behavior"; and/or "angry with child"
**In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' analysis of National Survey of Children's Health

Parents who experience inordinate stress in meeting the demands of their role may be at risk for poor health, and may be more likely to use coercive discipline, putting their children at increased risk for maltreatment and behavior problems.[1]

As measured in a nationally representative survey, children's parents are considered to be stressed if they responded "usually" or "always" to one or more of three questions about how they felt during the past 30 days: their child was much harder to care for than other children; they were often bothered a lot by their child's behavior; and/or they were angry with their child.

Toddlers (age one or older) are more likely to have parents reporting stress than are parents of infants. Young children with special health care needs are also more likely than children without such needs to have parents reporting stress. **Infants and toddlers living in poverty are more than three times as likely as their counterparts in more economically secure families to have parents who report stress. Parental stress is also more prevalent in the case of Latino infants and toddlers than it is for their black peers, who in turn are more likely than white infants and toddlers to live with parents with stress.**

1 McGroder, S. (2000). Parenting among low-income African American single mothers with pre-school age children: Patterns, predictors, and developmental correlates. Child Development, 71(3), 752-771.

Neighborhood and Family Context

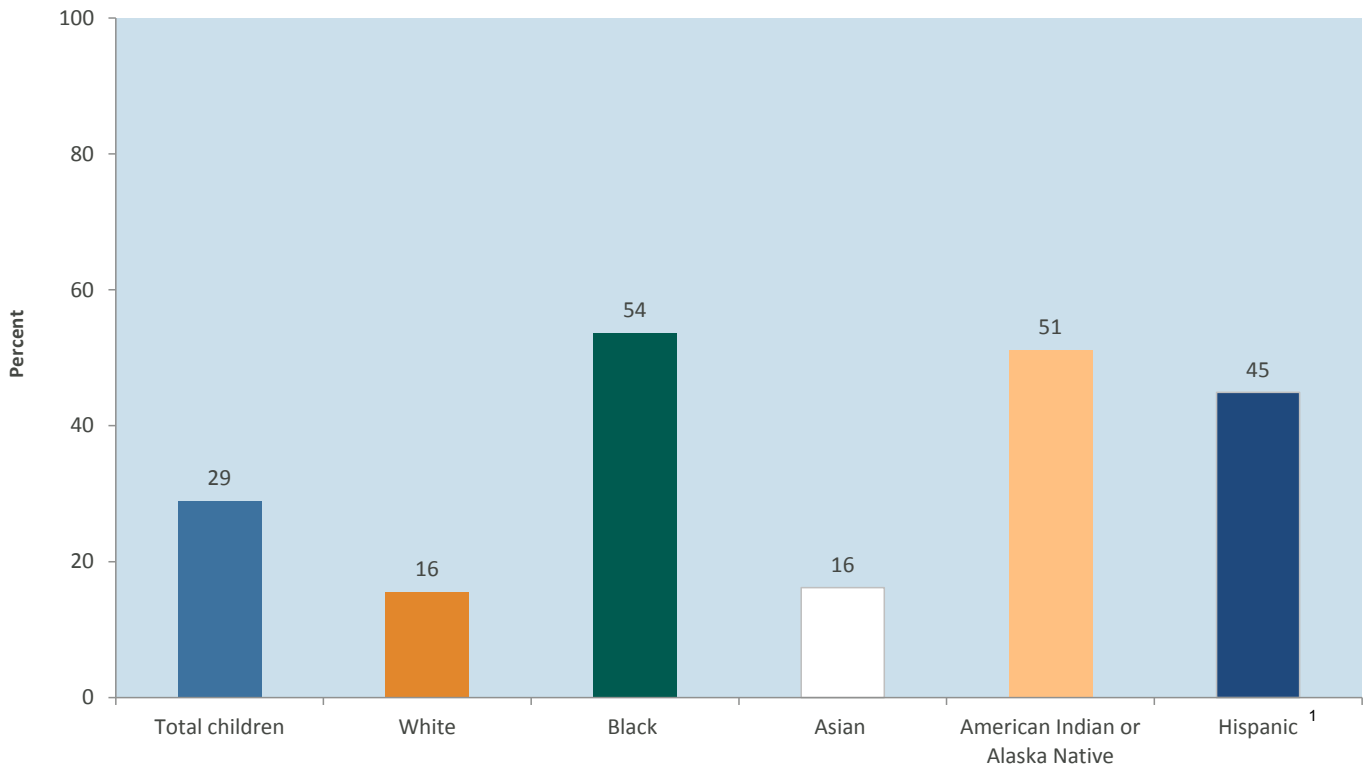
concentrated poverty

Beyond the deleterious effects of family-level poverty on young children, research finds that residing in communities where there are large proportions of residents living in poverty confers additional disadvantages. For example, there are worse outcomes in the areas of physical and mental health, such as asthma, diabetes, and depression; crime rates are higher in neighborhoods of concentrated poverty; and the quality of housing and schools is lower than in other communities.[1]

Here, areas with concentrated poverty are defined as census tracts where 20 percent or more of residents are poor. Nearly one in three infants and toddlers live in areas of concentrated poverty, and one in 20 live in areas with poverty rates of 40 percent or more. In order to get reliable estimates of concentrated poverty by race/Hispanic origin, we must broaden the age range to children younger than five. Young black or American Indian/Alaska Native children are more than three times as likely as their white counterparts to live in concentrated poverty.

1 Bishaw, A. (2011). Areas with concentrated poverty: 2006-2010. American Community Survey Brief. U.S. Census Bureau. Retrieved from http://www.census.gov/prod/2011pubs/acsbr10-17.pdf

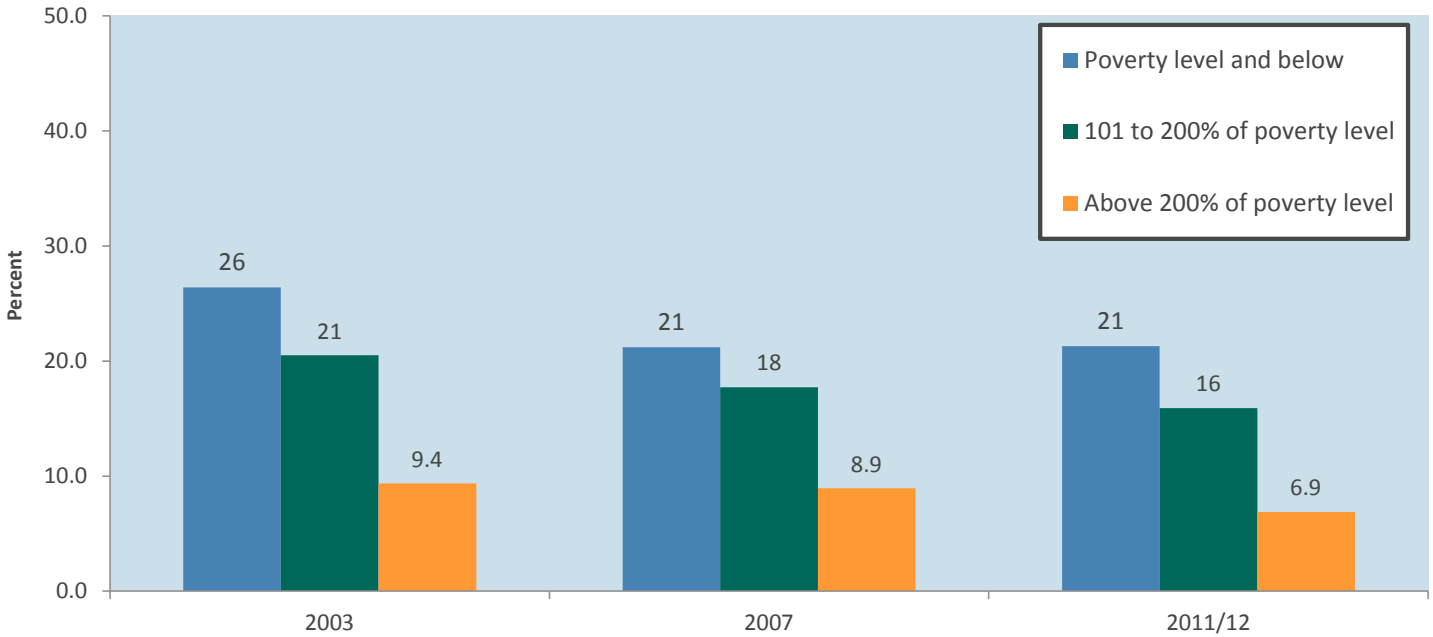
Children Birth through Four Living in Concentrated Poverty,* Total, and by Race/Hispanic Origin: 2007-2011



*Concentrated poverty is defined as a census tract where 20 percent or more of the population has incomes below the poverty line.
[1] Hispanics may be any race
Source: Child Trends' analysis of the American Community Survey, available at American Factfinder: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

neighbor-hood safety

Percentage of Children Ages Birth through Two Whose Parents Report are Living in Unsafe Neighborhoods,* by Poverty Level:** 2003, 2007, and 2011/12



*Children in unsafe neighborhoods are those whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"
**In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' original analyses of data from the National Surveys of Children's Health.

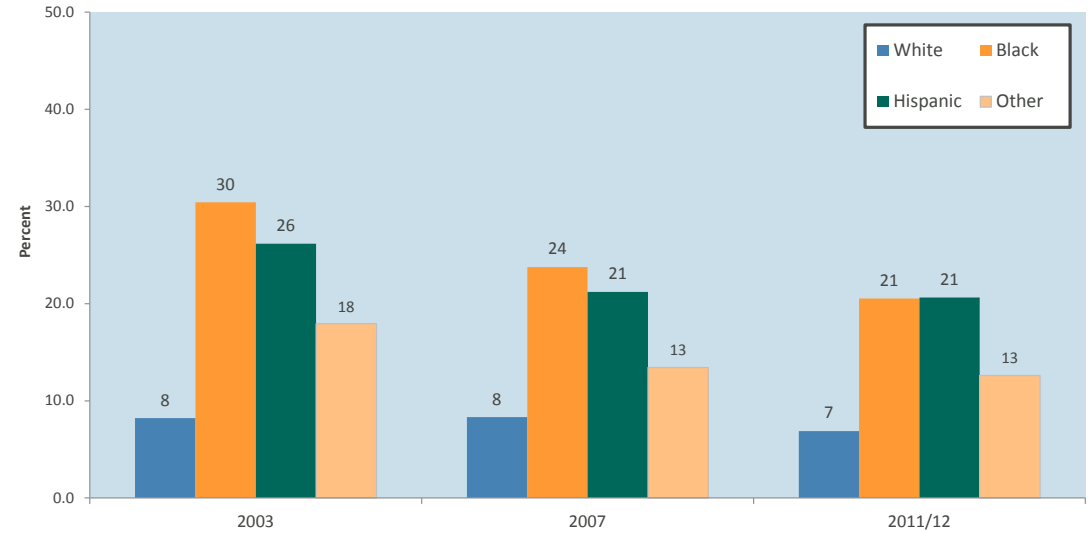
Safety is one of the primary concerns parents have for their young children. Neighborhoods that are unsafe are associated with high rates of infant mortality and low birthweight, juvenile delinquency, high school dropout, child abuse and neglect, and poor motor and social development among pre-school children. Parents who live in neighborhoods they perceive as unsafe are more likely to experience stress, and they are more likely to restrict opportunities for their children to play outdoors or go on outings.[1]

1 Child Trends DataBank. (2012). Neighborhood safety. Retrieved from http://www.childtrends.org/?indicators=neighborhood-safety

In 2011/12, about one in eight infants and toddlers lived in neighborhoods their parents considered to be never or only sometimes safe. Young Latino and black children, and all children living in poverty, were more than two-and-a-half times as likely to live in unsafe neighborhoods as were their white, or their more economically secure, counterparts.

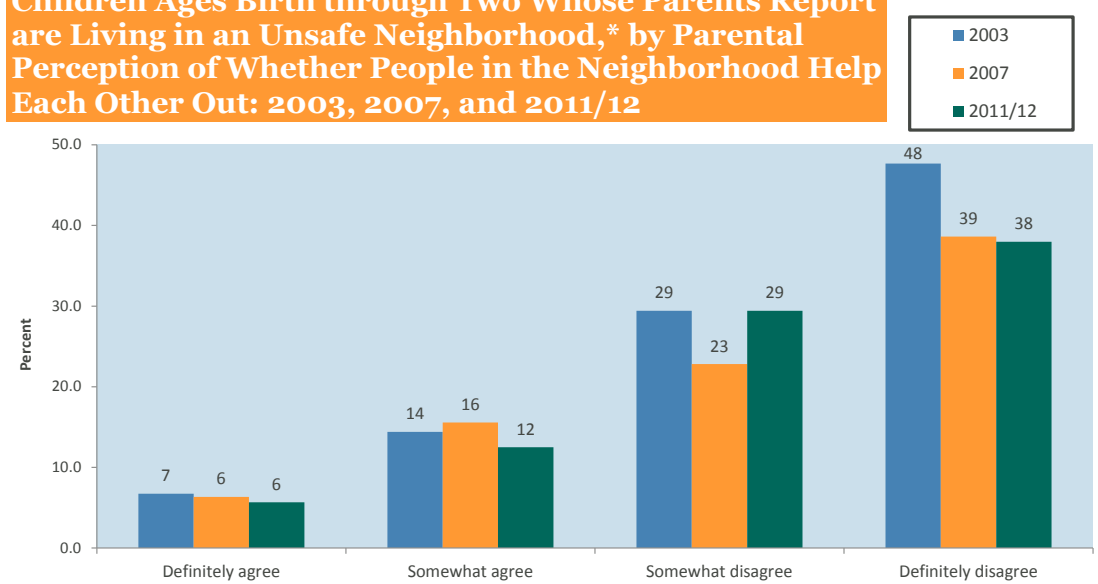
An additional dimension to families' experience of their neighborhoods is their perception of the level of support they feel neighbors extend to each other. For those infants and toddlers whose parents "definitely" agreed that neighbors "help each other out" in 2011/12, only six percent felt their neighborhoods were unsafe, compared with the more than one in three who said they "definitely" disagree.

Percentage of Children Ages Birth through Two Whose Parents Report are Living in Unsafe Neighborhoods,* by Race/Hispanic Origin: 2003, 2007, and 2011/12



*Children in unsafe neighborhoods refers to children whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Children Ages Birth through Two Whose Parents Report are Living in an Unsafe Neighborhood,* by Parental Perception of Whether People in the Neighborhood Help Each Other Out: 2003, 2007, and 2011/12



*Children in unsafe neighborhoods refers to children whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

births to unmarried women

More than ever before, women are having births outside of marriage. This is a trend not limited to the U.S.; in several developed nations, more than half of all births are to women who are unmarried. Infants born to unmarried mothers are statistically at greater risk for economic hardship and other related poor outcomes.[1]

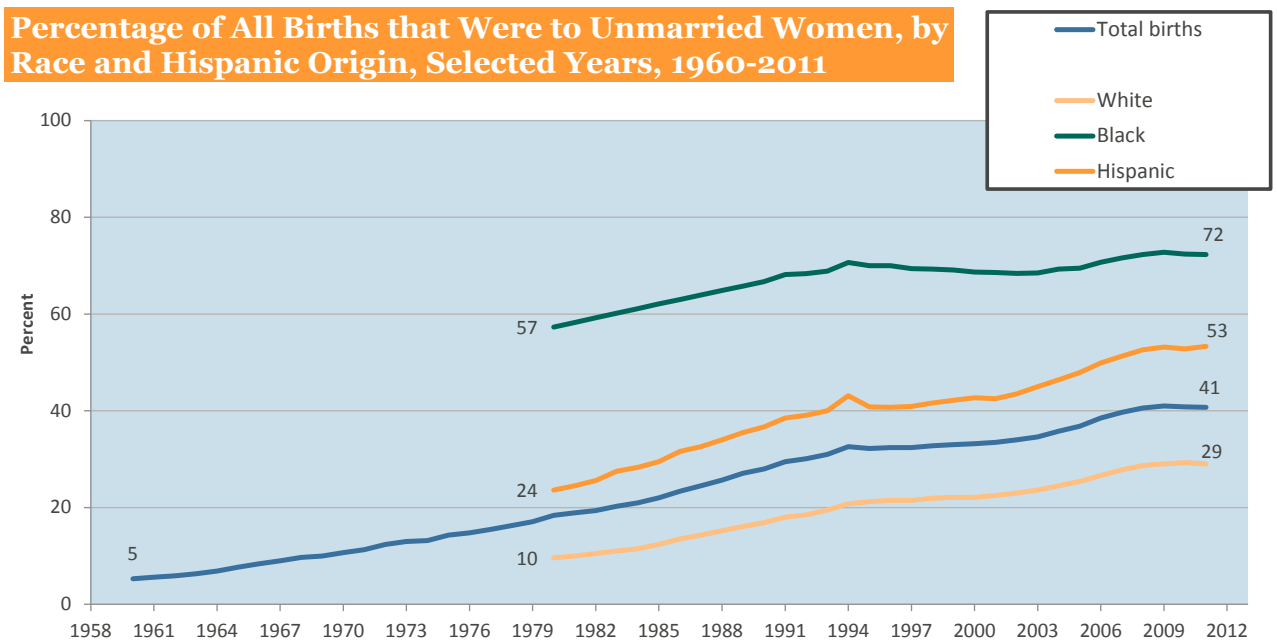
Contrary to what some expect, the great majority of these births occur to women in their twenties and thirties, not to teens. In about six out of ten of cases, mothers, though unmarried, are cohabiting at the time of the birth. However, relatively few of these cohabiting relationships will be sustained throughout the child's early years.[2]

There are marked disparities by race/ethnicity in the percentage of births that are to unmarried women:

- Among black women, they are seven in ten births;
- Among Latinas, they are a slim majority; and
- Among white women they are about three in ten births.

In contrast to the sustained rise among white and Latina women, among black women this percentage has leveled off.

Percentage of All Births that Were to Unmarried Women, by Race and Hispanic Origin, Selected Years, 1960-2011



Sources: Data for 1960-1969: Ventura, S. J. & Bachrach, C. A. (2000) Nonmarital childbearing in the United States, 1940-1999. *National vital statistics reports, 48* (16). Hyattsville, Maryland: National Center for Health Statistics. Table 4. Data for 1970-1998 from National Center for Health Statistics. *Health, United States 2002 With Chartbook on Trends in the Health of Americans*. 2002. Table 9 ; Data for 1999-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm Preliminary data for 2011: Hamilton, B. E., Martin, J. A., Ventura, S. J. (2012). Births: Preliminary data for 2011. National Vital Statistics Reports, 61 (5). Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf

1 Child Trends DataBank. (2012). Births to unmarried women. Retrieved from http://www.childtrends.org/?indicators=births-to-unmarried-women

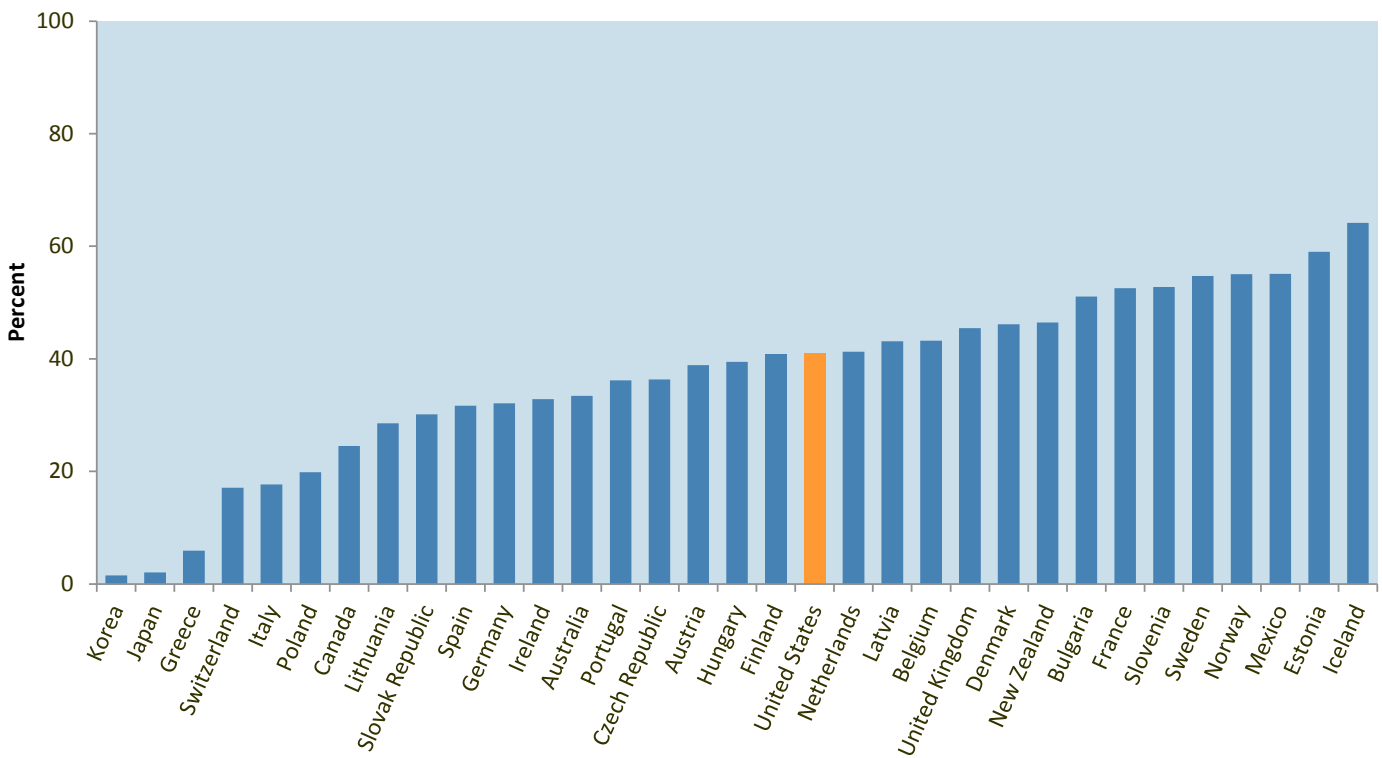
2 Copen, C. E., Daniels, K., & Mosher, W. D. (2013). First premarital cohabitation in the United States: 2006-2010 National Survey of Family Growth. National Health Statistics Reports, no. 64. Retrieved from http://www.cdc.gov/nchs/data/nhsr/nhsr064.pdf

More so than age, mothers' education is strongly associated with the probability that a birth will occur outside marriage:

- For women with less than a high school education, 83 percent of first births occur in the absence of marriage;
- For women with a high school diploma or some college, that drops to 58 percent; and
- For college graduates, it drops further, to 12 percent.[1]

1 Hymowitz, K., Carroll, J. S., Wilcox, W. B., Kaye, K. (2013). Knot yet: The benefits and costs of delayed marriage in America. National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from http://twentysomethingmarriage.org/

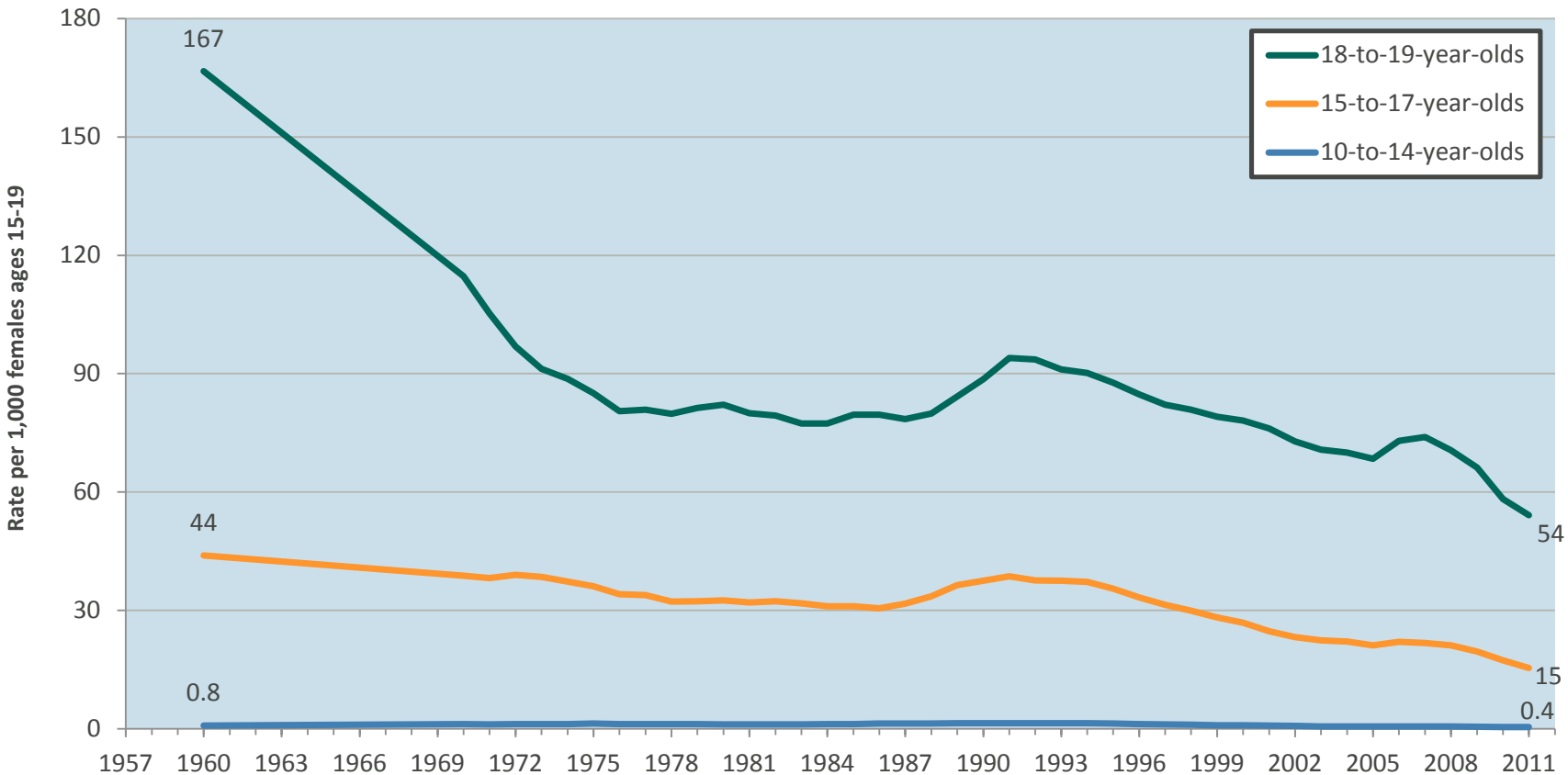
Proportion of Births to Unmarried Women in 33 Countries: 2009*



* Data refer to 2007 for Japan, Italy, Ireland, Australia, Belgium and New Zealand; 2006 for Korea; 2005 for Canada.
Sources: Data for United States: Martin, J. A., Hamilton, B. E., Ventura, S. J., Osterman, M. J. K., Et al. (2011). Births: Final data for 2009. *National Vital Statistics Reports, 60*(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf. All other data: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

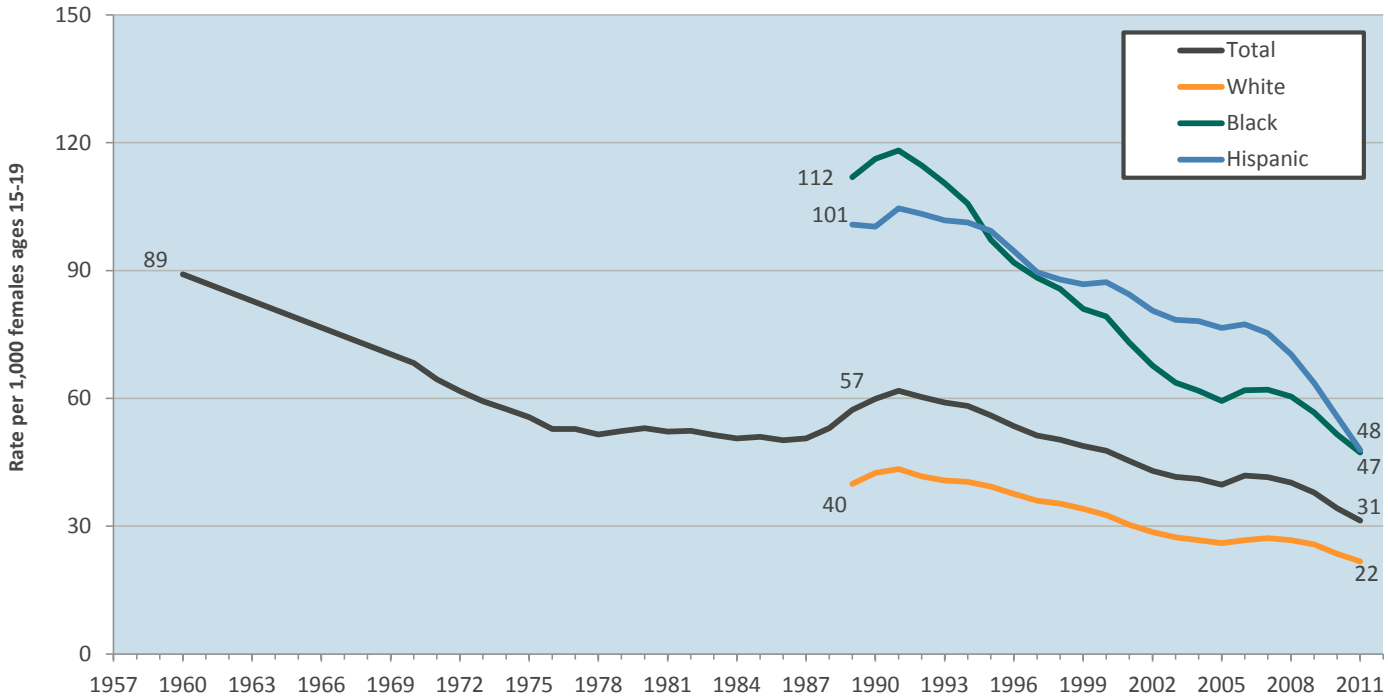
births to teens

Birth Rates (per 1,000) for Females Younger than 20, by Age, Selected Years, 1960-2011



Sources: Data for 1960 from: National Center for Health Statistics. *Health, United States, 2001 With Urban and Rural Health Chartbook*. Hyattsville, Maryland: 2001, Table 3; Data fo 1970-2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

Birth Rates (per 1,000) for Females Ages 15 to 19, by Race and Hispanic Origin, Selected Years, 1960-2011



Sources: Data for 1960 from: National Center for Health Statistics. *Health, United States, 2001 With Urban and Rural Health Chartbook*. Hyattsville, Maryland: 2001, Table 3; Data fo 1970-2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. *National Vital Statistics Reports, 62*(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

The number of infants who are born to teens is relatively small and, as a proportion of all births, has declined substantially in the past twenty years. However, these are babies who face inordinate risks.

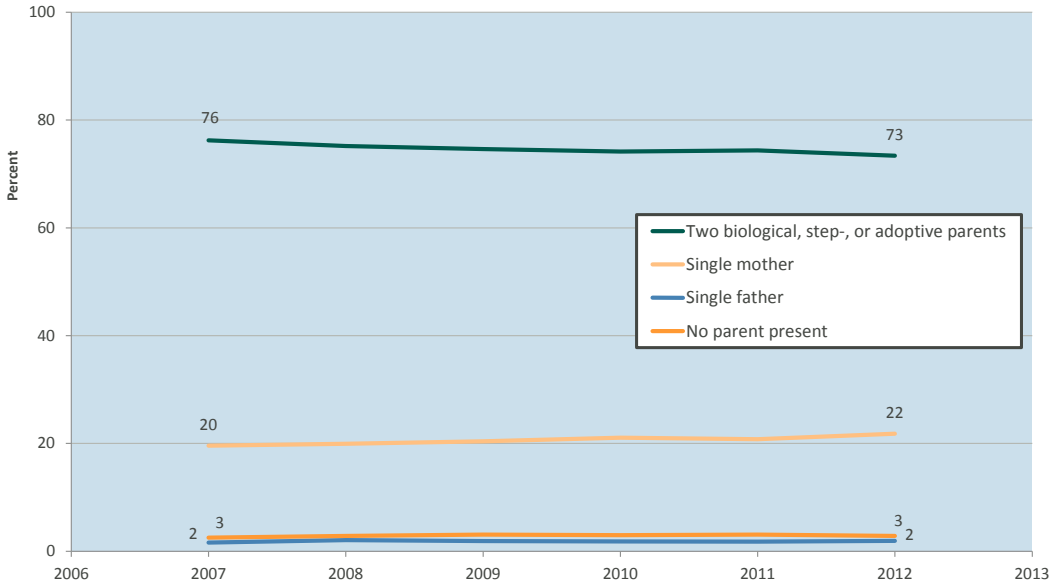
Children born to teen mothers are more likely to be born prematurely, to be born at a low birthweight, and to die as infants, compared with children born to mothers in their twenties and early thirties. In addition, their mothers are likely to be at a disadvantage, both educationally and economically.[1]

Birth rates have fallen among white, black, and (especially) Latina teens. However, rates among the latter two groups are twice as high as they are among white teens. The U.S. teen birth rate is still high by the standards of developed countries. In 2011, about 330,000 babies were born to women ages 15-19, and about 4,000 to 10- to 14-year-olds.

1 Child Trends DataBank. (2012). Teen births. Retrieved from http://www.childtrends.org/?indicators=teen-births

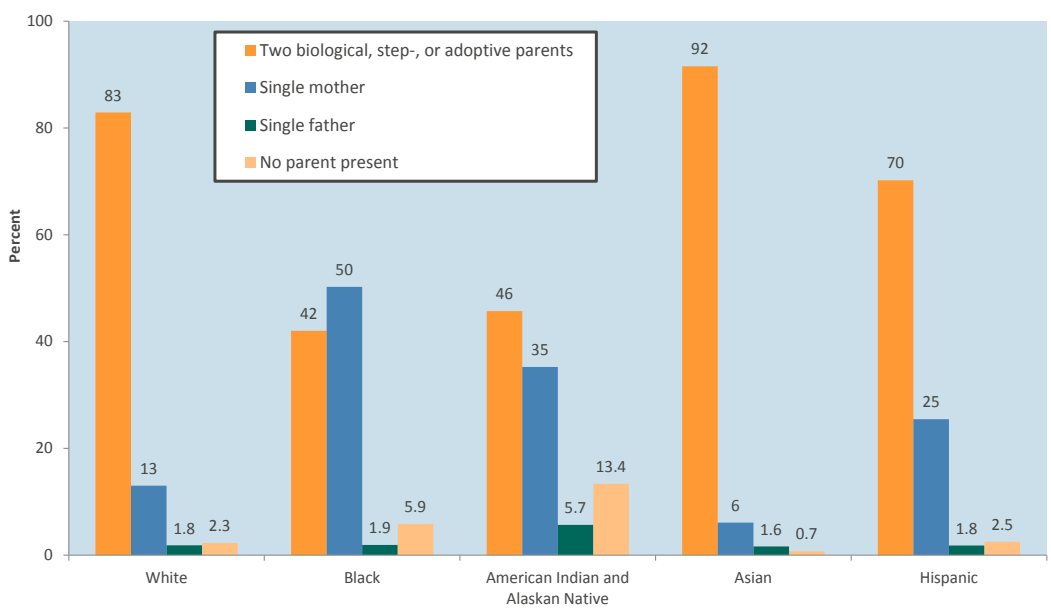
family structure

Family Structure among Children Ages Birth through Two, 2007-2012



Source: Child Trends' calculations from the Current Population Survey

Family Structure Among Children Ages Birth through Two, Percentages by Race and Hispanic Origin, 2012

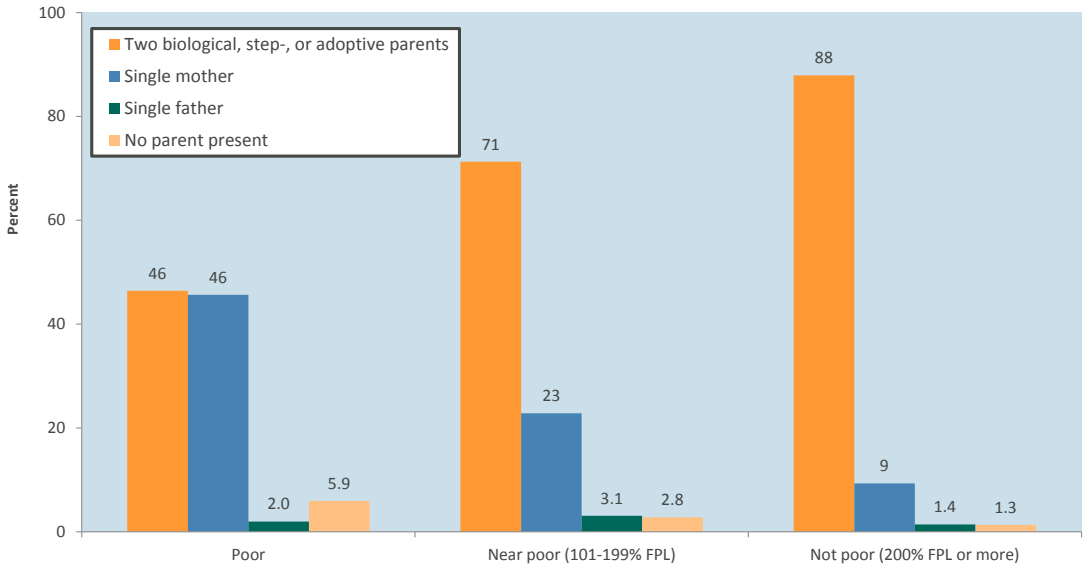


Source: Child Trends' analysis of the Current Population Survey: March Supplement

Both mothers and fathers play important roles in the growth and development of young children. Strongly linked to a child's well-being are the number and the type of his or her parents (e.g., biological, step) in the household, as well as parents' relationship with each other. **More so than at any time in recent history, young children are raised outside of marriage, and often by one parent only.**

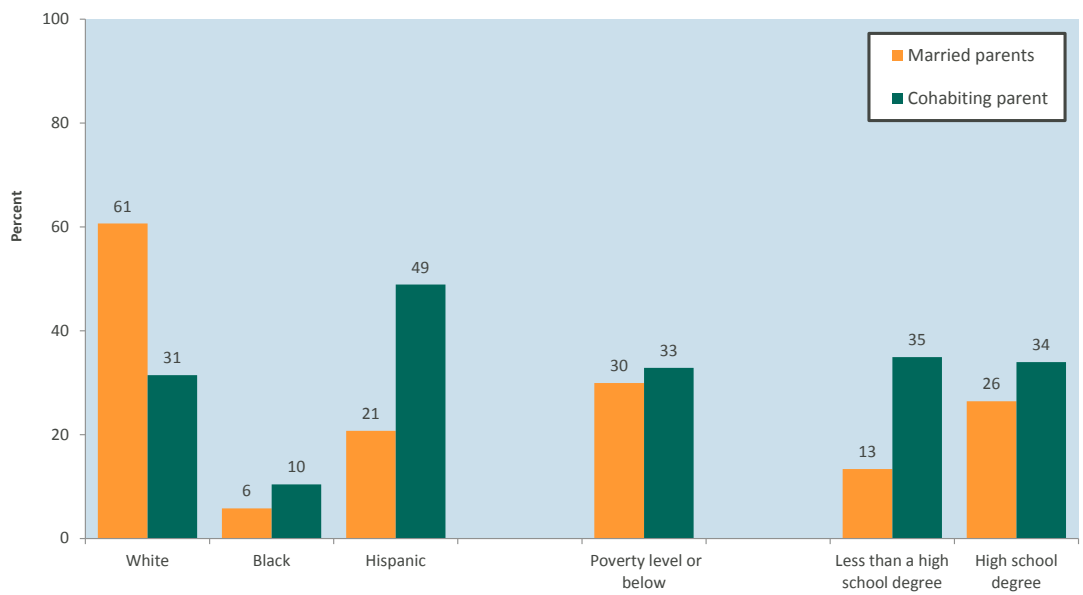
Among young children, those living with no biological parents or in single-parent households are less likely than children with two biological parents to exhibit behavioral self-control, and more likely to be exposed to high levels of aggravated parenting, than are children living with two biological parents. Single-parent families have much lower incomes, on average, than do two-parent families, while families headed by cohabiting partners fall in-between. Research indicates, however, that the income differential only partially accounts for the negative effects in many areas of child and youth well-being (including health, educational attainment and assessments, behavior

Children Ages Birth through Two, Percentages in Selected Family Income Groups, by Family Structure: 2012



Source: Child Trends' analysis of the Current Population Survey: March Supplement

Children Ages Birth through Two, Percentages Living with Married and Cohabiting Parents, by Race and Hispanic Origin, Poverty, and Parental Education, 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health.

problems, and psychological well-being) associated with living outside of a married, two-parent family.[1]

For today's young adults, marriage is increasingly separated from parenthood.[2] As of 2012, nearly three-quarters of infants and toddlers reside with two parents; about one in five lives with their mother only, and small percentages with their father only, or with no parent. As noted previously, family structure and family income are strongly associated, with the prevalence of single mothers with an infant or toddler twice as high among poor as in near-poor families, and four times as high as in families who are not low-income. Infants or toddlers with a single mother are also disproportionately black, Native American/Alaska Native, or Latino, whereas those in two-parent families are disproportionately white or Asian.

Although nearly two-thirds of infants and toddlers are in households headed by two married adults, one in six lives with parents who are cohabiting rather than married. Nearly one in three Latino infants and toddlers lives with cohabiting parents, compared with about one in seven for their black peers, and one in ten for whites. **Nearly half of young children living with cohabiting parents are in poverty; a third have parents who have not finished high school, while the parents of another third have only a high school education.**

1 Child Trends DataBank. (2013). Family structure. Retrieved from http://www.childtrends.org/?indicators=family-structure

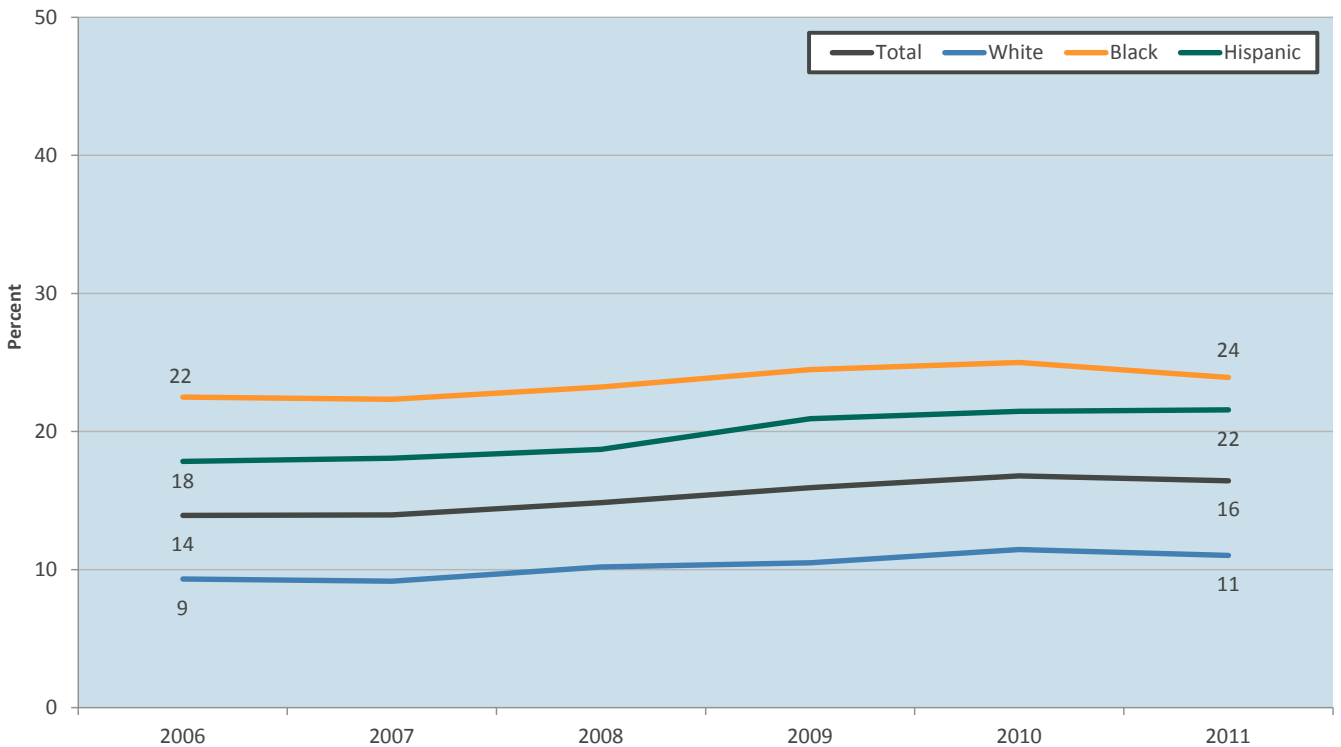
2 Hymowitz, K., Carroll, J. S., Wilcox, W. B., Kaye, K. (2013). Knot yet: The benefits and costs of delayed marriage in America. National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from http://twentysomethingmarriage.org/

grandparent-headed households

In recent years more U.S. children are living with grandparents, who may additionally have primary responsibility for their care. The circumstances surrounding children's residence with grandparents are diverse, influenced by families' economic security, family structure, health conditions of parents and/or children, and cultural norms. **There can be both advantages and disadvantages associated with children's living with grandparents, but a disproportionate share of grandparent-headed families have incomes below the poverty level.**[1]

As of 2011, about one in six infants and toddlers lived in households headed by grandparents. This is an increase of 18 percent since 2006. Comparing young children living in grandparent-headed households with those not living in such arrangements, those in the former group are more likely to be black or Latino, and to be living in households that are near-poor.[2]

Percentage of Children Ages Birth through Two who Live in Households Headed by Grandparents, by Race/Hispanic Origin, 2006-2011



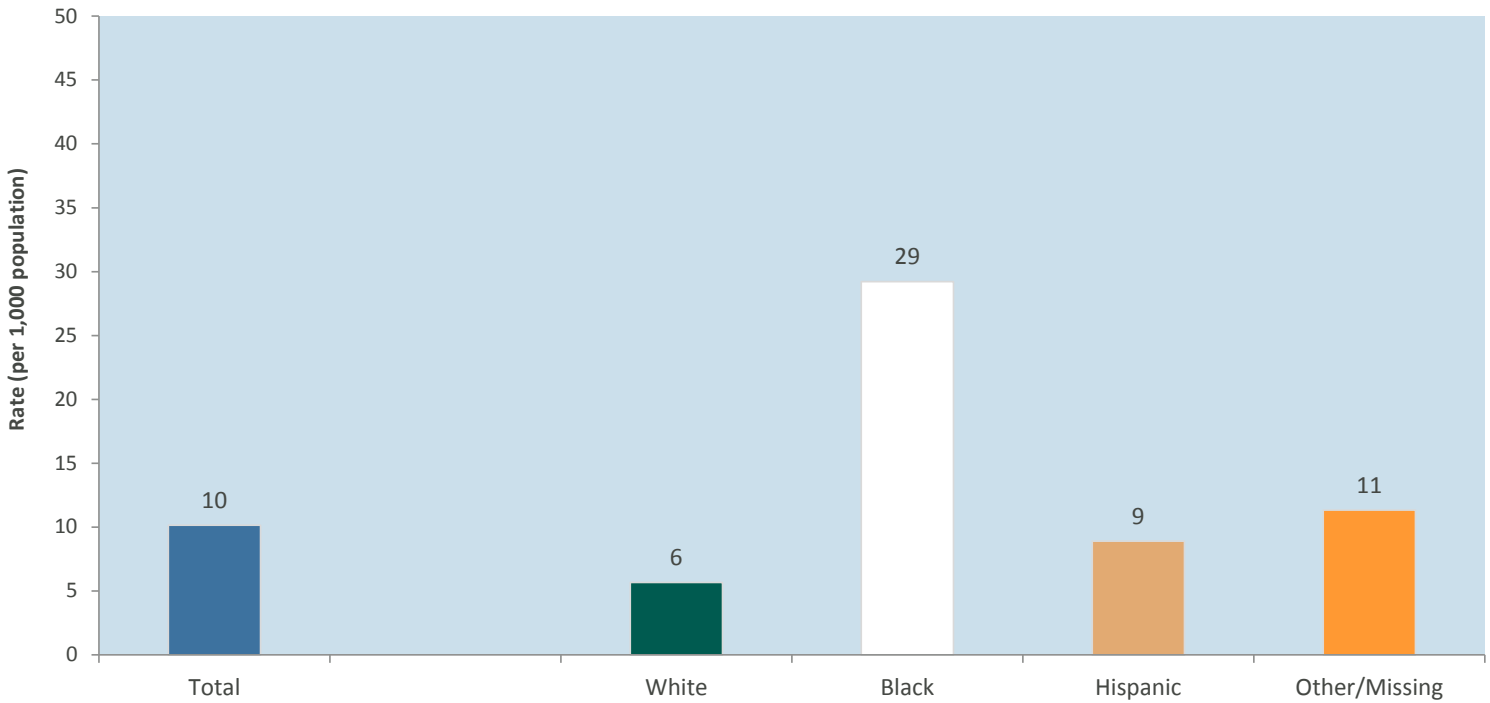
Source: Child Trends' calculations from the American Community Survey

1 Murphey, D., Cooper, M., & Moore K. A. (2012). Grandparents living with children: State-level data from the American Community Survey. Child Trends Research Brief. Retrieved from http://www.childtrends.org/Files/Child_Trends-2012_10_01_RB_Grandparents.pdf
Murphey, D., Cooper, M., & Moore K. A. (2012). Children living with and cared for by grandparents: State-level data from the American Community Survey. Child Trends Research Brief. Retrieved from http://www.childtrends.org/Files/Child_Trends-2012_10_01_RB_Grandchildren.pdf

2 Child Trends' analysis of the American Community Survey, U.S. Census Bureau, Public Use Microdata Sample.

foster care

Infants in Foster Care per 1,000 Population, Total, and by Race and Hispanic Origin, 2000-2008

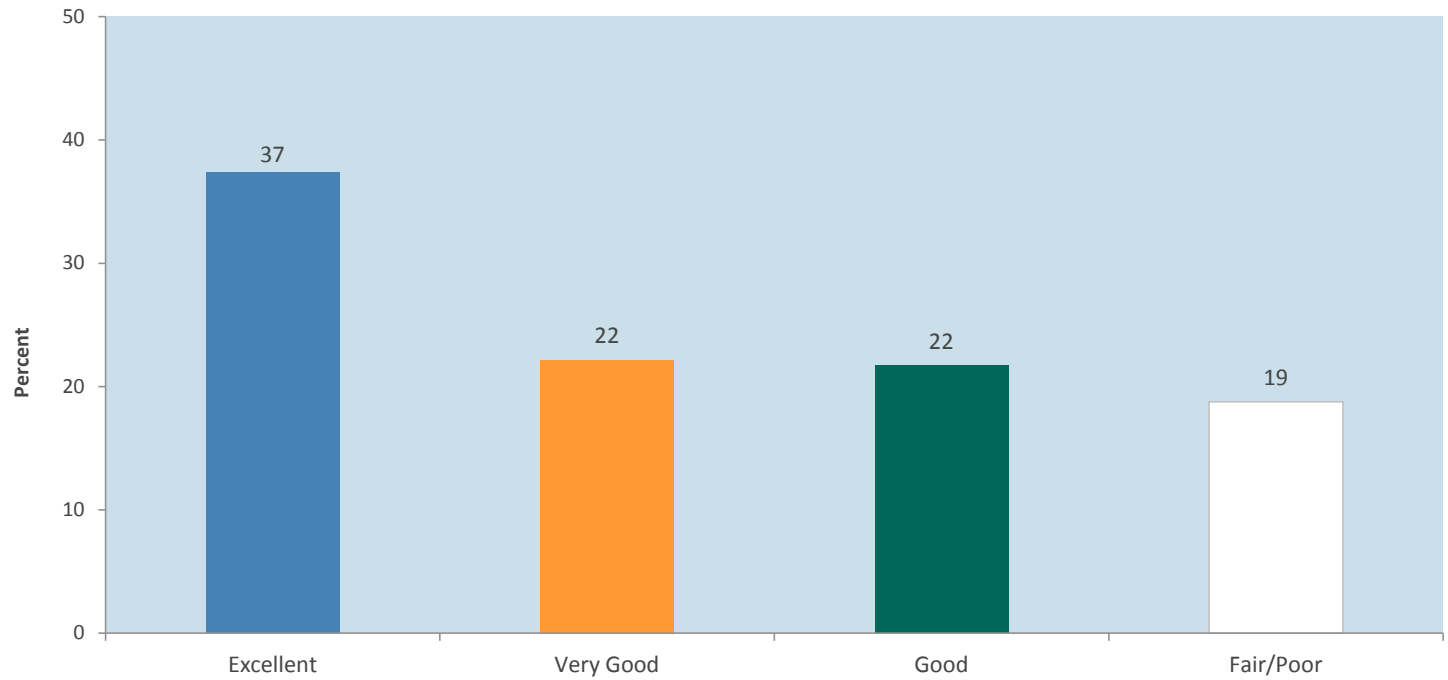


Source: Population data from Child Trends' calculations from Intercensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/intercensal/national/nat2010.html. Foster care data from Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot*. Chicago, IL: Chapin Hall.

A child's placement into foster care is a marker of serious family distress, often including child maltreatment. Of the birth families of babies in foster placements, nearly two-thirds had prior involvement with the child welfare system. In 60 percent of the birth families, caseworkers report active use of alcohol or drug abuse by caregivers; domestic violence is reported in 46 percent of birth families; 42 percent of infants were being cared for by an adult with a serious mental health or emotional problem.[1]

1 Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the infants in out-of-home care? An epidemiological and developmental snapshot. Chapin Hall Issue Brief. Retrieved from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf

Percentage of Infants in Foster Care by Health Status, 2000-2008



Source: Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot*. Chicago, IL: Chapin Hall.

Because infancy is the period in which attachment relationships—which have long-term implications for social-emotional well-being—are established, foster care poses an exceptional risk for babies. Thus, almost by definition, infants in foster care have experienced multiple traumas.[1]

Infants are more likely than children in any other age group to be placed in foster care. Infants comprise one in four of children admitted to foster care for the first time. On average, they will spend more of their childhood years in foster care than will older children who enter care. However, infants are adopted at higher rates than are older children.[2]

The annual placement rate for infants is about nine in one thousand; by comparison, for older children it is about two per thousand. The best available data show that black infants comprise the single largest share of babies in foster care (39 percent), followed by white and Latino infants. As a group, compared with older children in care, infants in care have poorer health.[3]

1 Child Trends DataBank. (2012) Foster care. Retrieved from http://childtrendsdatabank.org/alphalist?q=node/199
2 Ibid.
3 Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the infants in out-of-home care? An epidemiological and developmental snapshot. Chapin Hall Issue Brief. Retrieved from http://www.chapinhall.org/sites/default/files/publications/06_08_11_Issue%20Brief_F_1.pdf

adopted infants and toddlers

About two percent of the U.S. child population is adopted; as of 2007, these included approximately 102,000 infants and toddlers.[1]

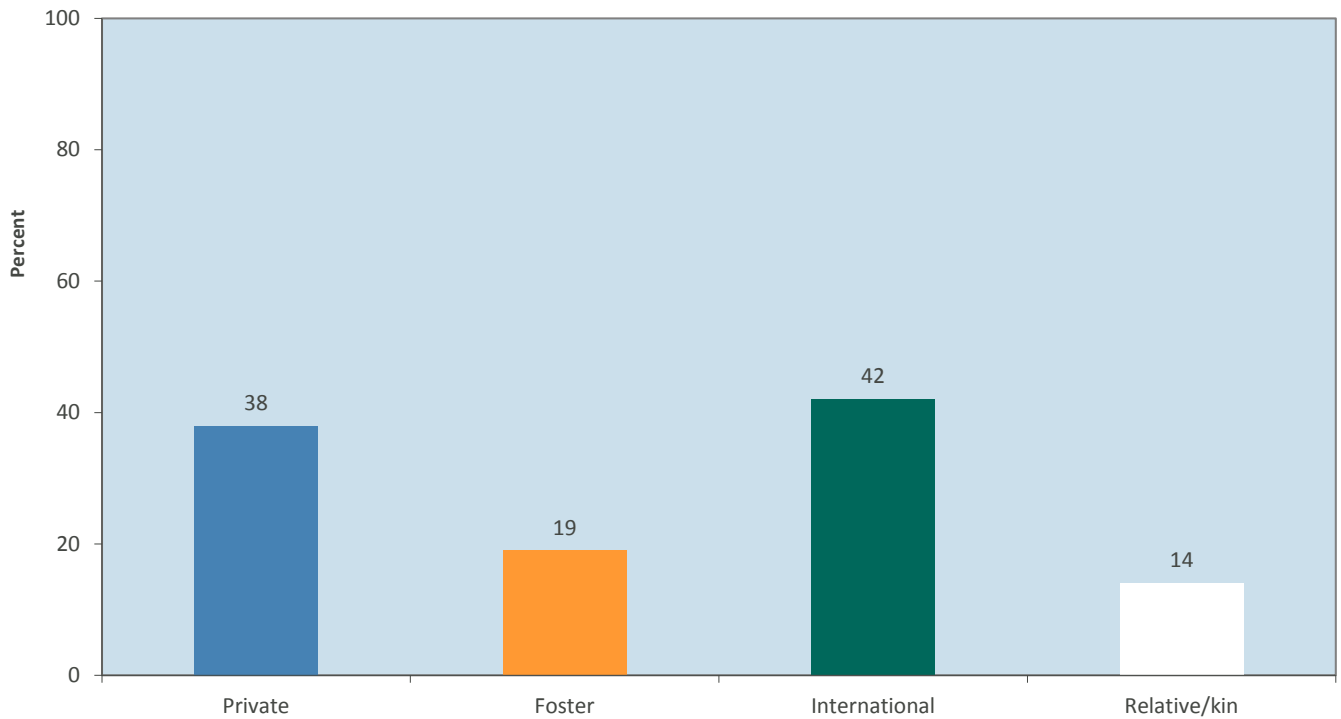
In this country, children come into adoption through one of three primary routes. As of 2007, the single largest group of adopted infants and toddlers (42 percent) were adopted from other countries. Nearly as many (38 percent) were domestic, private-agency-assisted adoptions. About one in five (19 percent) were adopted from foster care. Among all adoptions, one in seven (14 percent) were by relatives.

As a group, the youngest adopted children are more ethnically and racially diverse than the overall population: seven in ten are non-white or Latino.

Children adopted from foster care, or from countries outside the U.S., typically have experienced difficult circumstances, which may have included abuse or neglect, the loss of ties with parents and siblings, and multiple foster care placements.

1 Vandivere, S., Malm, K., & Radel, L. (2009). Adoption USA: A chartbook based on the 2007 National Survey of Adoptive Parents. U.S. Department of Health and Human Services, Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. Available at http://aspe.hhs.gov/hsp/09/nsap/chartbook/index.cfm

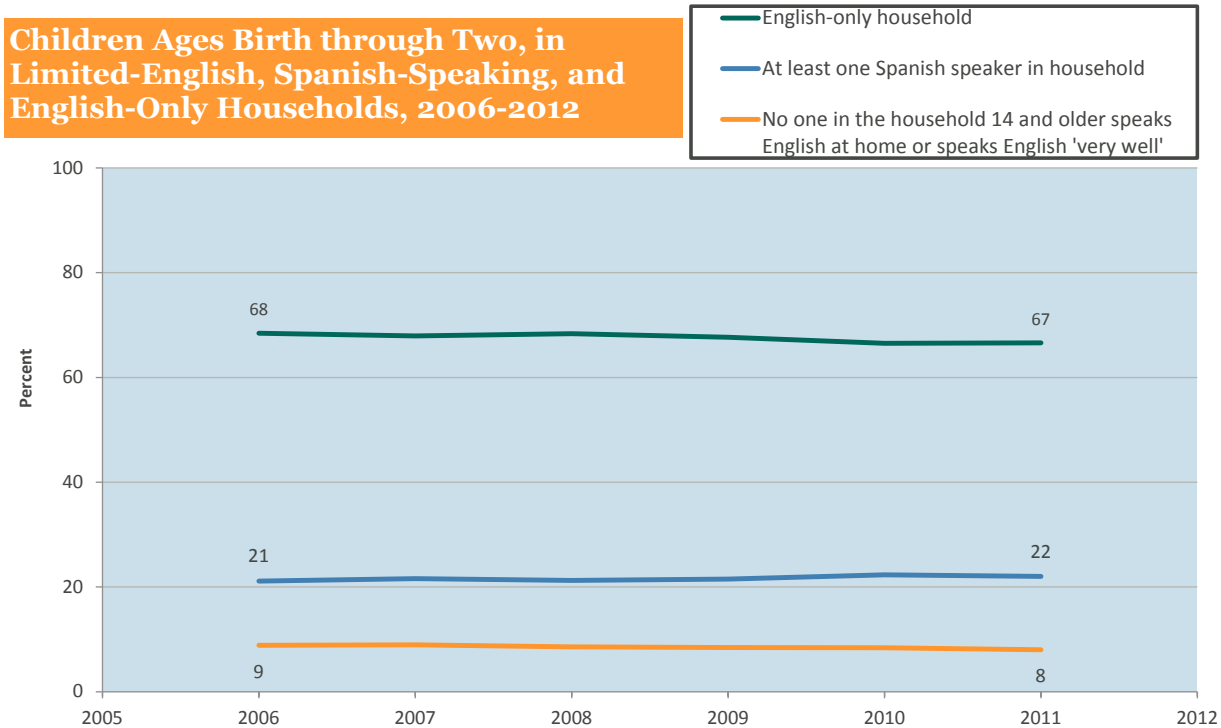
Adopted Children, Ages Birth Through Two, Percentages by Adoption Type, 2007



Source: Child Trends' analysis of the National Survey of Adoptive Parents.

English proficiency

Children Ages Birth through Two, in Limited-English, Spanish-Speaking, and English-Only Households, 2006-2012



Note: Limited English households include households where people speak languages other than Spanish.
Source: Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.

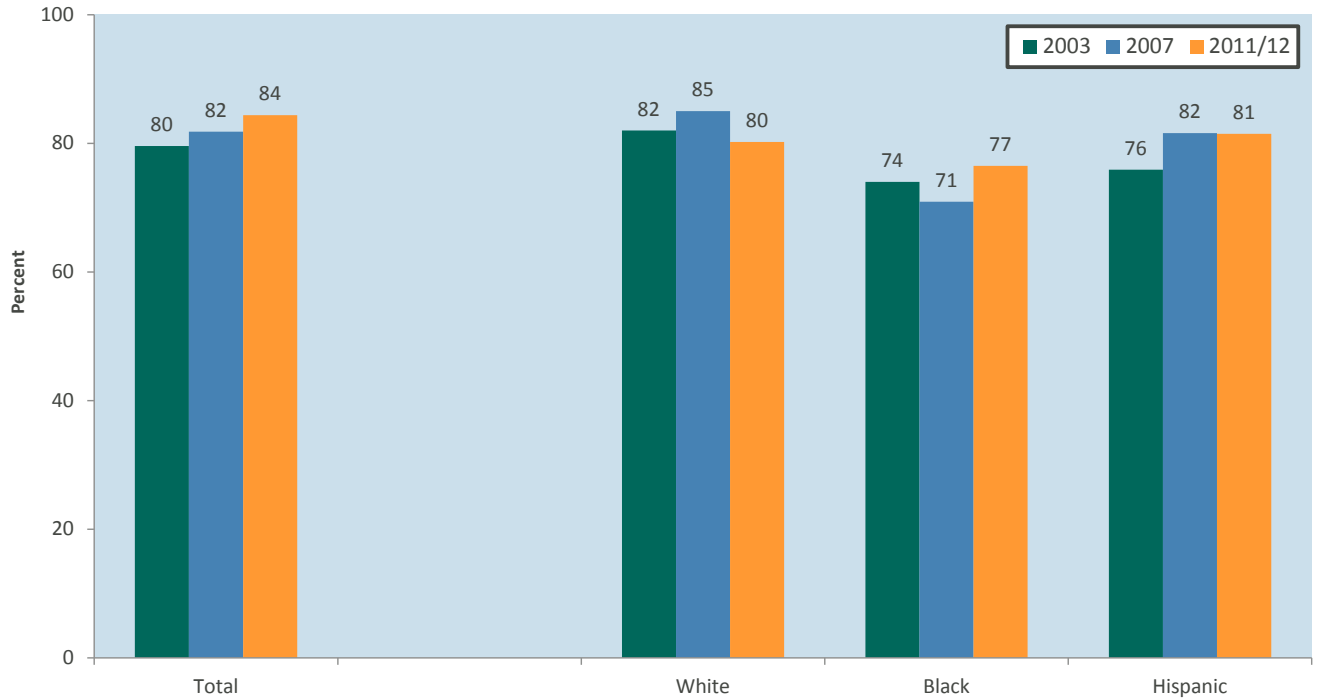
Perhaps nowhere is the growing diversity of American culture more apparent than in the language environment of infants and toddlers. Research supports the cognitive and other benefits for children of growing up in a multi-lingual milieu.[1] However, young children's parents who have limited English proficiency may face difficulty in navigating the various service systems associated with meeting their own, and their children's, needs. For example, families in which one or more parents who have limited English proficiency are less likely to receive a child care subsidy.[2]

Learning language is one of most important accomplishments of the infant-toddler period. Young children who are exposed to a language-rich environment reap advantages in later cognitive and social development. For children who are not English-language speakers, research supports the effectiveness of direct dual-language instruction.[3]

About one in 13 infants and toddlers lives in a household where no adult speaks English at home, and all adults speak English less than "very well." One in five (22 percent) lives in households where someone speaks Spanish. **Just two-thirds of infants and toddlers live in households where English is the only language spoken.**

1 Office of Head Start. National Center on Cultural and Linguistic Responsiveness. (2013). The benefits of being bilingual. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/cultural-linguistic/docs/benefits-of-being-bilingual.pdf
2 Firgens, E. & Matthews, H. (2012). State child care policies for limited English proficient families. Center for Law and Social Policy. Retrieved from http://www.clasp.org/admin/site/publications/files/CCDBG-LEP-Policies.pdf
3 Beltrán, E. (2012). Preparing young Latino children for school success: Best practices in language instruction. Issue Brief No. 25. National Council of La Raza. Retrieved from http://www.nclr.org/index.php/publications/preparing_young_latino_children_for_school_sucess_best_practices_in_language_instruction/

Percentage of Children, Ages Birth through Two, Who Ate Meals with their Families at least 4 Days in the Past Week, Total, and by Race/Hispanic Origin: 2003, 2007, and 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health

Having an infant or toddler eat with other family members may not always be practical, but research suggests that shared mealtimes are associated with a number of benefits. Among those most relevant to the youngest children are increased vocabulary, and exposure to a wider variety of foods that may lead to their adopting healthier eating habits. Research suggests that having a television on during mealtimes does not substitute for shared family conversations, and may promote unhealthy eating.[1]

Data from 2011/12 show that more than eight in ten babies and toddlers ate meals with their families at least four days per week. Young children in families who are in poverty are slightly less likely to share family meals than children in families with higher incomes. Regardless of race/Hispanic origin, large majorities of children frequently eat meals with family, though black children are slightly less likely to do so than are white or Latino children.

1 Child Trends DataBank. (2012). Family meals. Retrieved from http://www.childtrends.org/?indicators=family-meals

reading, singing songs, telling stories

Children develop literacy skills and an awareness of language long before they are able to read. Since language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.[1]

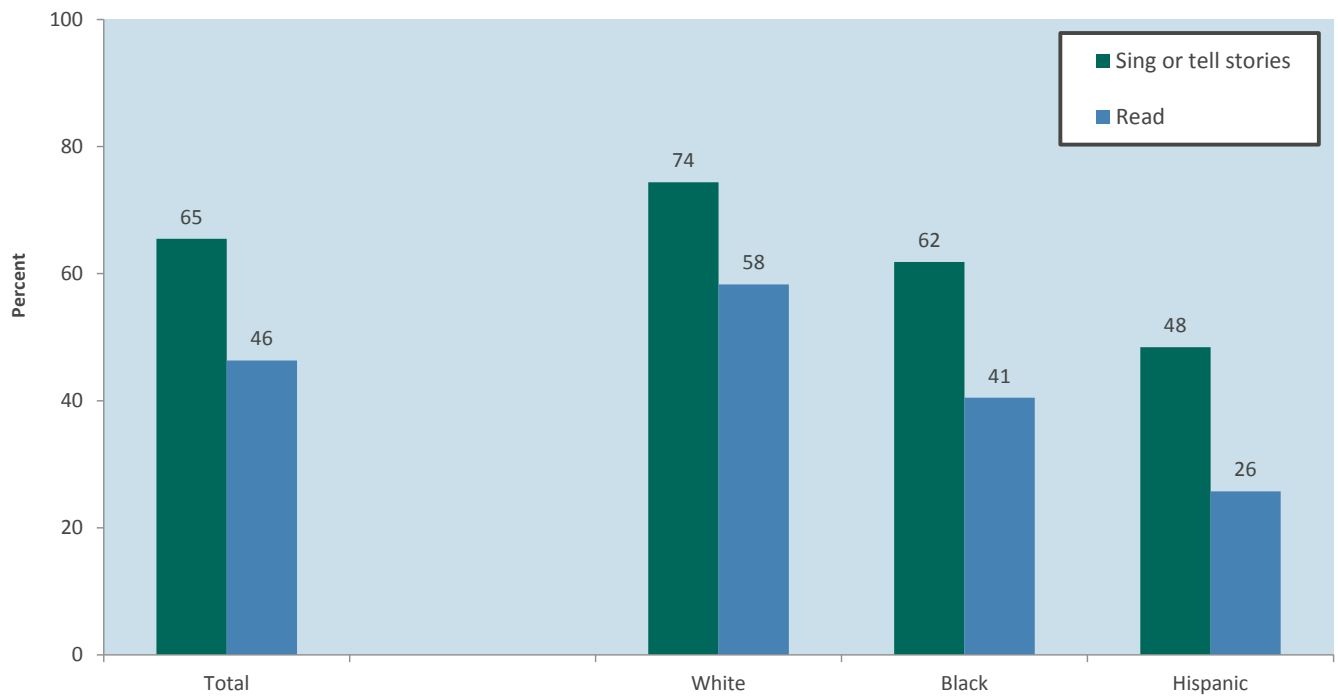
Young children who are regularly read to have a larger vocabulary; higher levels of phonological, letter name, and sound awareness; and better success at decoding words. The number of words in a child's vocabulary can be an important indicator of later academic success. Children's vocabulary use at age three is a strong predictor of language skill and reading comprehension at ages 9-10.[2]

Just under half of children ages birth through two (46 percent) were read to by a family member every day during the past week. Children in families with higher levels of income are more likely to be read to regularly: about three in ten young children living in poverty are read to every day, compared with six in ten who live in families with higher

1 Child Trends DataBank. (2012). Reading to young children. Retrieved from http://www.childtrends.org/?indicators=reading-to-young-children

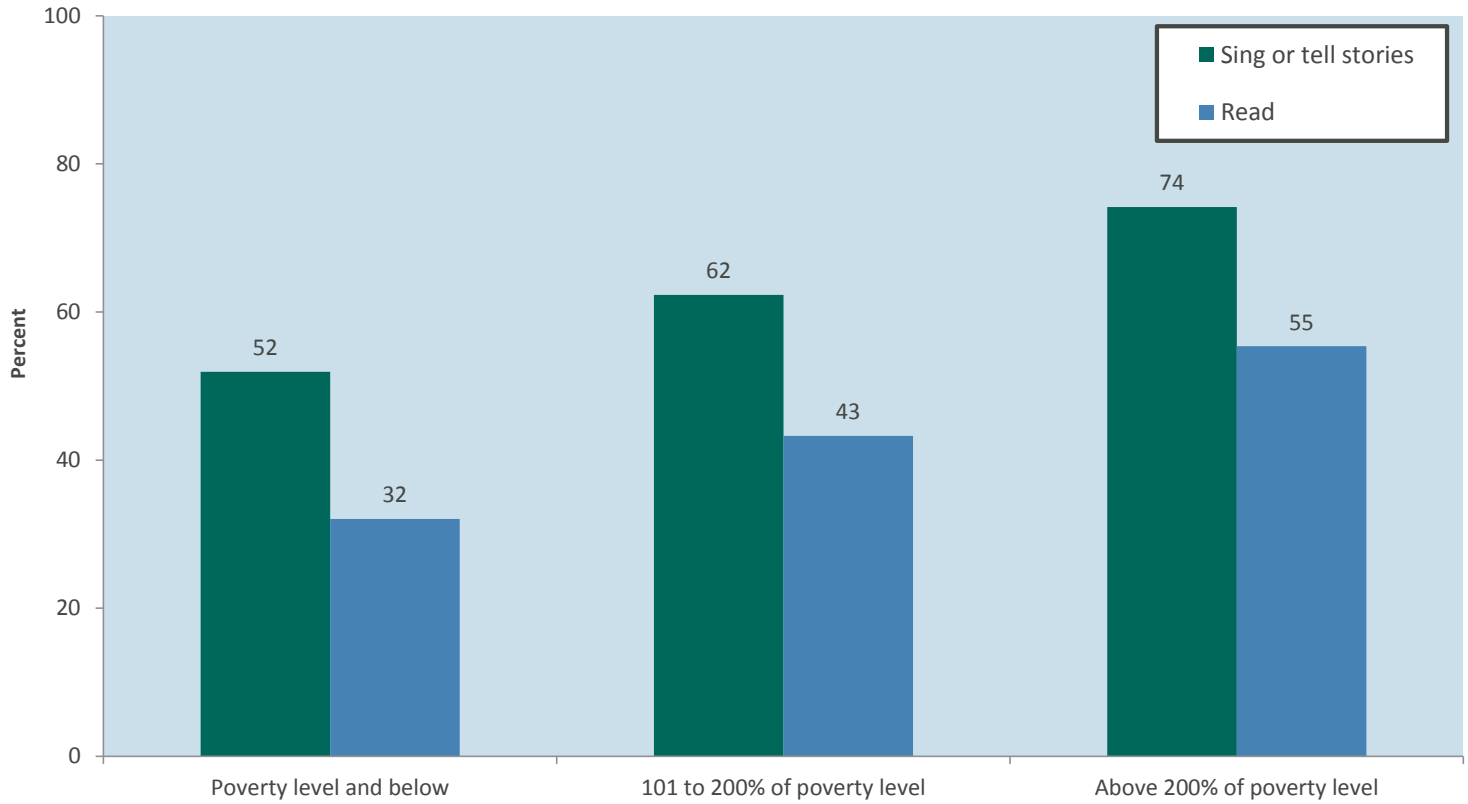
2 Ibid.

Percentage of Children, Ages Birth through Two, Who Had A Family Member Read, Sing, or Tell Them Stories Everyday in the Past Week, Total, and by Race/Hispanic Origin: 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health

Percentage of Children, Ages Birth through Two, Who Had A Family Member Read, Sing, or Tell Them Stories Everyday in the Past Week, by Poverty Level: 2011/12



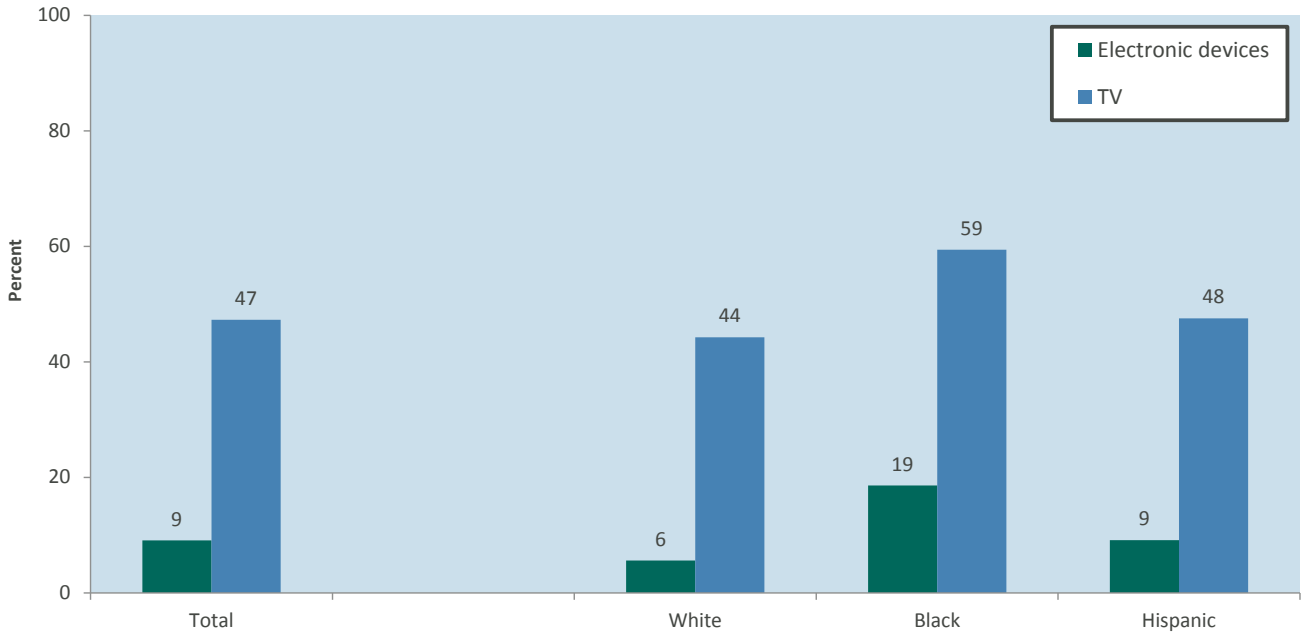
Source: Child Trends' analysis of the National Survey of Children's Health

incomes. White children are about twice as likely as Latinos to have family members read to them frequently; black children fall in between.

Another shared activity that promotes early literacy skills and provides opportunities for closeness between young children and other family members is singing songs or telling stories together. About two-thirds of infants and toddlers experience these activities every day, according to their parents. **Young children who are poor are less likely than their peers in wealthier families to be sung to or told stories every day. Black and Latino infants and toddlers are less likely than their white counterparts to have this experience.**

use of tv and electronic devices

Percentage of Children, Ages Birth through Two, Who Spent More than an Hour In Front of the Television* or Using Electronic Devices** on an Average Weekday, Total, and by Race and Hispanic Origin: 2011/12



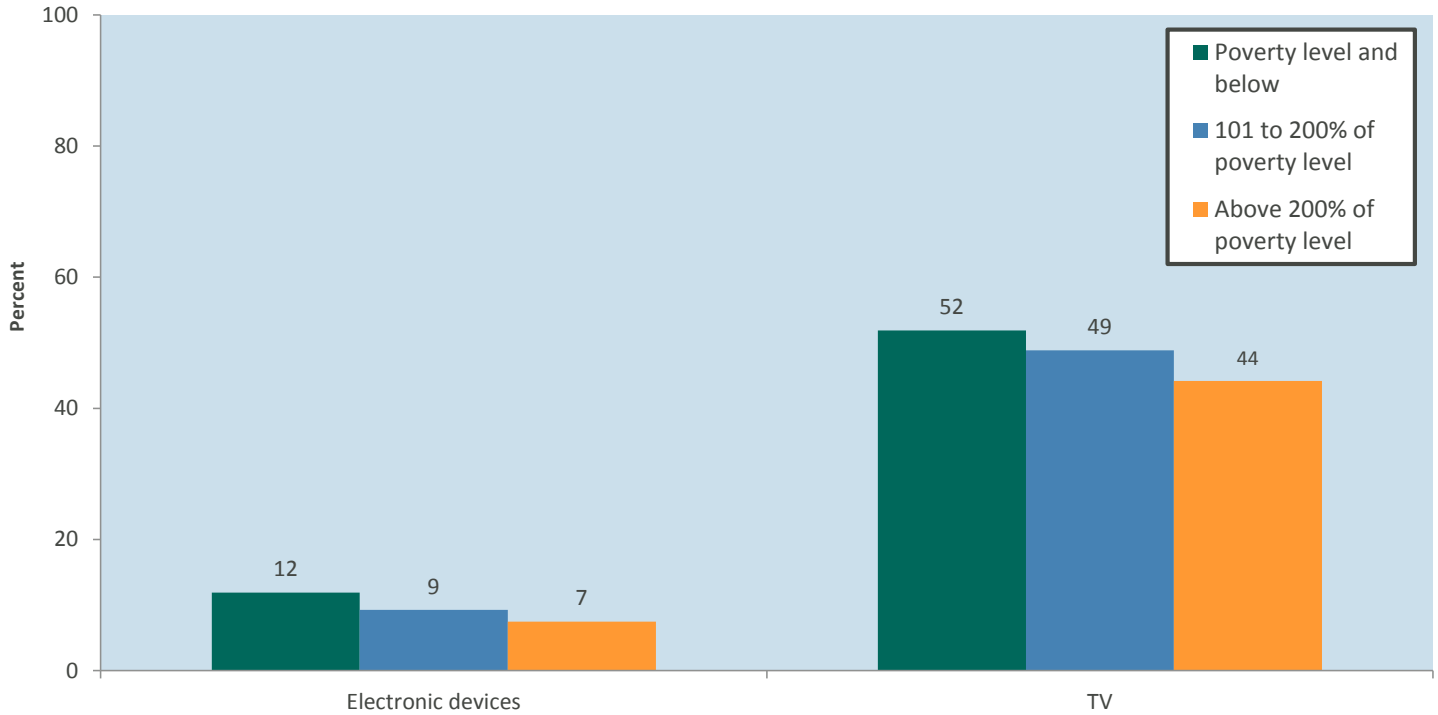
* Time in front of a television includes time watching tv or videos, or playing video games.
** Usage of electronic devices includes usage of computers, cell phones, handheld video games, and other electronic devices.
Source: Child Trends' analysis of the National Survey of Children's Health

The American Academy of Pediatrics discourages the use of television and other electronic media for children younger than two, and for older children recommends no more than two hours per day.[1] Nevertheless, data from a number of surveys show that U.S. infants and toddlers are exposed to a great deal of these media, starting in the earliest months of life. According to a 2011 report, nearly half (47 percent) of children in this age group watch TV or DVDs on a typical day, with average viewing at nearly two hours for those who do so. Forty-three percent watch TV at least daily. Nearly a third (29 percent) have a television in their bedroom[2]—a practice that research finds more likely to interfere with positive development.[3] A third of babies and toddlers live in homes where television is on constantly, regardless of whether anyone is watching it.[4]

A recent national survey confirms this picture. **Nearly half of infants and toddlers (according to parents' report) spend an hour or more per weekday in front of a television, either watching programs or playing video games.** Slightly under one-third are reported to watch "none" on a typical

1 American Academy of Pediatrics, Council on Communications and Media. (2011). Media use by children younger than two years. Policy Statement. Pediatrics, 128(5), 1040-1045.
2 Common Sense Media. (2011). Zero to Eight: Children's media use in America. Retrieved from http://www.commonsensemedia.org/sites/default/files/research/zerotoeightfinal2011.pdf
3 Strasburger, V. C., Jordan, A. B. & Donnerstein, E. (2010). Health effects of media on children and adolescents. Pediatrics, 125(4), 756-767.
4 Rideout, V. & Hamel, E. (2006). The media family: Electronic media in the lives of infants, toddlers, preschoolers, and their parents. Kaiser Family Foundation. Retrieved from http://www.kff.org/entmedia/upload/7500.pdf

Percentage of Children, Ages Birth through Two, Who Spent More than An Hour In Front of the Television* or Using Electronic Devices** on an Average Weekday, by Family Poverty Level: 2011/12



* Time in front of a television includes time watching tv or videos, or playing video games.
** Usage of electronic devices includes usage of computers, cell phones, handheld video games, and other electronic devices.
Source: Child Trends' analysis of the National Survey of Children's Health

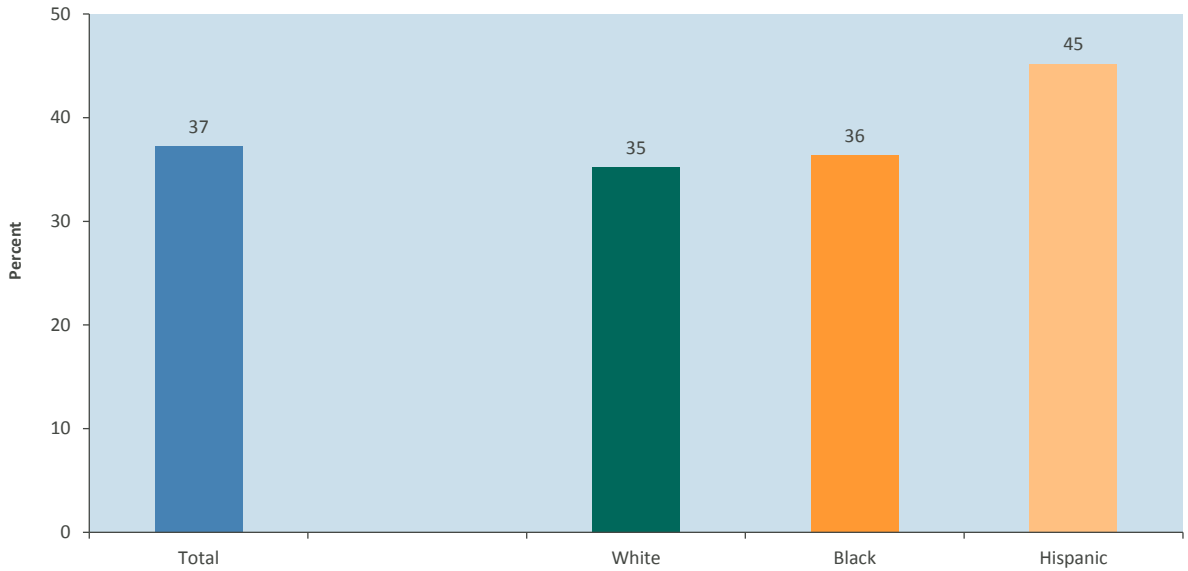
weekday. Black infants and toddlers, and those living in poverty, are more likely than their counterparts to watch an hour or more.

Other 2011/12 data supplement these by reporting on use of computers, cell phones, handheld video games, and "other electronic devices." Parents report that more than one in five infants and toddlers uses these on an average weekday, and one in 11 uses them for an hour or more. For this age group, such devices typically are intended as "learning toys," but they often mimic the appearance of the tablets and smart phones adults use. Young black children are more than three times as likely as their white counterparts to be "heavy" users of these media (an hour or more on a typical weekday). Young children in poverty are about half again as likely to be "heavy" users as those in families with incomes at least twice the poverty level.

Public/ Private Supports

parental leave

Among Women Who Took Leave For Their Last Pregnancy,* Percentage For Whom No Portion Was Paid: 2006-2010



*Including only pregnancies in the past five years that resulted in a live birth, and the child was not put up for adoption.
Source: Child Trends' original analyses of data from the National Survey of Family Growth.

The people most important in a young child's life are his or her parents. Particularly in the earliest months after birth, when an attachment bond is forming, babies and their parents need time together to learn a set of routines, responsibilities, and expectations new to them both. This relationship-building period is foundational for the child's optimal social, emotional, and cognitive development.

Workplace demands can threaten parents' ability to follow this agenda. Nearly all developed countries acknowledge the critical importance to society of the early parenting period by ensuring that new parents, or at least mothers, can take a temporary leave from work without jeopardizing their employment.

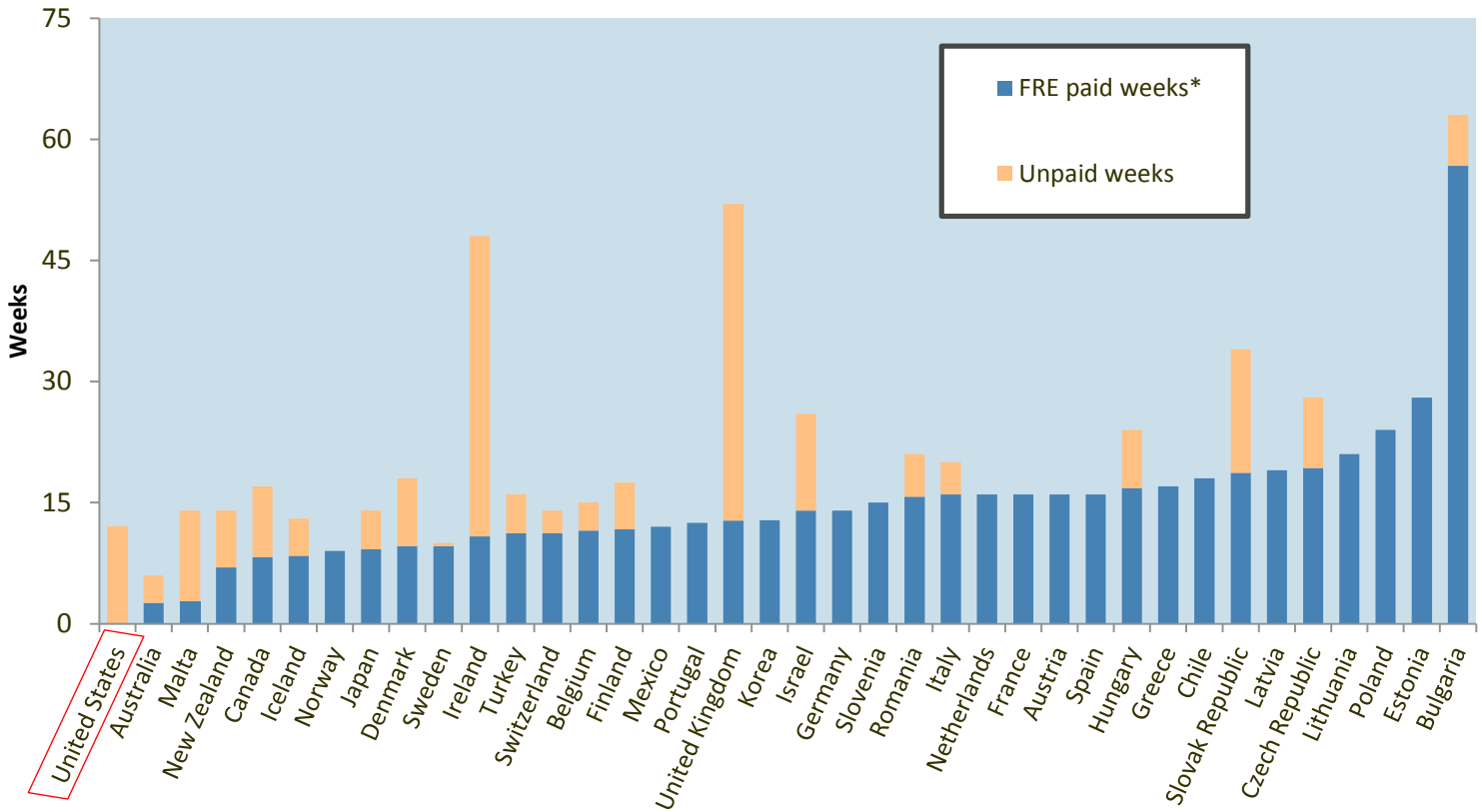
The U.S. is the only developed nation not to guarantee any paid maternal leave. Policies around parental leave in the U.S. are markedly different from those of other countries. When such leave is offered, it is usually unpaid, which makes it for many new parents an untenable option. The Family and Medical Leave Act of 1993 (FMLA) guarantees—for qualifying employees[1]—up to 12 weeks of unpaid leave for specified reasons (that include the birth of a child). However, a recent survey finds that many FMLA-covered employers are not complying with its provisions.[2]

Data from 2006-10 show that, among women who had a recent birth, two-thirds worked during their pregnancy; the percentage working was highest among white women, and lowest among Latinas. Of those who worked during their pregnancy, about two-thirds took maternity leave; of this group, the majority received some paid leave; however, more than a third received no pay while on leave. **About one in six of those taking any maternity leave received at least nine weeks of paid leave. Latinas were less likely than black or white women to receive nine or more weeks of paid leave.**

Paternity leave is much less available and less likely to be reimbursed than is maternity leave.[3]

1 Employees must be part of a firm with at least 50 workers within 75 miles of the worksite; must have worked at least twelve months with the firm, and have worked 1,250 hours during the past year.
2 Matos, K. & Galinsky, E. (2012). 2012 National Study of Employers. Families and Work Institute. Retrieved from http://familiesandwork.org/site/research/reports/NSE_2012.pdf
3 National Partnership for Women & Families. (2012). Dads expect better: Top states for new dads. Retrieved from http://www.nationalpartnership.org/site/DocServer/Dads_Expect_Better_June_2012.pdf?docID=10581

Number of Weeks of Employment-Protected Maternity Leave , and Number of Paid Weeks,* in 38 Developed Countries: 2007



*FRE (full-rate equivalent) paid weeks are calculated as the duration of leave in weeks x total public payment as a percent of the average wage earnings received. Thus, if a mother normally made $1,000 a week, and the government paid $10,000 for 15 weeks of leave, she would have 10 weeks of FRE paid leave and 5 weeks of unpaid leave.

Source: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

child care: enrollment, quality, cost, subsidy

The types of care employed mothers predominantly use for their children (ages birth through two) have changed only slightly in the past 25 years:

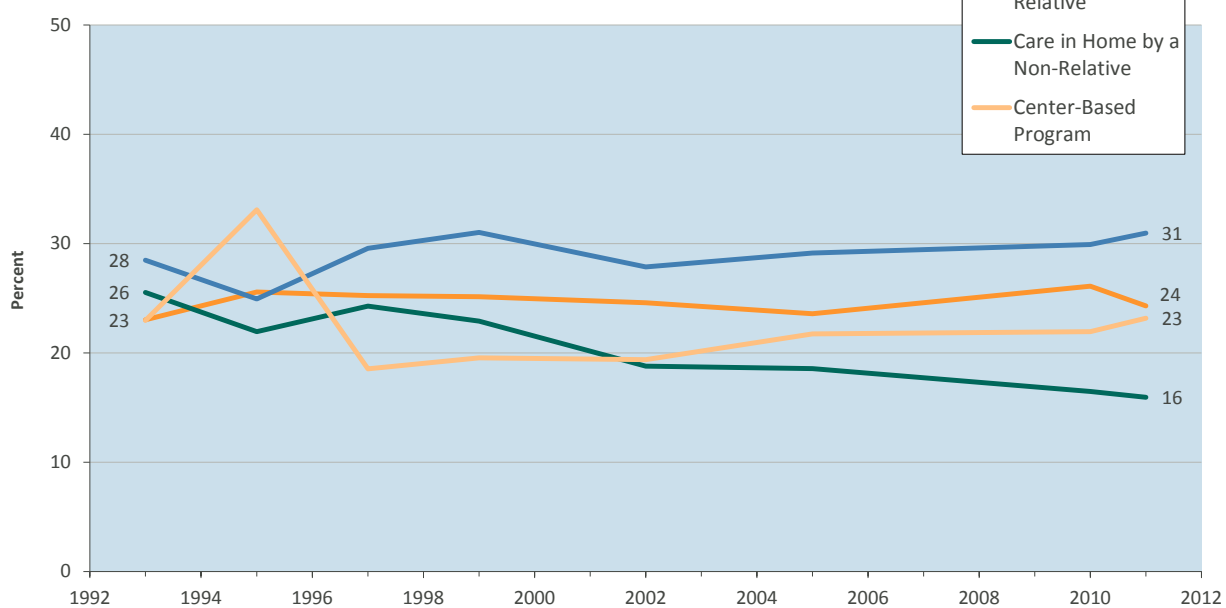
- Between 1993 and 2011, the percent of these children whose primary caregiver during working hours was a parent has fluctuated between 23 and 26 percent.
- The proportion in center-based programs has increased from 19 to 23 percent between 1997 and 2011.
- The percentage of children who were cared for by a relative has followed a generally upward trend, going from 25 to 31 percent between 1999 and 2011.
- The strongest trend has been a consistent decrease in the percentage of children who were cared for by a non-relative at home, which declined from 26 to 16 percent between 1993 and 2011.[1]

Numerous studies have documented an association between high-quality care and children's positive development. The strongest evidence of positive long-term outcomes associated with early childhood programs comes from studies of intensive and comprehensive programs targeting the most vulnerable children.[2] Recent research

1 Child Trends DataBank. (2013). Child care. Retrieved from http://www.childtrends.org/?indicators=child-care

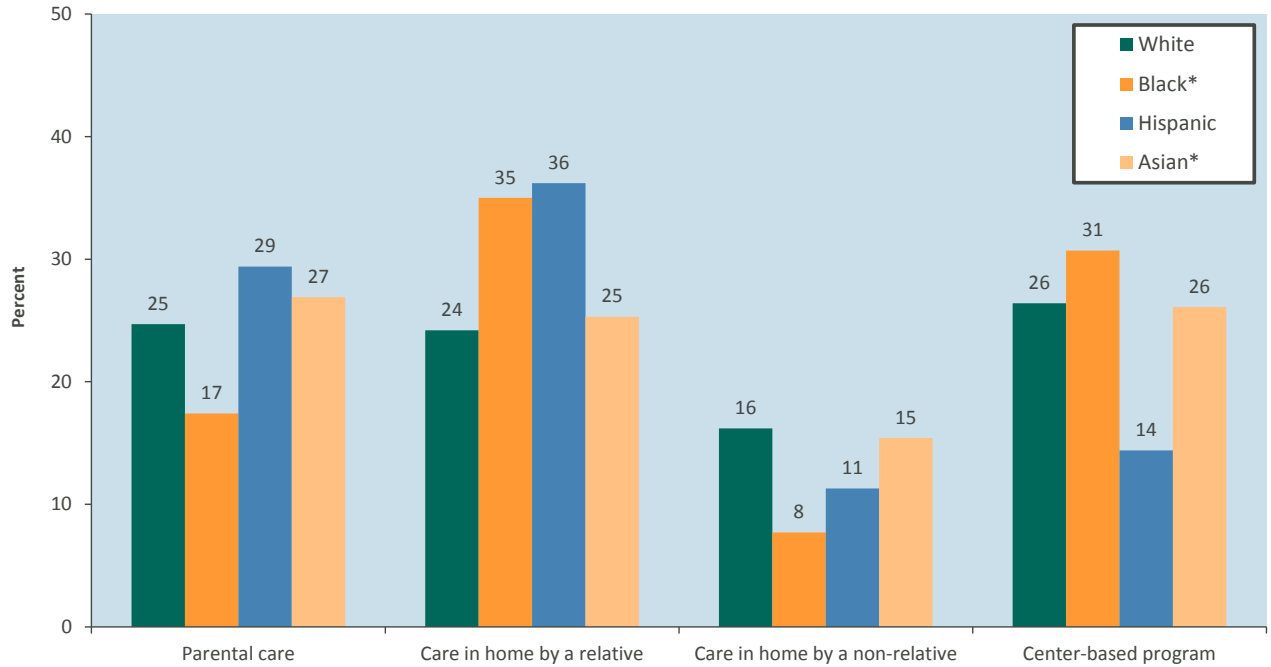
2 Burger, K. (2010). How does early childhood care and education affect cognitive development? An international review of the effects of early interventions for children from different social backgrounds. Early Childhood Research Quarterly, 25, 140-165; Reynolds, A. J., Magnuson, K. A., & Ou, S.-R. (2010). Preschool-to-third grade programs and practices: A review of research. Children and Youth Services Review, 32, 1121-1131.

Percentage of Children with Employed Mothers, Ages Birth through Two, by Primary Type of Care Arrangement, Selected Years, 1993-2011



Sources: Child Trends' calculations based on US Census Bureau. Who's minding the kids? Child care arrangements: Detailed tables {various years}. Survey of Income and Program Participation (SIPP) Data on Child Care. Available at http://www.census.gov/hhes/childcare/data/sipp/index.html.

Percentage of Children with Employed Mothers, Ages Birth through Four, by Primary Type of Care Arrangement, and by Race and Hispanic Origin: 2011



* All data for Asians and Blacks include Hispanics.

Source: Child Trends' calculations based on US Census Bureau. Who's minding the kids? Child care arrangements: Detailed 2011. Survey of Income and Program Participation (SIPP) Data on Child Care. Available at http://www.census.gov/hhes/childcare/data/sipp/index.html.

has suggested that a relatively high level of quality is needed in order to affect child outcomes.[3]

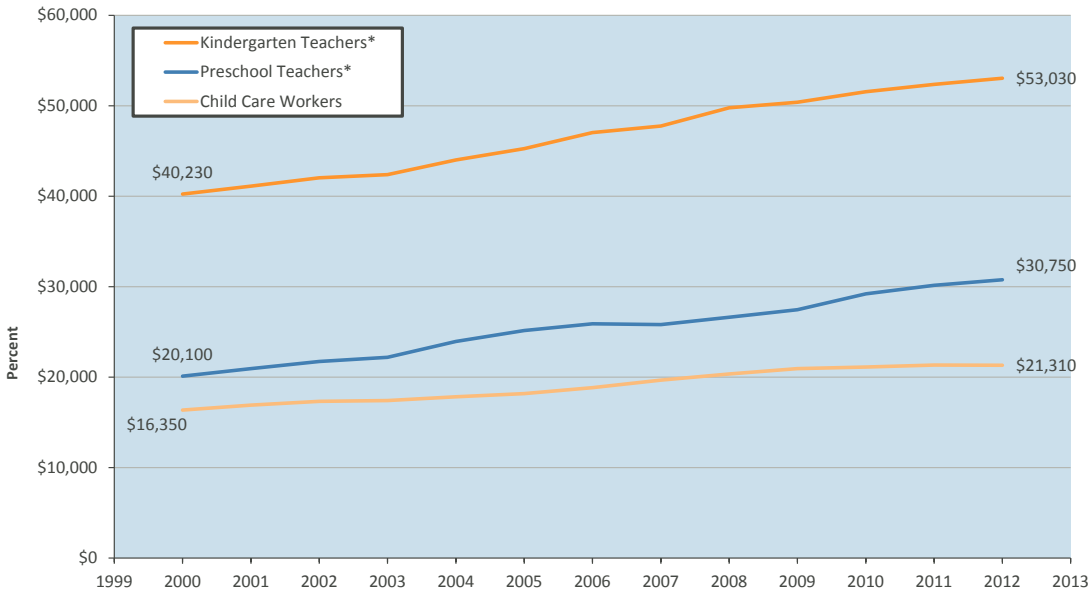
States use multiple ways to invest in the quality of child care. First, their licensing systems are designed to ensure the health and safety of children. Second, states use monies received from the Child Care and Development Fund (CCDF), which includes a specific set-aside for improving the quality and availability of programs serving infants. Finally, states invest in professional development systems and services that articulate standards for high quality care, provide supports for providers and programs to achieve those standards, and provide parents access to ratings of program quality.

In the absence of national regulatory standards for early childhood care, states vary enormously in the quality controls they have instituted.

- While 44 states conduct annual health and safety inspections for regulated providers, fewer (34) address the specific health and safety measures recommended by Child Care Aware of America, a respected national organization: immunizations, positive guidance and discipline, hand-washing, fire drills, medication safety, illness/accidents, sleep position for infants, safe storage of hazardous materi-

3 Burchinal, M., Vandergrift, N., Pianta, R., & Mashburn, A. (2010). Threshold analysis of association between child care quality and child outcomes for low-income children in pre-kindergarten programs. Early Childhood Research Quarterly, 25(2), 166-176. Doi: http://dx.doi.org/10.1016/j.ecresq.2009.10.004

Average Annual Pay* of Child Care Workers: 2000-2012



*Data are are not adjusted for inflation.
**These figures do not include special education teachers.
Source: Bureau of Labor Statistics. {various years} Occuapational employment and wages. Available at: http://www.bls.gov/schedule/archives/all_nr.htm#OCWAGE.

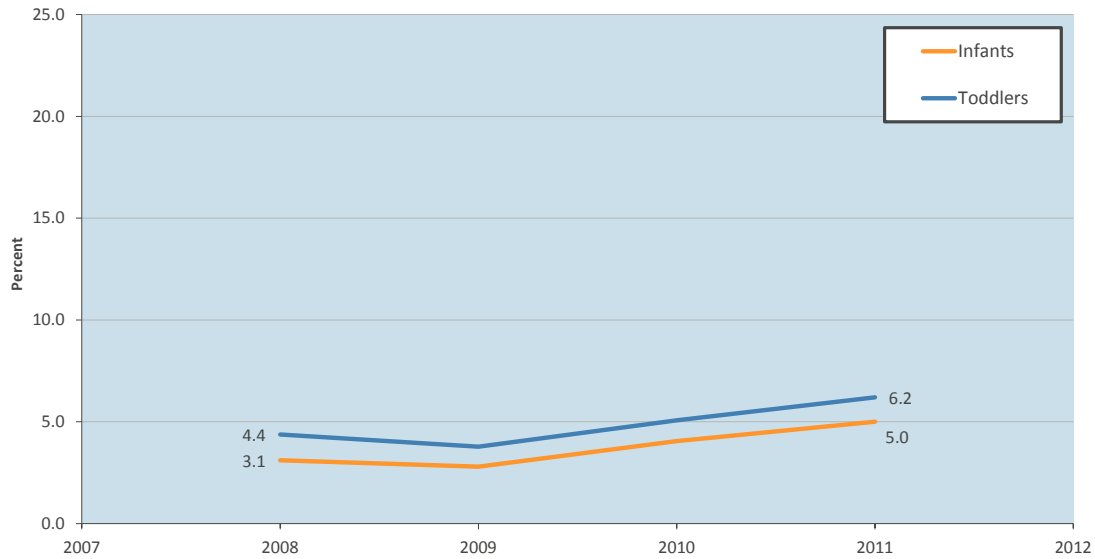
als, safe playgrounds, and emergency preparedness.

- Fifteen states fail to mandate for programs serving infants staff:child ratios consistent with the recommendations of the National Association for the Education of Young Children; and 28 states' requirements fall short of NAEYC's recommendations on group-size for infant care.
- Fewer than half the states (22) require that child care centers provide program activities across all the developmental domains (motor development, language and literacy, social, etc.).
- Fifteen states lack any quality rating system for providers.

The compensation and qualifications of providers can be weak, but still informative, proxies for quality. Though many infants and toddlers are cared for by relatives, friends, or neighbors, a significant proportion is cared for by professional early care and education providers. According to 2009 Census data, approximately 1.8 million adults were paid to provide early care and education services in a variety of settings.[4] Using data from Census's 2009 American Community Survey, a recent report from the U.S. Government Accountability Office found **the majority of early care and education providers have less than a bachelor's degree, and earn average annual salaries between $11,500 and $18,000.**[5] Though some states have workforce registries that serve as a repository of information about early care and education providers' education and training, national statistics on the early childhood workforce are flawed because they tend to exclude providers that care for children in their own

4 http://www.gao.gov/assets/590/588577.pdf
5 http://www.gao.gov/assets/590/588577.pdf

Percent of Eligible* Infants and Toddlers Served by Head Start Programs, School Years 2008-2011



*Head Start guidelines require that at least 90% of children enrolled live at or below 100% FPL. The other 10% do not have income restrictions. The figures here are based on the number of infants and toddlers living below 100%FPL.
Sources: Head Start Data: HHS/ACF/OHS. (2012). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Eligiblity data: Child Trends' analysis of the Current Population Survey, March Supplement. Downloaded from: http://www.census.gov/cps/data/cpstablecreator.html.

home, and do not distinguish between providers in different types of care settings.[6]

Child care can be prohibitively expensive, particularly for low-income families, and families with infants. Cost of care varies by community, age of the child in care, and the type of care used. Low-income families tend to use home-based care settings for infants and toddlers, such as licensed/regulated family child care providers that care for the child in their home or family members, friends, or neighbors.[7] Child care centers and nannies tend to be more expensive than these home-based arrangements.

A 2012 report from Child Care Aware, a national network of child care resource and referral agencies, found that center-based child care for infants exceeded annual median rent payments in 22 states, and the cost of in-state tuition at a four-year public college in 35 states.[8] Additionally, Child Care Aware found the average annual cost of center-based infant care to be more than 10 percent of the state median income for a two-parent family in all but 10 states.[9]

The largest federal child care subsidy program is the CCDF, serving nearly half-a-million infants and toddlers (as well as older children) in 2009. In 2012, $5.2 billion in federal funds was allocated to states, territories, and tribes to administer this program to children ages birth through 12.[10] The CCDF is administered through block grants by states, with guidance from the federal government. The stated goals of the CCDF subsidies are to promote parental employment among low-income families, and to promote the quality and accessibility of child care.[11] Child care subsidies are administered via vouchers to parents, or slots with contracted providers, and cover a portion of parents' child care expenses. Low-income parents who receive subsidies (in addition to paying less for child care) have higher rates of employment, and experience fewer work disruptions due to child care challenges than comparable parents who do not receive subsidies.[12]

6 http://www.gao.gov/assets/590/588577.pdf; http://www.nap.edu/openbook.php?record_id=13238&page=5
7 Halle, T., Hair, E., Nuenning, M., Weinstein, D., Vick, J., Forry, N., & Kinukawa, A. (2009). Primary child care arrangements of U.S. infants: Patterns of utilization by poverty status, family structure, maternal work status, maternal work schedule, and child care assistance. Research brief prepared for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation.
8 http://www.naccrra.org/sites/default/files/default_site_pages/2012/cost_report_2012_final_081012_0.pdf
9 http://www.naccrra.org/sites/default/files/default_site_pages/2012/cost_report_2012_final_081012_0.pdf
10 http://www.acf.hhs.gov/programs/occ/resource/child-care-and-development-fund
11 http://www.acf.hhs.gov/sites/default/files/occ/ccdf_factsheet.pdf
12 Smith, K. & Adams, N. (2013). Child care subsidies critical for low-income families amid rising child care expenses. Policy Brief No. 20. Carsey Institute. Retrieved from http://carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/PB-Smith-Adams-Child-Care-Subsidies-web_0.pdf

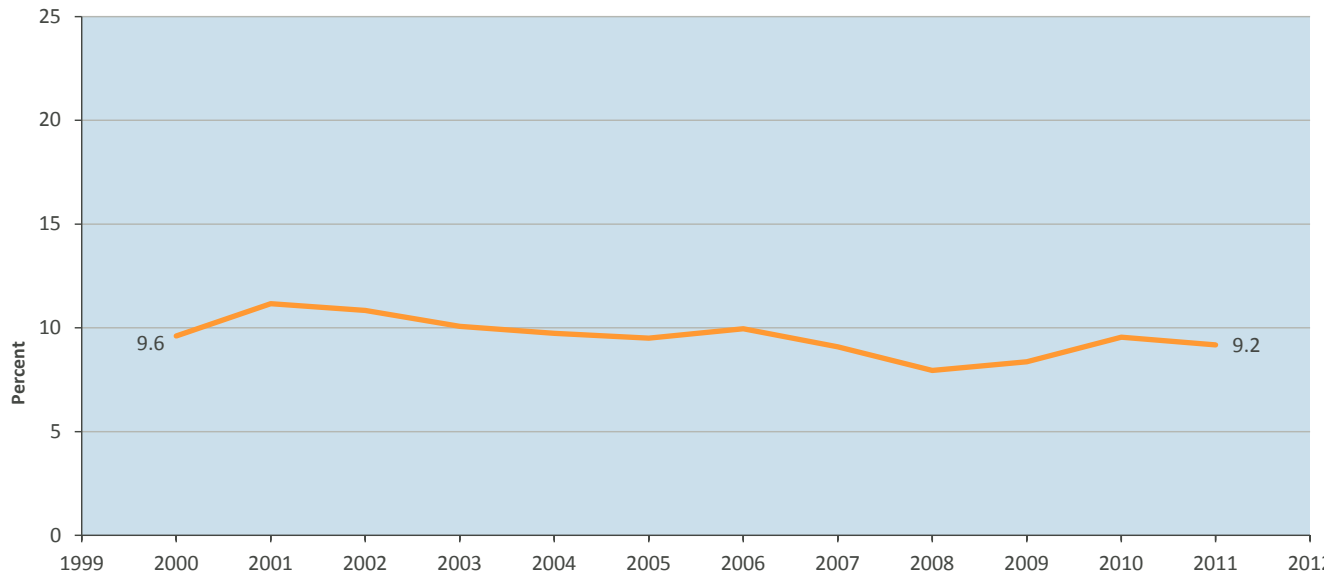
Child Trends estimates that less than one in ten (nine percent) of eligible infants and toddlers received a CCDF subsidy in 2011. As of 2012, 23 states had wait lists for their subsidy programs, and many have raised the co-payments eligible families are responsible for, or have reduced the length of time parents can receive this assistance while looking for a job.[13]

Early Head Start (EHS) is a comprehensive child development and family support program for infants, toddlers, and pregnant women in low-income families. Apart from family income, each EHS program sets its own eligibility criteria, targeting their services to best meet the needs of families and children in their community. Services may be delivered in centers, family child care homes, or individual family homes. In addition, EHS programs must allocate at least 10% of their enrollment slots to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act.[14] In 2012, EHS served about 176,000 infants and toddlers, and about 16,000 pregnant women.[15]

In several developed countries, more than half of infants and toddlers are in formal care arrangements. The U.S., with about a third of its youngest children in formal care, is near the middle of the pack.

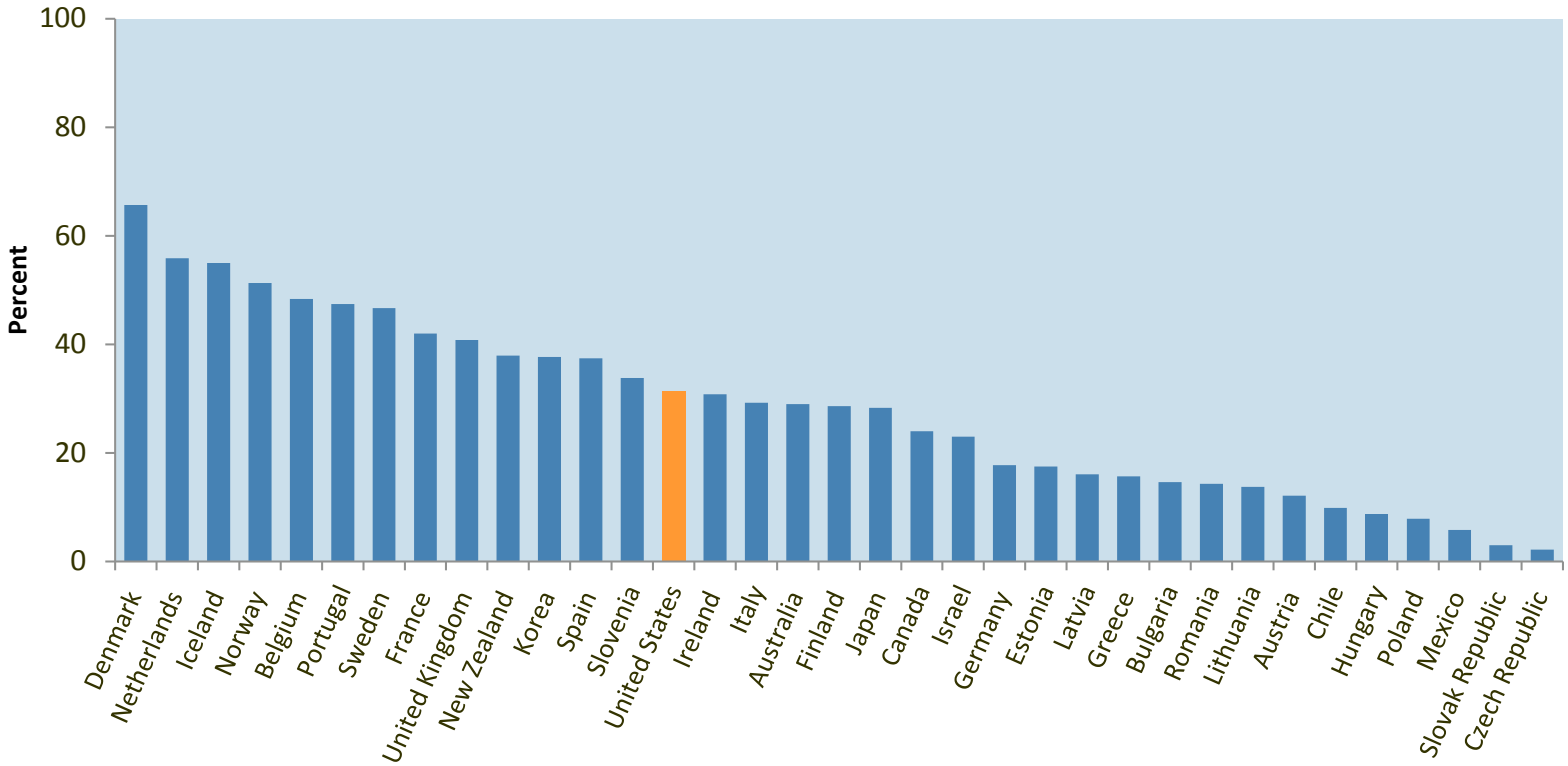
13 Ibid.
14 Early Head Start National Resource Center. http://www.ehsnrc.org/ChildEligible.htm
15 HHS/ACF/OHS. (2012). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Includes those enrolled in Migrant Early Head Start.

Percentage of Eligible* Infants and Toddlers Served by a Child Care Subsidy Program: 2000-2011**



*Eligibility for subsidy differs across states. The data presented here is based on infants and toddlers living at or below 185% FPL, as this is the eligibility criteria for most social services.
**Data for 2011 are preliminary and may be modified at a later date.
Sources: Data for child care subsidies: ACF 801 administrative data (total number of children served multiplied by the % in each age range). Office of Child Care, Administration for Children and Families, Department of Health and Human Services. *Child care and development fund* statistics. Available at: http://www.acf.hhs.gov/programs/occ/resource/ccdf-statistics. Eligibility data: Child Trends analysis of the Current Population Survey, December Food Security Supplement.

Percentage of Children Ages Birth Through Two in Formal Child Care in 35 Developed Countries: 2008*



*U.S. data refer to 2005.

Source: OECD. (2012). OECD Family Database. Paris: OECD. Available at: www.oecd.org/social/family/database

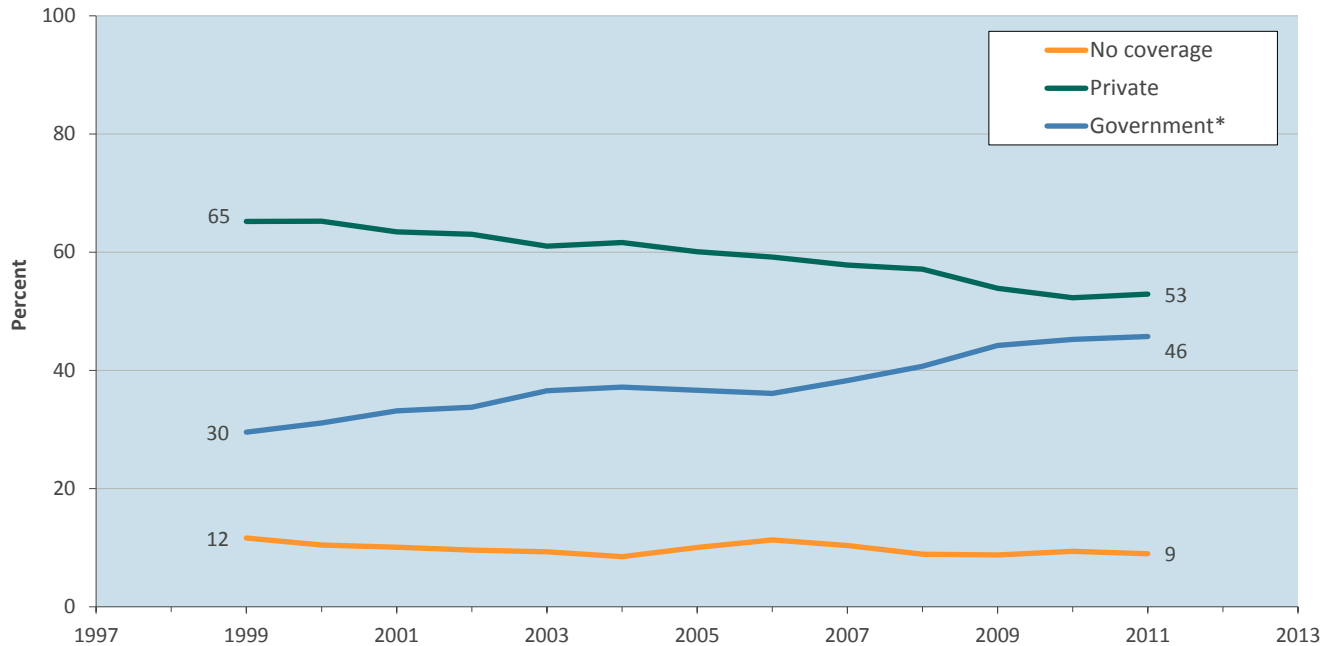
health insurance

Children not covered at all by health insurance, or who experience gaps in coverage, are less likely than those with continuous insurance coverage to have a regular source of health care, and are more likely than children continuously insured to have medical care delayed or unmet, and to have prescriptions unfilled. Gaps in coverage can be particularly detrimental for children with chronic health conditions, such as asthma, that require frequent, consistent preventive monitoring by health care providers.[1]

In 2011, about one in eleven infants and toddlers was uninsured at the time of the survey. Among sub-populations, young American Indian/Alaska Native children stand out, with one in six uninsured. Just over half had private health insurance, and 46 percent were covered by public insurance (chiefly, Medicaid). In this age group there has been a trend in recent years toward greater reliance on coverage by public programs, and less on private insurance carriers; **overall rates of coverage have risen slightly. Nevertheless, infants and toddlers living in poverty, and particularly those with family incomes greater than the poverty level but still considered low-income, are more likely to be uninsured than are their peers with higher family incomes.**

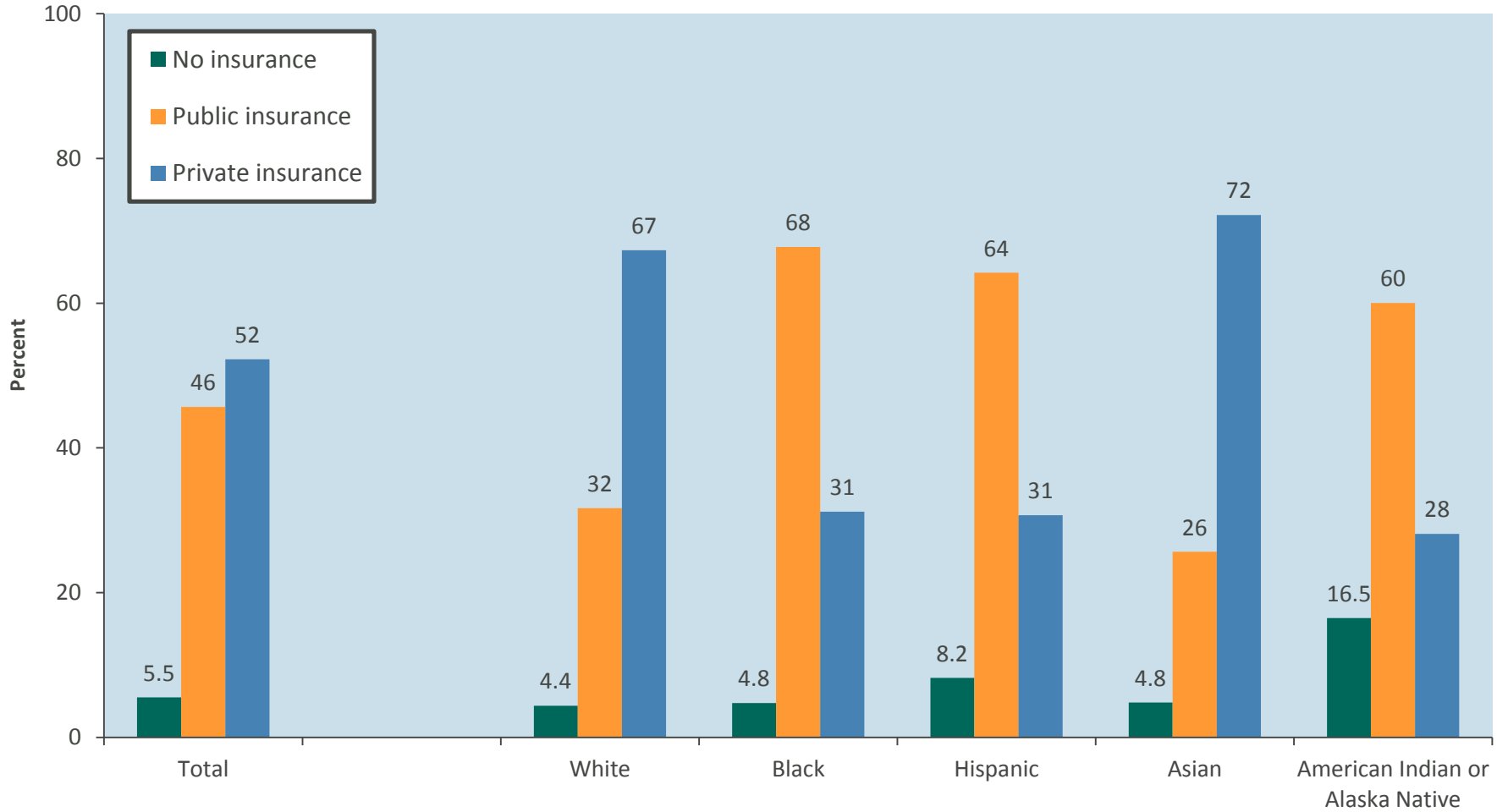
1 Child Trends DataBank. (2012). Health care coverage. Retrieved from http://www.childtrends.org/?indicators=health-care-coverage

Children, Ages Birth through Two Years, Covered by Health Insurance at Any Point in the Past Year, Percentage by Type of Insurance: Selected Years, 1999-2011



*Government health insurance consists primarily of Medicaid, but also includes such coverage as Medicare, State Children's Health Insurance Programs (SCHIP), and Medical Care Program of the Uniformed Services (CHAMPUS/Tricare).
Source: CPS Annual Social and Economic Supplement, Table HIB-3 http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html.

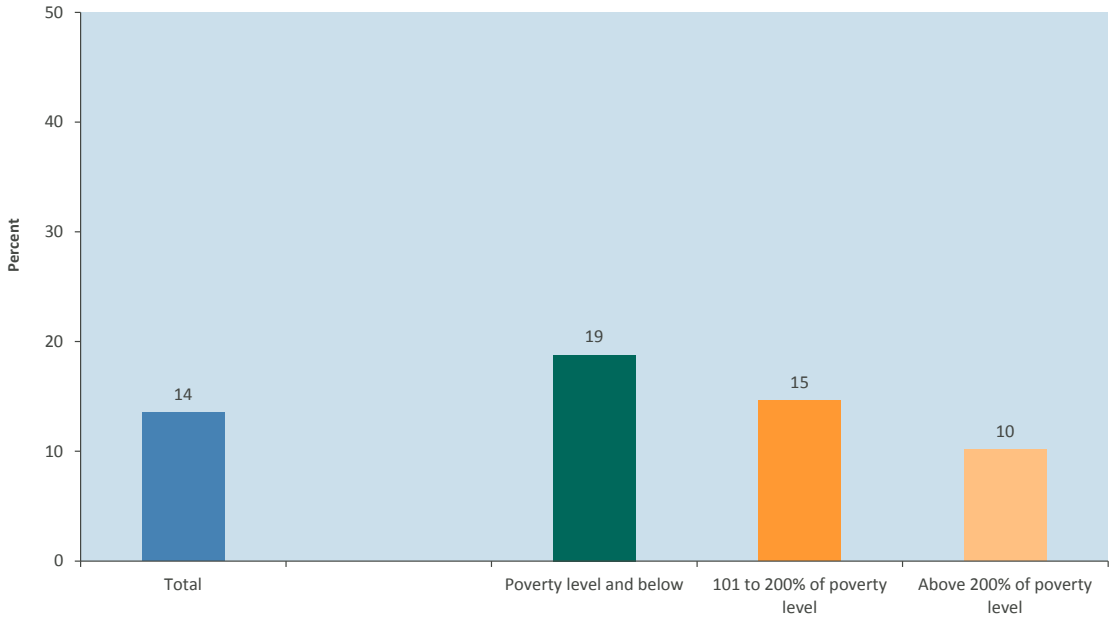
Current Health Insurance Status* of Children Ages Birth Through Two, 2008-2011, Total, and by Race and Hispanic Origin: 2011



* Health insurance status is the coverage the child had on the day of the survey.
Source: Child Trends' analysis of American Community Survey, PUMS data.

home visiting services

Percentage of Children and Parents who Received One or More Home Visits During Pregnancy or Before Age Three, Total, and by Family Income, 2011/12



Source: Child Trends' analysis of the National Survey of Children's Health

In many European countries, a home visit, by a nurse or para-professional, is offered to (and welcomed by) families with newborns, especially those with a first child. Parents receive advice and information about health and safety, child development, and other parenting concerns. In the U.S., home visiting programs are increasingly part of communities' efforts to improve outcomes for the most disadvantaged families. When well implemented, home visiting programs in the U.S. have been shown to reduce rates of infant low birthweight, child maltreatment, and childhood injuries; increase access to health care, and lengthen the interval between a young mother's births; and improve parenting practices and children's learning and behavior.[1]

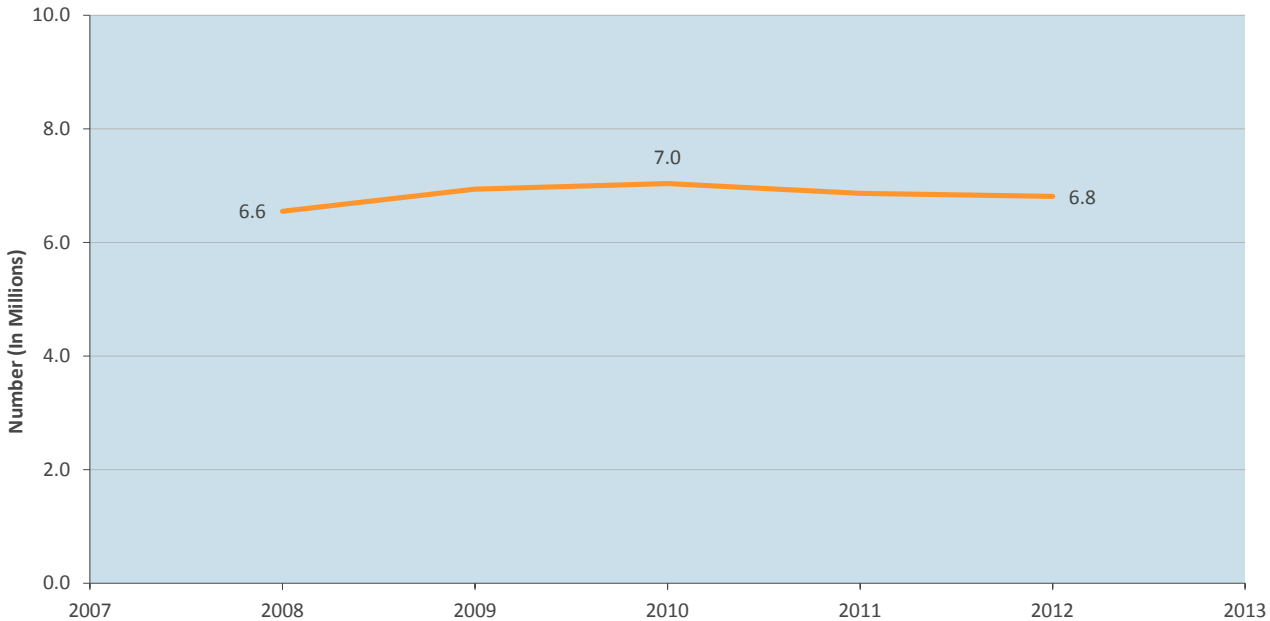
In 2011/12, about one in seven parents or children received one or more home visits between pregnancy and the child's third birthday. Families living in poverty were nearly twice as likely to receive a home visit as were families with incomes at least double the poverty level. Black children were more likely to have gotten a home visit than were their white or Latino peers. Families with single mothers were more likely than two-parent families to have received a home visit.

For this report, we also examined home visit receipt among a more restricted of group of children whose mothers met two or more of the following criteria: they had low income, they were unmarried, or they were 20 or younger. Mothers older than 20 were also included in this group, but only if this was their first child. Among this sub-sample, one in four (25 percent) reported receiving a home visit.

1 Kahn, J. & Moore, K. A. (2010). What works for home visiting programs: Lessons from experimental evaluations of programs and interventions. Child Trends Fact Sheet. Retrieved from http://www.childtrends.org/Files/Child_Trends-2010_7_1_FS_WWHomeVisitpdf.pdf

WIC

Number (in Millions) of Infants and Children, Ages Birth through Four, Served by the WIC Program, Fiscal Years, 2008-2012*



*2012 are preliminary data
Source: USDA. (2013).Monthly Data: Agency Level, Participation and Program Costs by Category per person. Available at: http://www.fns.usda.gov/pd/wicmain.htm.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program was developed in 1974 to improve the nutrition of low-income pregnant women and new mothers (≤ 185% of the federal poverty level), and their infants and children (ages birth to four years).[1] WIC provides nutritious foods (via vouchers that can be used at participating food stores), nutrition information, and screenings and referrals to health, welfare, and social services.[2] WIC services are provided through county health departments and community-based agencies, including hospitals, mobile and migrant health clinics, community centers, schools, and public housing sites.[3] As of 2012, nearly seven million infants and toddlers (through age four), and about two million pregnant and post-partum women participated in WIC. This represents about one in six of all eligible infants, six in ten older children, and about one in ten eligible women.[4]

1 http://www.fns.usda.gov/wic/faqs/faq.htm
2 http://www.fns.usda.gov/wic/aboutwic/wicataglance.htm
3 Ibid.
4 Martinez-Schiferl, M. Zedlewski, S., & Giannarelli, L. (2013). National and state-level estimates of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) eligibles and program reach, 2010. Final Report. U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. Retrieved from http://www.fns.usda.gov/Ora/menu/Published/WIC/FILES/WICEligibles2010Vol1.pdf

supplemental nutrition assistance program

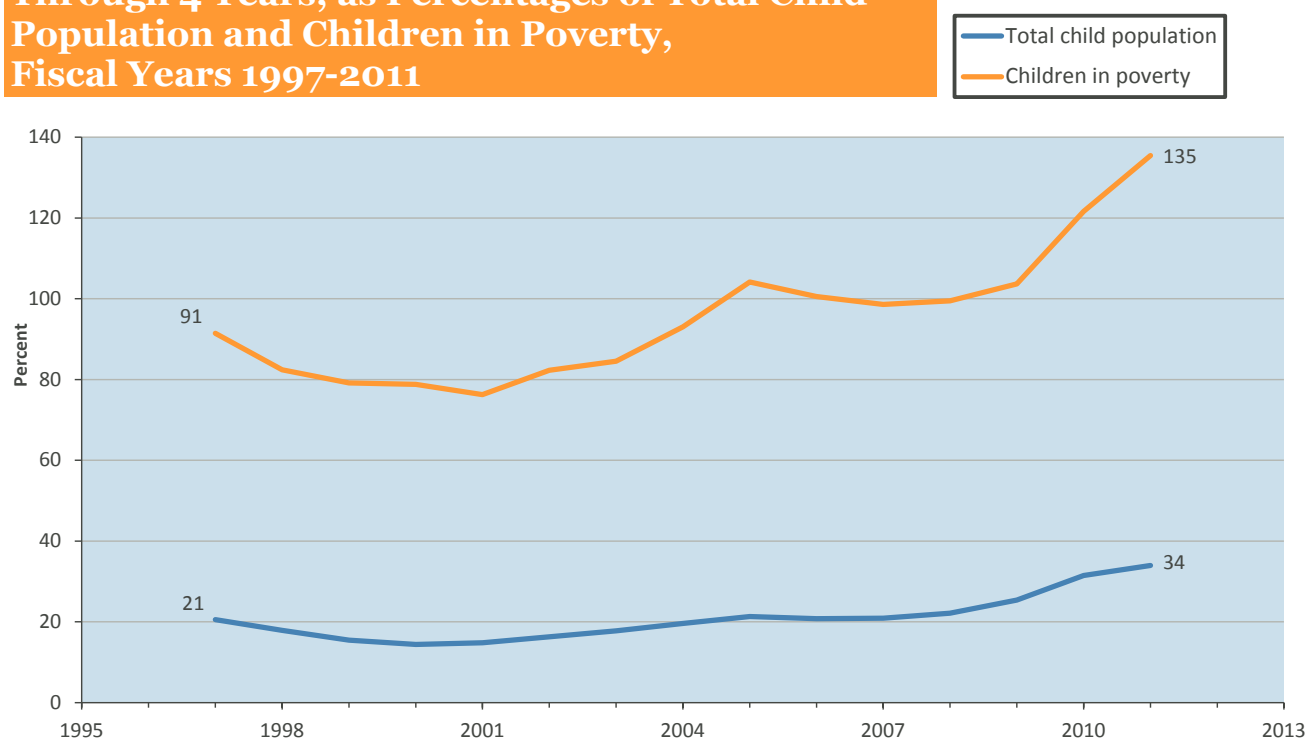
Ninety-six percent of eligible poor households with children receive assistance from the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program), a benefit designed to increase the food purchasing power of low-income households. SNAP is the largest of the federal Food and Nutrition Service programs. Receiving SNAP benefits increases what households spend on food, and the availability of calories and protein.[1] Also, when controlling for other relevant factors, several studies suggest SNAP receipt increases food security,[2] defined by the U.S. Department of Agriculture as having "access at all times to enough food for an active, healthy life for all household members."[3]

According to a nationally representative study, women with access to SNAP in the last three months of pregnancy had improved birth outcomes, as measured by birthweight. Additionally, there is evidence that SNAP benefits substantially reduce poverty among children.[4]

SNAP now serves more than one in three children under five. The recent economic downturn, combined with expanded eligibility requirements, contributed to the recent rise in receipt of these benefits.

1 Fox, M.K., Hamilton, W., Lin, B. (2004). Effects of food assistance and nutrition programs on nutrition and health: Volume 4, Executive summary of the literature review. Economic Research Service/USDA. p. 11. Available at: http://www.ers.usda.gov/publications/fanrr19-4/.
2 Ibid, p. 12.
3 Nord, M, Andrews, M, and Carlson, S. (2007). Household food security in the United States 2006. Economic Research Report No. ERR-49. Available at: http://www.ers.usda.gov/publications/ERR49
4 Tiehen, L, Joliffe, D., and Gundersen, C. (2012). Alleviating poverty in the United States: The critical role of SNAP benefits. U.S. Department of Agriculture, Economic Research Service. Retrieved from http://www.ers.usda.gov/publications/err132/

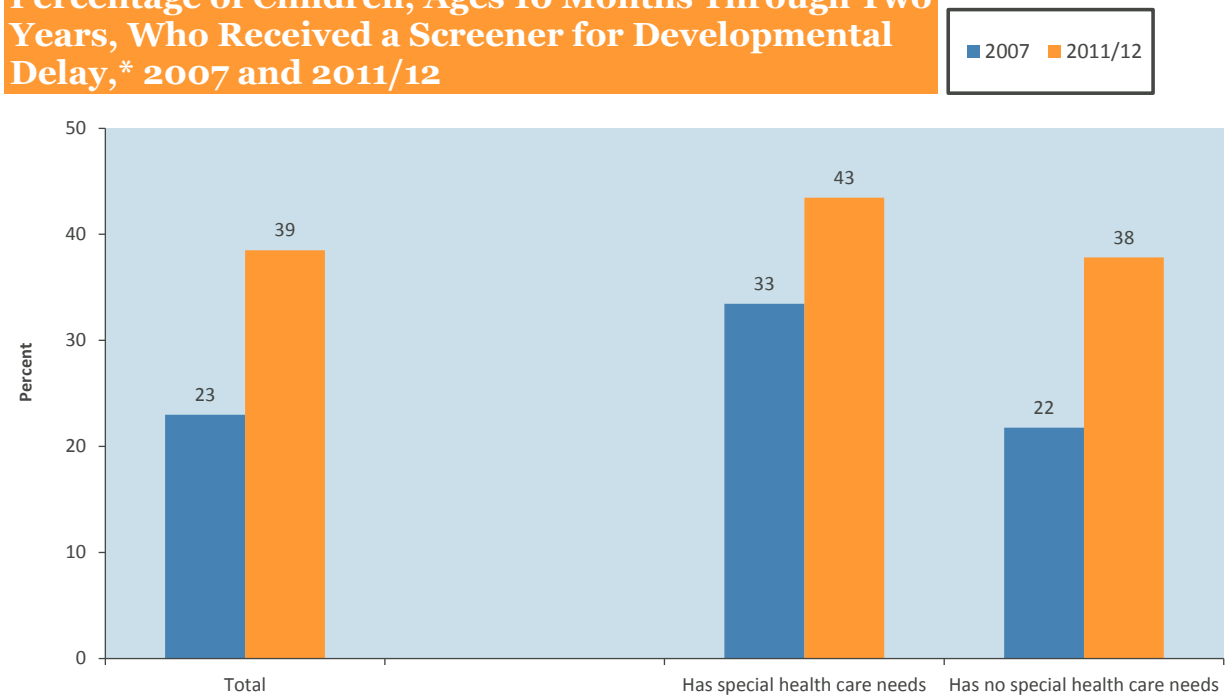
Child Recipents of Food Stamps/SNAP, Ages Birth Through 4 Years, as Percentages of Total Child Population and Children in Poverty, Fiscal Years 1997-2011



Sources: Data for number of participants: Department of Agriculture, Food and Nutrition Service. (2012). *Research: Supplemental nutrition assistance program studies: SNAP household characteristics reports*. Available at: http://www.fns.usda.gov/ORA/menu/Published/SNAP/SNAPPartHH.htm. Data for population and poverty population: Child Trends' analysis of the Current Population Survey, March Supplement.

developmental screening

Percentage of Children, Ages 10 Months Through Two Years, Who Received a Screener for Developmental Delay,* 2007 and 2011/12



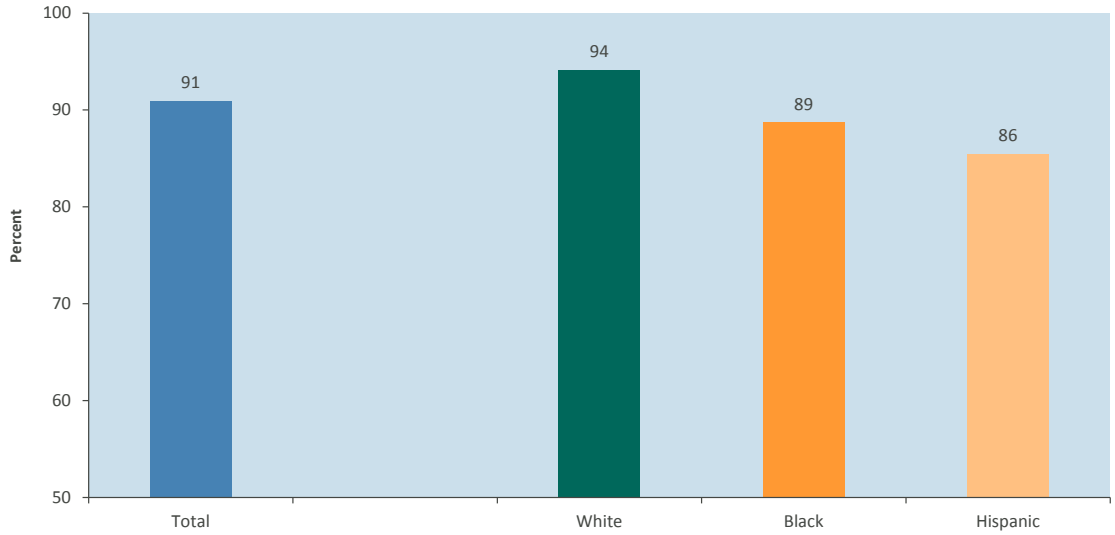
*Using a Standardized Developmental Screening tool.
Source: Child Trends' original analysis of data from the National Survey of Children's Health.

Developmental screening of young children is an efficient, cost-effective way to identify potential health or behavioral problems. In primary health care settings, the most effective screening tools rely on parent-reported information.[1] Research has found that children who get screening are more likely to be identified with developmental delays, referred for early intervention, and be determined eligible for early intervention services.[2] The American Academy of Pediatrics recommends that children, before their third birthday, receive developmental screening from their physicians at least three times.[3]

Clear progress has been made in improving rates of developmental screening among the youngest children. **In 2011/12, nearly 40 percent of infants and toddlers were screened, compared with 23 percent in 2007. Moreover, inequities by race/Hispanic origin seen in earlier years are now non-significant.** Children identified as having a special health care need were more likely to receive a screening than were children without such need.

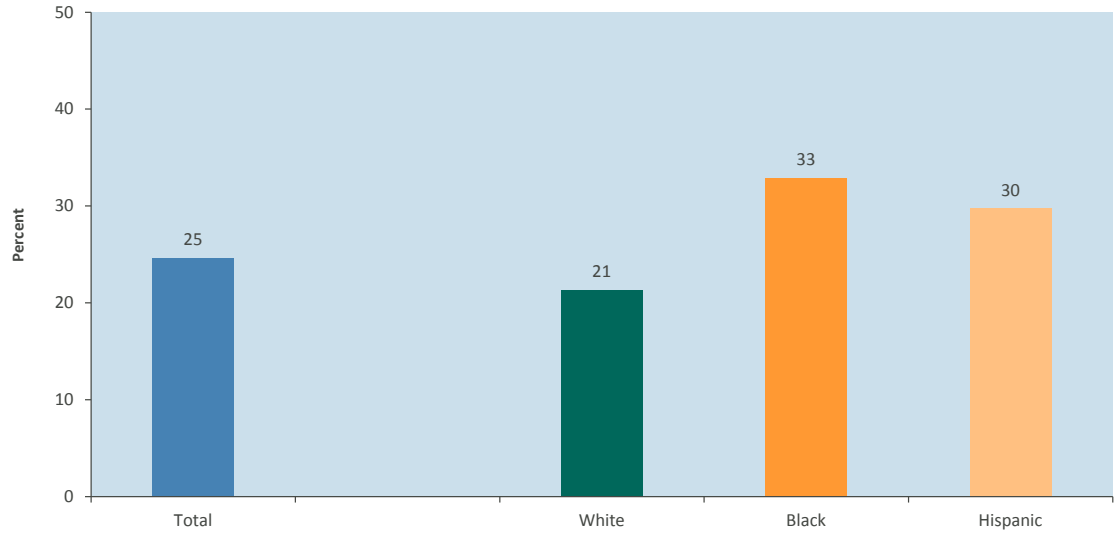
1 Glascoe, F. P. (2000). Early detection of developmental and behavioral problems. Pediatrics in Review, 21(8), 272-280.
2 Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., Hsu, D., Kyriakou, L, Baglivo, S., Kavanagh, J., & Pati, S. (2012). Effectiveness of developmental screening in an urban setting. Pediatrics, Published online December 17, 2012.
3 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. Pediatrics, 118(1), 405-420.

Percentage of Children, Ages Birth Through Two, Who Had a Preventive Medical Visit in the Past 12 Months, Total, and by Race and Hispanic Origin, 2011/12



Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Percentage of Children, Ages One Through Two, Who Had a Preventive Dental Visit in the Past 12 Months, Total, and by Race and Hispanic Origin, 2011/12



Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Preventive medical care (also known as "well-child care") is a critical opportunity to detect a possible developmental delay or disability, early treatment of which can lessen the future impact on both the child and family. In addition, well-child visits allow physicians to promote behaviors conducive to healthy development, and to give age–appropriate counseling, or anticipatory guidance. For example, physician guidance has been found to increase the likelihood that parents will read to their child, or that a child will be breastfed.[1]

According to data from a 2011/12 national survey, more than nine in ten infants and toddlers had at least one preventive pediatric visit in the past 12 months. However, children in poor families, and black and Latino children, were less likely to get well-child care.

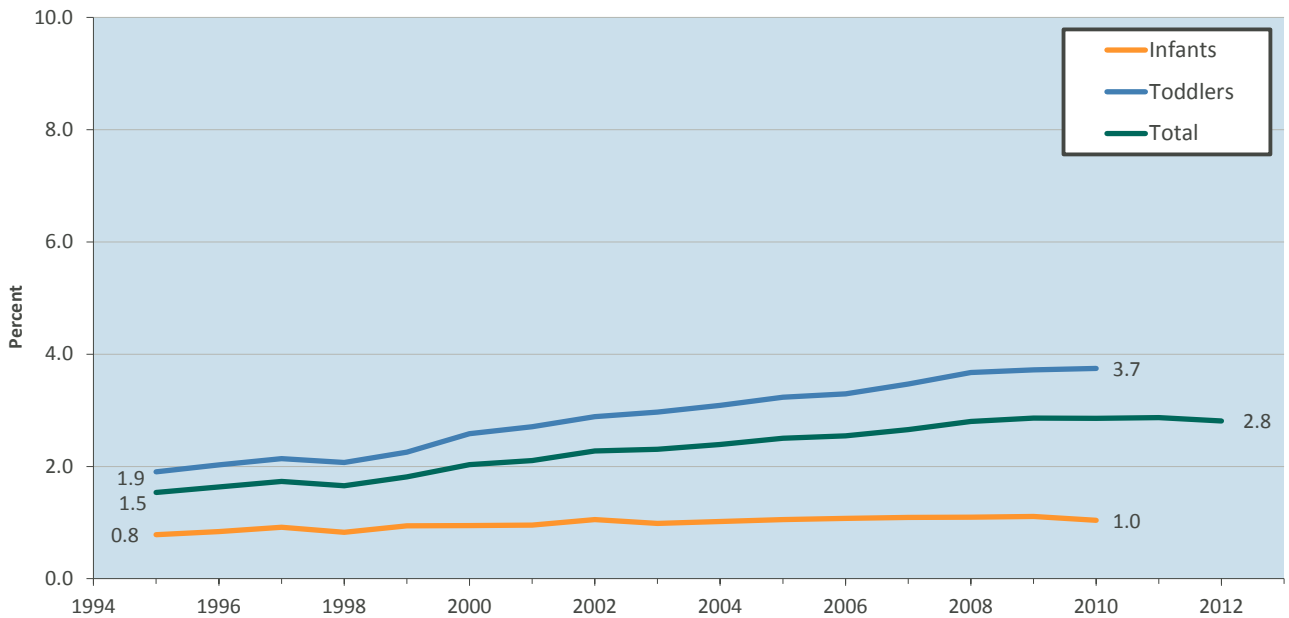
About one in four infants and toddlers (here, ages one through two years) has had a preventive dental care visit within the past year. Modest progress has been made on this indicator, for all examined race/ethnic groups, but disparities have actually widened: young black and Latino children are more likely than their white peers to have had a preventive dental visit. Poor children are more likely than their near-poor or not-poor counterparts to have had a preventive visit.

1 Child Trends DataBank. (2012). Well-child visits. Retrieved from http://www.childtrends.org/?indicators=well-child-visits

Public/Private Supports

early intervention services

Percentage of Infants and Toddlers Served by Early Intervention Services (Part C), 1995-2012



Sources: Data for 1995-2010: Danaher, J., Goode, S., & Lazara, A. (2011). Part C updates (12th edition). Chapel Hill, NC: The National Early Childhood Technical Assistance Center. Available at: http://ectacenter.org/~pdfs/pubs/partcupdate2011.pdf. Data for 2011-2012: Lazara, A., Danaher, J., & Goode, S. (2013). Part C Infant and Toddler Program: Federal appropriations and national child count 1987-2013. Chapel Hill, NC: The National Early Childhood Technical Assistance Center. Available at: http://www.ectacenter.org/~pdfs/growthcomppartc.pdf. Population data: Child Trends calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/national/totals/2012/index.html and http://www.census.gov/popest/data/intercensal/index.html.

Early intervention services, also known as the Program for Infants and Toddlers with Disabilities, was established in 1986 as part of the Individuals with Disabilities Act. The purpose of the program is to improve outcomes for infants and toddlers with disabilities through provision of direct services to the child as well as services to the family.[1] Early intervention services are offered, through states and territories, to children with identified disabilities or, in some states, to those who are at risk for developing a disability, between the ages of birth and two years. States' eligibility criteria for early intervention services vary,[2] as do the services they offer.

Funding provided by the program varies from year to year, depending upon Census-based estimates of the number of infants and toddlers in the general population. **In 2012, $442.7 million were used to provide services for approximately 337,000 infants and toddlers, which represents about 2.8 percent of this population.**[3] Research suggests that most children eligible for early intervention services do not receive them.[4]

1 http://ectacenter.org/partc/partc.asp#overview
2 http://ectacenter.org/~pdfs/topics/earlyid/partc_elig_table.pdf
3 http://ectacenter.org/partc/partcdata.asp
4 Rosenberg, S. A., Zhang, D., & Robinson, C. C. (2008). Prevalence of developmental delays and participation in early intervention services for young children. Pediatrics, 121(6), e1503-e1509.

Conclusion

Certainly, when the subject is America's youngest children, endings cannot yet be written. But just as surely, their transit through this period of development is brief. To the joy (and dismay) of their parents, they will eagerly set off to school, become challenging teenagers, and take the controls on where we head as a society. All stages of development are important in their own right, and it is misguided to set the needs of children at one stage against those of children (or adults) at another.

However, **there are compelling reasons to focus on our youngest children.** This period provides a foundation, increasingly resistant to alteration, for much of subsequent health, learning, emotional expression, and social relationships; and, accordingly, it is the time when, for many interventions, the "return on investment" is greatest.

So, where are the opportunities? If we scan the indicators in this report, several broad themes are evident:

First, we know more about our infants and toddlers than ever before. We have more data on this age group than at any time in our history, as well as the expertise to develop measures to further broaden our knowledge—including the understanding of what children need to flourish. This implies a responsibility to use the available indicators to inform, to the best of our ability, decision-making on their behalf.

Emerging science should inform policy and practice on behalf of very young children. For decades Americans have heard that children are the poorest age group in our society; and researchers and advocates have detailed the threats that poverty poses to children's health, cognition, and social-emotional development. Now, research on early brain development provides a startling new lens through which to understand those effects, defining poverty in the early years as a form of "toxic stress" that can fundamentally change basic brain architecture. These findings make an urgent and compelling case for addressing childhood poverty and other forms of trauma in the earliest years of life, before they become life-altering.

At the same time, research is progressing on delineating what it means to flourish, starting in infancy but, again, extending throughout the lifespan. Ironically, the research on serious adversity helps to underscore what all children need in order to thrive. By better marking that territory—as, presumably, the next generation of indicator reports will do—we will have taken an important step toward assuring a bright future for America's youngest children.

Second, there are great disparities—primarily related to economic circumstances—in the well-being of infants and toddlers. In a society where commentators have remarked for some time on the increasing polarization between "haves" and "have-nots," this bodes for a continuation, if not a deepening, of that trend. In turn, this has implications for the stability of the social contract, for the costs of providing for (or neglecting) those who fail to achieve self-sufficiency, for the competitiveness of the future workforce, and for the well-being of the generation of elders who will depend on today's youngest Americans, collectively and individually, to sustain them in a stage of life that has its own set of developmental vulnerabilities.

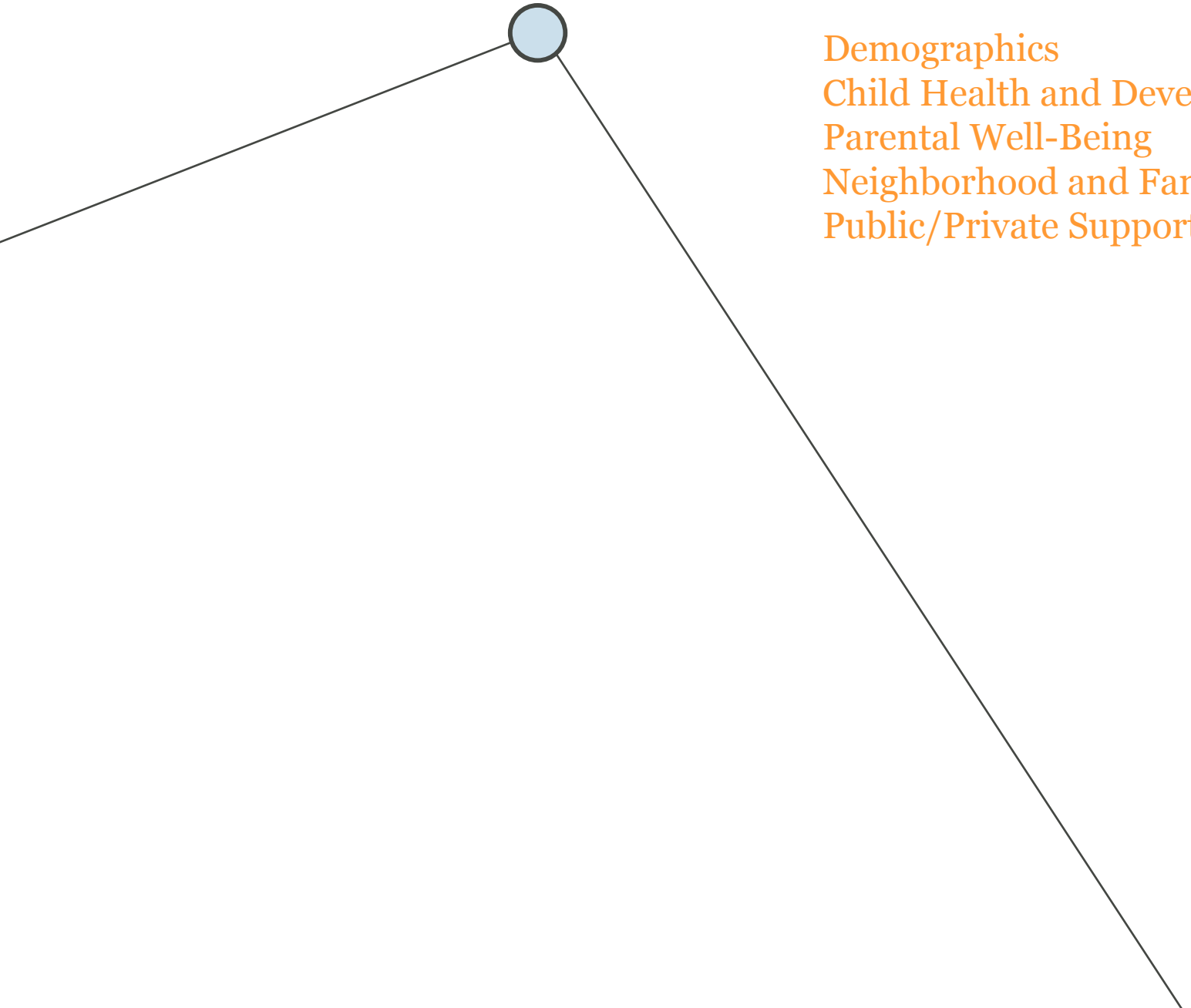
Two of the major drivers of these disparities—educational attainment, and the timing and circumstances of childbearing—are susceptible to public policy commitments, as well as to individual ones. Without such commitments, we face the prospect of an intergenerational perpetuation of disadvantage—and a potentially deepening divide. Poverty, of course, is the single condition that underlies most of this large-scale erosion of human capital. Unfortunately, as a society, we have become seemingly inured to these shameful statistics. Will putting on poverty the face of an infant or toddler re-awaken us to our responsibilities?

A final theme is the rapid and ongoing transformation of the society into which today's children are born and in which they will mature. Our world is both more diverse, and more interconnected in terms of its access to shared platforms of information (electronic media, the Internet), and how this affects assumptions about "normative" development. New forms of family structure, new strands of culturally conditioned parenting practices (for example, raising dual-language learners), and ubiquitous exposure (on a variety of screens) to images of wealth, violence, fantasy, and a thousand other aspects of human experience, are forcing a recalibration of how we envision optimal development—even as early as infancy and toddlerhood.

Our policies concerning young children need to reflect today's realities. As it stands, there are substantial gaps between what we know, and what we do. That's a mismatch we can ill afford.

Every baby is a new beginning—an invitation to reimagine what it means to be human, to be in relationship, to guide and to be guided. That is the promise of the youngest Americans, and the challenge to the rest of us.

Appendix



Demographics

Fertility Rates[1] (per 1,000 Women) by Race and Hispanic Origin, and Birth Rates[1] by Age: Selected Years, 1950-2011

	1950	1960	1970	19802	1985	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total	106.2	118.0	87.9	68.4	66.3	71.0	65.9	65.1	65.0	66.1	66.4	66.7	68.6	69.3	68.1	66.2	64.1	63.2
Race/Hispanic origin																		
White	-	-	-	62.4	-	62.8	58.5	57.7	57.6	58.9	58.9	59.0	60.3	61.0	60.5	59.6	58.7	58.7
Black	-	-	-	90.7	-	89.0	71.4	69.1	67.5	67.1	67.1	67.2	70.7	71.4	70.8	68.9	66.6	65.4
Hispanic	-	-	-	95.4	-	107.7	95.9	95.4	94.7	95.2	95.7	96.4	98.3	97.4	92.7	86.5	80.2	76.2
Asian or Pacific Islander[3]	-	-	-	73.2	68.4	69.6	60.9	62.5	63.4	64.2	64.5	63.0	63.6	65.3	63.3	61.3	59.2	59.9
American Indian or Alaska Native[3]	-	-	-	82.7	78.6	76.2	58.7	57.0	55.8	55.0	54.3	53.6	55.4	55.6	54.1	51.7	48.6	47.7
Age																		
10-14	1.0	0.8	1.2	1.1	1.2	1.4	0.9	0.8	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.4	0.4
15-19	81.6	89.1	68.3	53.0	51.0	59.9	47.7	45.0	42.6	41.1	40.5	39.7	41.1	41.5	40.2	37.9	34.2	31.3
20-24	196.6	258.1	167.8	115.1	108.3	116.5	109.7	105.6	103.1	102.3	101.5	101.8	105.5	105.4	101.8	96.2	90.0	85.3
25-29	166.1	197.4	145.1	112.9	111.0	120.2	113.5	113.8	114.7	116.7	116.5	116.5	118.0	118.1	115.0	111.5	108.3	107.2
30-34	103.7	112.7	73.3	61.9	69.1	80.8	91.2	91.8	92.6	95.7	96.2	96.7	98.9	100.6	99.4	97.5	96.5	96.5
35-39	52.9	56.2	31.7	19.8	24.0	31.7	39.7	40.5	41.6	43.9	45.5	46.4	47.5	47.6	46.8	46.1	45.9	47.2
40-44	15.1	15.5	8.1	3.9	4.0	5.5	8.0	8.1	8.3	8.7	9.0	9	9.4	9.6	9.9	10.0	10.2	10.3
45-54[4]	1.2	0.9	0.5	0.2	0.2	0.2	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7

1 The total number includes births to women of all ages, 15-44 years. The rate shown for all ages is the general fertility rate, which is defined as the total number of births per 1,000 women aged 15-44 years. Age-specific birth rates are defined as the total number of births per 1,000 women in a specific age group (between ages 15 and 44).
2 Data for estimates before 1980 are based on the race/ethnicity of the child, from 1980 on estimates are based on the race/ethnicity of the mother. Before 1980, data for the mother's marital status was estimated for the United States from data for registration areas in which marital status of mother was reported. For 1980 on, data for states in which the mother's marital status was not reported were inferred from other items on the birth certificate and included with data from the reporting states.
3 Includes all persons of Hispanic origin of that race.
4 Birth rates computed by relating births to women ages 45-54 years to women ages 45-49 years.
Sources: Data for 1950 through 1985 from: National Center for Health Statistics. Health, United States, 2002. With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland: 2002. Table 3. Data for 1990 through 2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. National Vital Statistics Reports, 62(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

Number of Children Ages Birth Through Two in the US, and Percentage by Race and Hispanic Origin, 2000, 2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	11,454,791	11,668,161	11,812,249	11,914,846	11,901,056	11,944,057	12,001,981	12,123,691	12,237,637	12,185,386	12,001,228	11,952,139	11,994,584
Percent													
White	58.3	57.3	56.1	55.3	54.7	54.0	53.1	52.1	51.3	50.7	50.5	50.0	49.5
Hispanic	19.9	20.8	21.8	22.5	23.1	23.7	24.4	25.0	25.4	25.6	25.6	25.9	26.3
Black	14.3	14.1	14.0	13.7	13.5	13.4	13.4	13.5	13.7	13.9	13.8	13.8	13.7
Asian	3.5	3.7	3.9	4.1	4.1	4.2	4.2	4.2	4.3	4.4	4.4	4.4	4.5
American Indian or Alaska Native	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Pacific Islander	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Two or more races	2.9	3.1	3.2	3.3	3.5	3.7	3.8	4.0	4.2	4.4	4.6	4.8	5.0

Source: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/national/totals/2012/index.html and http://www.census.gov/popest/data/intercensal/national/nat2010.html

Percent of Children, Ages Birth through Two Years, Who Live with Immigrant Parents, 2006-2011

	2006	2007	2008	2009	2010	2011
Total	23.1	23.6	23.8	24.4	23.4	23.8
Two foreign-born parents	11.7	12.0	12.0	11.7	11.3	11.1
One foreign-born parent, one native-born parent	6.2	6.4	6.3	6.4	6.2	6.5
Single parent, foreign-born	5.2	5.2	5.5	6.3	5.9	6.2

Source: Child Trends' calculations from the American Community Survey, Public Use Microdata Sample.

Percentage of Children, Ages Birth Through Two, in Deep Poverty, Poverty, and Who are Low Income, 2006-2012

	2006	2007	2008	2009	2010	2011	2012
Deep poverty (<50% FPL)	9.9	10.3	10.2	11.1	11.6	12.6	12.6
Poverty	21.1	21.0	21.5	22.3	24.5	26.1	25.3
Low income (<200% FPL)	43.2	43.8	43.3	44.0	46.4	47.8	48.1

Note: Year reflects the year that the question was asked. Question was asked regarding the previous 12 months.
Data refer to children residing with and related to the householder.
Source: CPS Annual Social and Economic Supplement, CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

Percentage of Children, Ages Birth Through Two, in Deep Poverty, Poverty, and Who are Low Income, by Race and Hispanic Origin, 2012

	Deep poverty (<50% FPL)	Poverty	Low income (<200% FPL)
Total	12.6	25.3	48.1
Race/ Hispanic Origin			
White	7.3	15.4	34.0
Black	24.5	44.5	65.9
Asian	5.6	14.4	34.8
American Indian or Alaska Native	36.7	47.9	70.2
Hispanic	16.6	35.0	65.6

Note: Year reflects the year that the question was asked. Question was asked regarding the previous 12 months.
Data refer to children residing with and related to the householder.
Source: CPS Annual Social and Economic Supplement, CPS Table Creator, http://www.census.gov/cps/data/cpstablecreator.html.

Child Health and Development

Estimated Life Expectancy (in Years) of Newborns, by Race and Gender, Selected Years 1930-2011

	1930	1950	1970	1975	1980	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 [2]
All races	59.7	68.2	70.8	72.6	73.7	74.7	75.4	75.8	76.1	76.5	76.7	76.7	76.8	76.9	76.9	77.1	77.5	77.4	77.7	77.9	78.1	78.5	78.7	78.7
Male	58.1	65.6	67.1	68.8	70.0	71.1	71.8	72.5	73.1	73.6	73.8	73.9	74.1	74.2	74.3	74.5	74.9	74.9	75.1	75.4	75.6	76.0	76.2	76.3
Female	61.6	71.1	74.7	76.6	77.4	78.2	78.8	78.9	79.1	79.4	79.5	79.4	79.3	79.4	79.5	79.6	79.9	79.9	80.2	80.4	80.6	80.9	81.0	81.1
White[1]	61.4	69.1	71.7	73.4	74.4	75.3	76.1	76.5	76.8	77.2	77.3	77.3	77.3	77.4	77.4	77.6	77.9	77.9	78.2	78.4	78.5	78.8	78.9	79.0
Male	59.7	66.5	68.0	69.5	70.7	71.8	72.7	73.4	73.9	74.3	74.5	74.6	74.7	74.8	74.9	75.0	75.4	75.4	75.7	75.9	76.1	76.4	76.5	76.6
Female	63.5	72.2	75.6	77.3	78.1	78.7	79.4	79.6	79.7	79.9	80.0	79.9	79.9	79.9	79.9	80.0	80.4	80.4	80.6	80.8	80.9	81.2	81.3	81.3
Black[1]	-	-	64.1	66.8	68.1	69.3	69.1	69.6	70.2	71.1	71.3	71.4	71.8	72.0	72.1	72.3	72.8	72.8	73.2	73.6	74.0	74.5	75.1	75.3
Male	-	-	60.0	62.4	63.8	65.0	64.5	65.2	66.1	67.2	67.6	67.8	68.2	68.4	68.6	68.8	69.3	69.3	69.7	70.0	70.6	71.1	71.8	72.1
Female	-	-	68.3	71.3	72.5	73.4	73.6	73.9	74.2	74.7	74.8	74.7	75.1	75.2	75.4	75.6	76.0	76.1	76.5	76.8	77.2	77.6	78.0	78.2

1 Data for whites and blacks include Hispanics.
2 2011 data are preliminary
Sources: Sources: Data for 1930-1999: Arias E. (2003) United States life tables, 2000. National Vital Statistics Reports 51(3). Hyattsville, Maryland: National Center for Health Statistics. Tables 10 and 12. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_03.pdf Data for 2000-2009: Kochanek, K. D., Xu, J., Murphy, S. L., Miniño, A. M., Kung, H.(2012). Deaths: Final data for 2009, National Vital Statistics Reports 60(3). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf. Data for 2010-2011: Hoyert, D. L., Xu, J. (2012). Deaths: Preliminary data for 2011. National Vital Statistics Reports 61 (6). Hyattsville, MD: National Center for Health Statistics. Available at: www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

Percent of Infants Born in the Indicated Year Expected to Die Before Reaching Age 3, by Race and Gender, Selected Years 1999-2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
All races	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.7	0.8	0.7
Male	0.9	0.9	0.8	0.9	0.9	0.8	0.8	0.8	0.8	0.8
Female	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Non-Hispanic white	-	-	-	-	-	-	-	0.6	0.6	0.6
Male	-	-	-	-	-	-	-	0.7	0.7	0.7
Female	-	-	-	-	-	-	-	0.6	0.6	0.6
Hispanic	-	-	-	-	-	-	-	0.6	0.6	0.6
Male	-	-	-	-	-	-	-	0.7	0.7	0.7
Female	-	-	-	-	-	-	-	0.6	0.6	0.6
White[1]	0.7	0.6	0.6	0.7	0.6	0.6	0.6	0.6	0.6	0.6
Male	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Female	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
Black[1]	1.6	1.5	1.5	1.6	1.5	1.5	1.5	1.5	1.4	1.4
Male	1.8	1.7	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.5
Female	1.4	1.4	1.4	1.4	1.4	1.3	1.3	1.3	1.3	1.2

1Data for whites and blacks include Hispanics.
Sources: United States Life Tables 1999-2008, updated using revised intercensal populations.
http://www.cdc.gov/nchs/products/life_tables.htm#life

Percentage of Infants Born at a Low and Very Low Birthweight,[1] By Mother's Race and Hispanic Origin, Selected Years 1970-2011

	1970	1975	1980	1985	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Low birthweight (less than 2,500 grams)	7.9	7.4	6.8	6.8	7.0	7.3	7.4	7.5	7.6	7.6	7.6	7.7	7.8	7.9	8.1	8.2	8.3	8.2	8.2	8.2	8.2	8.1
Race/Hispanic origin																						
White[2]	-	-	5.7	5.6	5.6	6.2	6.4	6.5	6.6	6.6	6.6	6.8	6.9	7.0	7.2	7.3	7.3	7.3	7.2	7.2	7.1	7.1
Black[2]	-	-	12.7	12.6	13.3	13.2	13.1	13.1	13.2	13.2	13.1	13.1	13.4	13.6	13.7	14.0	14.0	13.9	13.7	13.6	13.5	13.3
Hispanic[2]	-	-	6.1	6.2	6.1	6.3	6.3	6.4	6.4	6.4	6.4	6.5	6.6	6.7	6.8	6.9	7.0	6.9	7.0	6.9	7.0	7.0
Asian or Pacific Islander[3]	-	-	6.7	6.2	6.5	6.9	7.1	7.2	7.4	7.5	7.3	7.5	7.8	7.8	7.9	8.0	8.1	8.1	8.2	8.3	8.5	8.4
American Indian or Alaska Native[3]	8.0	6.4	6.4	5.9	6.1	6.6	6.5	6.8	6.8	7.2	6.8	7.3	7.2	7.4	7.5	7.4	7.5	7.5	7.4	7.3	7.6	7.5
Plurality of birth																						
Singleton	-	-	-	-	5.9	6.0	6.0	6.1	6.1	6.1	6.0	6.0	6.1	6.2	6.3	6.4	6.5	6.5	6.4	6.4	6.4	6.3
Twin or more	-	-	-	-	51.9	54.9	55.7	56.2	56.9	57.1	56.8	57.2	57.6	58.2	58.5	59.3	59.2	59.0	58.6	58.3	57.6	57.8
Very low birthweight (less than 1,500 grams)	1.2	1.2	1.2	1.2	1.3	1.4	1.4	1.4	1.5	1.5	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.4
Race/Hispanic origin																						
White[2]	-	-	0.9	0.9	0.9	1.0	1.1	1.1	1.2	1.2	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.1
Black[2]	-	-	2.5	2.7	2.9	3.0	3.0	3.1	3.1	3.2	3.1	3.1	3.2	3.1	3.2	3.3	3.2	3.2	3.0	3.1	3.0	3.0
Hispanic[2]	-	-	1.0	1.0	1.0	1.1	1.1	1.1	1.2	1.1	1.1	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Asian or Pacific Islander[3]	-	-	0.9	0.9	0.9	0.9	1.0	1.1	1.1	1.1	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.1	1.2	1.2
American Indian or Alaska Native[3]	1.0	1.0	0.9	1.0	1.0	1.1	1.2	1.2	1.2	1.3	1.2	1.3	1.3	1.3	1.3	1.2	1.3	1.3	1.3	1.3	1.3	1.3
Plurality of birth																						
Singleton	-	-	-	-	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1
Twin or more	-	-	-	-	10.7	11.3	11.7	12.0	12.1	12.0	11.6	11.8	11.7	11.4	11.5	11.7	11.4	11.6	11.3	11.1	10.8	10.9

"-" Indicates data not available.

1 Excludes live births with unknown birthweight. Percent based on live births with known birthweight.

2 Trend data for Hispanics, Whites, and Blacks are affected by expansion of the reporting area for an Hispanic-origin item on the birth certificate and by immigration. These two factors affect numbers of events, composition of the Hispanic population, and maternal and infant health characteristics. The number of States in the reporting area increased from 22 in 1980, to 23 and the District of Columbia (DC) in 1983-87, 48 states and DC in 1990, and all states and DC for 1993 and later.

3 The race groups American Indian or Alaska Native and Asian or Pacific Islander include Hispanics.

Sources: Data for 1970-2001: National Center for Health Statistics. (2003). Health United States, 2003 with Chartbook on Trends in the Health of Americans. National Center for Health Statistics. Table 12. Available at http://www.cdc.gov/nchs/data/hus/hus03.pdf Data for 2002: Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Menacker, F., Munson, M.L. (2003). Births: Final data for 2002. National vital statistics reports, 52 (10). Hyattsville, Maryland: National Center for Health Statistics. Available athttp://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_10.pdf Data for 2003 very low birthweight: National Center for Health Statistics. (2005). Health, United States, 2005 With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland: Table 13. Available at http://www.cdc.gov/nchs/data/hus/hus05.pdf. All other data for 2003: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2005). Births: Final data for 2003. National Vital Statistics Reports, 54(2). Hyattsville, MD: National Center for Health Statistics. Tables 24, 25, and 33. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf. Data for 2004: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2006). Births: Final data for 2004. National Vital Statistics Reports, 55(1). Hyattsville, MD: National Center for Health Statistics. Tables 23, 24. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_01.pdf Data for 2005: Hamilton, B.E., Martin, J.A., and Ventura, S.J. (2006). Births: Final data for 2005. National Vital Statistics Reports, 56(6). Hyattsville, MD: National Center for Health Statistics. Tables 23, 24. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf Data for 2006: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2009). Births: Final data for 2006. National Vital Statistics Reports, 57(7). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf Data for 2007: Hamilton, B.E., Martin, J.A., and Ventura, S.J. (2010). Births: Final data for 2007. National Vital Statistics Reports, 58(24). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_24.pdf Data for 2008: Martin J.A., Hamilton, B.E., Sutton, P.D., and Ventura, S.J. (2010). Births: Final data for 2008. National Vital Statistics Reports, 59(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf Data for 2009: Martin, J. A., Hamilton, B. E., Ventura, S. J., Osterman, M. J. K., Kirmeyer, S., Mathews, T. J., and Wilson, E. C. (2011). Births: Final data for 2009. National Vital Statistics Reports 60(1). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf. Data for 2010: Martin J. A., Hamilton B. E., Ventura S. J., Osterman M. J. K., Wilson E. C., and Mathews T. J. (2012). Births: Final data for 2010. National vital statistics reports, 61(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf

Infant and Toddler Death Rates (per 100,000), by Sex and Race/Hispanic Origin for Selected Years, 1980-2011

	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
Under 1 year[1]	1279.3	1094.5	960.3	779.7	736.7	687.0	709.5	704.9	695.9	710.2	705.8	702.5	678.9	659.7	623.4	598.3
Sex																
Male	1418.1	1226.9	1069.7	855.7	806.5	755.1	778.6	782.1	766.0	782.2	773.5	768.2	742.7	725.0	680.2	648.8
Female	1134.1	955.8	845.7	700.0	663.4	616.0	637.2	624.0	622.7	634.9	635.0	633.6	612.5	591.5	564.0	545.4
Race/Hispanic origin[2]																
White	-	-	-	-	596.5	555.4	575.9	576.5	564.4	562.6	564.2	559.7	542.8	550.7	529.3	523.2
Black	-	-	-	-	1426.1	1304.5	1263.6	1273.8	1284.7	1311.2	1303.1	1250.0	1270.8	1214.9	1102.1	1051.3
Hispanic[3]	-	-	-	-	596.3	536.9	555.5	576.0	561.8	583.1	563.8	570.5	553.1	525.6	510.7	457.9
Asian or Pacific Islander	-	-	-	-	483.0	412.5	427.4	463.1	418.3	430.8	414.7	441.8	421.9	393.3	389.3	377.7
American Indian or Alaskan Native	-	-	-	-	598.4	650.4	822.1	795.8	899.0	818.9	878.0	921.7	579.1	498.4	455.3	444.8
Ages 1-4	63.9	51.8	46.8	40.6	32.4	33.4	31.4	31.8	30.3	29.9	29.1	29.4	29.3	27.4	26.5	26.2
Sex																
Male	72.6	58.5	52.4	44.8	35.9	37.1	35.5	35.4	32.9	34.0	31.3	32.3	32.7	30.1	29.6	29.0
Female	54.7	44.8	41.0	36.2	28.7	29.6	27.1	28.0	27.7	25.6	26.9	26.5	25.8	24.6	23.3	23.3
Race/Hispanic origin[2]																
White	-	45.3	37.6	33.9	28.5	30.1	27.1	27.6	26.8	26.2	25.0	25.5	26.1	25.0	24.7	24.1
Black	97.6	80.7	76.8	70.3	49.9	47.5	47.1	46.8	44.8	41.8	43.3	42.2	44.2	39.8	38.1	38.2
Hispanic[3]	-	46.1	43.5	36.7	29.6	30.2	29.3	29.8	27.1	28.7	26.5	26.3	25.9	24.7	22.7	23.5
Asian or Pacific Islander	43.2	40.1	38.6	25.4	21.6	22.3	23.4	22.5	21.3	19.2	19.6	21.7	18.6	16.1	17.9	13.5
American Indian or Alaskan Native	-	-	-	-	42.4	48.0	45.2	50.3	54.4	59.2	54.4	54.9	38.9	27.5	29.4	27.3

*Data based on preliminary estimates and may be revised.
1 Death rates for "Under 1 year" (based on population estimates) differ from infant mortality rates (based on live births)
2 Estimates for blacks, Asians, Pacific Islanders, American Indians, and Alaska Natives may include Hispanics.
3 Persons of Hispanic origin may be of any race.

Sources: Data by race/ethnicity, 1980-1998: Federal Interagency Forum on Child and Family Statistics. (2002) America's Children: Key National Indicators of Well-Being, 2002. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office. Tables Health 6.A., Health 6.B. and Health 7. Available at: http://www.childstats.gov/pdf/ac2002/ac_02.pdf. Data for 1980-2010 Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2009 on CDC WONDER Online Database. Available at: http://wonder.cdc.gov/ucd-icd10.html. Populatation data for denominators for infant death rates for 1980-1998: Intercensal population estimates, Census Bureau. Available at: http://www.census.gov/popest/data/intercensal/index.html. Data for 2011: Hoyert, D.L., Xu, J. (2012) Deaths: Preliminary data for 2011. National Vital Statistics Reports, 61(6). Hyattsville, MD: National Center for Health Statistics. Table 1. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.

Substantiated Victims of Child Maltreatment, Ages Birth Through Two, Total and by Type of Maltreatment: 2011

	Number of unique victims	Percentage of total victims[1]	Unique victims per 1,000 population[1]
Total	182,742	100.0	15.3
Type of maltreatment			
Medical neglect	5,212	2.9	0.4
Neglect	159,753	87.4	13.4
Physical abuse	28,565	15.6	2.4
Psychological maltreatment	12,946	7.1	1.1
Sexual abuse	1,650	0.9	0.1

1Because some victims have suffered multiple types of maltreatment, the rates by type add up to more than the total rate, and percentages of total add up to more than 100 percent.

Source: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, Child Maltreatment 2011 (Washington, DC: U.S. Government Printing Office, 2012). Exhibit 3-G and Table 3-4. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

Infant and Toddler Homicide (Ages Birth Through Two) Rate per 100,000: 1990-2010

	1990	1991	1992	1993	1994	1995	1996	1997	1998[1]	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	5.2	5.9	5.3	5.7	5.4	5.4	5.4	5.1	5.2	5.1	5.4	5.3	5.1	4.9	4.9	4.8	4.9	5.1	5.2	4.8	4.8
Sex																					
Male	5.4	6.3	5.7	6.4	6.0	6.0	5.4	5.7	5.5	5.3	6.0	6.1	5.4	5.7	5.0	5.4	5.5	5.7	5.8	5.2	5.4
Female	5.0	5.5	4.8	5.0	4.8	4.7	5.3	4.3	4.9	4.9	4.8	4.4	4.7	4.2	4.8	4.2	4.3	4.6	4.5	4.4	4.2
Race/Hispanic origin																					
White	2.8	3.5	3.5	3.4	3.4	3.4	3.6	3.3	3.4	3.6	3.6	3.6	3.5	3.5	3.4	3.6	3.7	3.9	4.0	3.6	3.9
Black	15.2	16.0	14.0	15.9	13.4	13.6	13.8	12.3	14.0	12.6	14.7	13.1	12.5	11.6	11.3	10.8	11.8	11.9	12.0	11.6	10.7
Hispanic	4.9	5.5	4.0	5.1	5.4	4.5	4.4	4.5	4.0	3.9	4.3	4.3	4.2	4.4	4.8	4.0	4.0	4.4	4.0	3.5	3.6

1 Methods for computing homicide rates were changed in 1999; these 1998 rates have been modified so they are comparable to the 1999 and 2000 rates
Source: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013)

Among Children Under Six Years Old Who are Tested, Percentage who have Elevated Blood Lead Levels,[1] 1997-2011

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total[2]	7.6	6.5	5.0	4.0	3.0	2.6	2.3	1.8	1.5	1.2	0.9	0.7	0.6	0.6	0.6
Age															
0 to 11 months	2.2	1.9	1.4	1.2	0.9	-	-	-	-	-	-	-	-	-	-
12 to 23 months	6.3	5.6	4.1	3.2	2.5	-	-	-	-	-	-	-	-	-	-
24 to 35 months	9.6	8.5	6.5	5.2	4.0	-	-	-	-	-	-	-	-	-	-

1 Elevated blood lead levels are defined as blood lead levels greater than or equal to 10 micrograms per deciliter (µg/dL).
2 The data for the Total row come from the CDC's National Surveillance Data, provided by state and local health departments.
- Data are not available.
Sources: Data by age: Department of Health and Human Services Centers for Disease Control and Prevention. (2003). Surveillance for elevated blood lead levels among children - United States 1997-2001 [Electronic Version]. Morbidity and Mortality Weekly Report, 52, 24. Retrieved September 9, 2009 from http://www.cdc.gov/mmwr/PDF/ss/ss5210.pdf. Data for 1997-2011 totals: Centers for Disease Control and Prevention. (3/2012). Lead - CDC's National Surveillance Data (1997-2009). Retrieved May 25 2012, from http://www.cdc.gov/nceh/lead/data/national.htm

Percentage of Children Ages Birth Through Two with Current Asthma: 2011/12

Total	5.5
Sex	
Male	6.2
Female	4.8
Race/Hispanic origin	
White	4.1
Black	9.8
Hispanic	6.9
Poverty level	
Poverty level and below	9.6
101 to 199% of poverty level	-
200% of poverty level and above	3.1
Insurance coverage[1]	
Private insurance	3.1
Public insurance[2]	7.7
Not insured	8.4

"-" = Indicates data not available
1 Children covered by both public and private insurance are placed in the private insurance category.
2 Public health insurance for children consists mostly of Medicaid or other public assistance programs, including State plans. It does not include children with only Medicare or the Civilian Health and Medical Care Program of the Uniformed Services (CHAMPUS/CHAMP-VA/Tricare).
Source: Child Trends' analysis of National Health Interview Survey

Rate of Unintentional Injuries Treated in Emergency Rooms, per 100,000 Population, Ages Birth Through Two, Selected Years, 2000-2011

	2000[2]	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total non-fatal injuries	1,497,132	1,468,275	1,405,335	1,368,976	1,411,886	1,366,912	1,394,099	1,362,742	1,398,162	1,486,275	1,539,095	1,534,280
Non-fatal injuries (rate per 100,000 population)	13,114	12,584	11,897	11,490	11,864	11,444	11,616	11,240	11,425	12,197	12,805	12,853
Sex												
Male	14,747	13,930	13,202	12,565	13,052	12,574	12,703	12,236	12,783	13,253	13,944	14,101
Female	11,382	11,170	10,523	10,363	10,611	10,257	10,470	10,192	10,006	11,092	11,616	11,547
Race/Hispanic origin												
White	10,748	10,320	9,811	10,181	10,226	9,372	9,734	9,672	11,088	12,394	12,070	12,086
Black	14,157	14,121	13,111	11,171	12,046	10,270	9,961	8,203	9,014	9,216	9,496	10,223
Hispanic[1]	9,215*	7,606*	6,029*	4,392	4,930*	4,898*	5,766*	4,528	5,526	6,126	7,026*	7,326*
Mechanism												
Fall	5,865	5,702	5,442	5,318	5,461	5,211	5,237	5,035	5,282	5,951	6,082	6,031
Struck by/ against object or person	2,428	2,155	2,007	1,830	1,872	1,830	1,956	1,881	1,918	1,868	2,017	1,894
Bite/sting	990	926	866	923	970	955	1,009	917	916	936	1,052	1,178
Foreign Body	682	600	542	523	594	548	608	619	600	588	660	693
Overexertion	419	457	488	428	501	486	533	534	477	545	603	608
Cut/pierce	491	516	413	415	413	415	369	384	396	404	409	445
Fire/burn	545	531	487	445	445	463	423	392	369	367	383	410
Poisoning	633	627	591	460	360	304	331	284	247	304	319	274
Other transportation	89	248	238	252	220	199	211	213	201	199	221	202
Occupant of a motor vehicle	336	258	283	241	224	197	199	156	169	164	171	191
Unknown/unspecified	244	315	311	311	298	309	231	287	272	298	250	254
All others	392	248	229	343	505	526	508	540	579	572	638	675
Age group												
Less than 1 year	6,930	5,936	6,185	5,868	6,028	5,819	5,938	5,641	5,746	6,225	6,520	6,790
1 to 2 years	16,205	16,068	14,769	14,305	14,834	14,281	14,498	14,153	14,321	15,119	15,875	15,904

* Based on a small sample, estimate is unstable.
1 Hispanics may be of any race
2 Non-fatal injury reports from 2000 are not comparable to later years because of seasonal effects.
3 starting in 2011, totals for blacks include Hispanics
Sources: National Center for Injury Protection and Control. (2012). WISQARS online, non-fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/nonfatal.html.

Rate of Unintentional Fatal Injuries, per 100,000 Population, Ages Birth Through Two, Selected Years, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total fatal injuries	1,976	1,993	1,912	1,962	2,046	2,108	2,128	2,261	2,226	2,069	1,987
Fatal injuries (rate per 100,000 population)	17.3	17.1	16.2	16.5	17.2	17.7	17.7	18.7	18.2	17.0	16.5
Sex											
Male	19.6	19.1	19.0	19.0	19.3	19.8	19.8	21.1	20.6	20.1	19.1
Female	14.9	15.0	13.3	13.9	15.0	15.5	15.6	16.1	15.7	13.7	13.9
Race/Hispanic origin											
White	16.0	15.9	14.3	16.0	17.1	16.8	16.0	17.8	18.2	16.0	16.3
Black	28.3	26.0	29.3	26.8	26.7	27.3	31.5	33.7	29.7	29.5	26.5
Hispanic1	13.6	14.6	13.1	12.3	12.7	15.2	14.1	12.4	12.6	12.8	11.7
American Indian or Alaska Native	31.6	40.0	23.7	28.6	34.5	30.9	41.1	41.2	38.2	26.2	35.3
Asian or Pacific Islander	7.7	6.3	9.2	6.6	7.0	6.1	7.1	8.3	7.2	7.0	8.6
Mechanism											
Motor vehicle traffic	4.0	3.7	3.4	3.2	3.4	3.3	3.1	2.9	2.2	2.2	2.2
Suffocation	5.6	6.1	6.3	6.2	6.9	7.0	7.9	9.0	9.6	8.2	8.4
Drowning	3.7	3.3	3.1	3.1	3.2	3.5	3.0	3.0	2.9	3.0	2.9
Poisoning	0.3	0.3	0.4	0.4	0.2	0.3	0.3	0.4	0.3	0.4	0.2
Other transportation	0.8	0.6	0.6	0.8	0.8	1.0	0.9	0.9	0.9	0.9	0.8
Fire/burn	1.7	1.4	1.2	1.3	1.1	1.2	1.0	1.1	0.8	0.8	0.8
Falls	0.3	0.3	0.4	0.5	0.5	0.3	0.4	0.4	0.3	0.4	.17*
Other	1.0	1.2	0.9	1.0	1.1	1.0	1.0	1.1	1.2	1.2	1.3
Age group											
Less than 1 year	23.1	24.2	23.7	23.4	25.6	26.3	27.5	29.9	30.7	27.7	28.1
1 to 2 years	14.4	13.3	12.3	12.8	12.6	12.9	12.3	12.2	11.2	10.9	10.9

1 Hispanics may be of any race
Sources: National Center for Injury Protection and Control. (2012). WISQARS online, fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/fatal.html
Source: National Center for Injury Protection and Control. (2013). WISQARS online, fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/fatal.html

Percentage of Children Who Are Overweight or Obese, Selected Years 1999-2010

	1999-2002	2003-2006	2007-2008	2009-2010
Obese[1]				
Ages 0-12	-	-	9.5	9.7
Sex				
Male	-	-	10.0	11.3
Female	-	-	9.0	8.1
Race/Ethnicity				
White	-	-	8.7	8.4
Black	-	-	10.3	8.7
Mexican American	-	-	9.2	15.7
Ages 2-5[2]	10.3	12.4	10.4	12.1
Sex				
Male	9.9	12.8	10.0	14.4
Female	10.7	12.1	10.7	9.6
Race/Ethnicity				
White	8.6	10.7	9.1	9.2
Black	8.8	14.9	11.4	18.9
Mexican American	13.1	16.7	13.7	15.5
Overweight[1]				
Ages 2-5[2]	12.3	12.0	10.8	14.6
Sex				
Male	13.1	12.7	11.0	15.3
Female	11.6	11.2	10.7	13.8
Race/Ethnicity				
White	12.2	12.5	8.3	14.6
Black	14.4	9.9	14.6	10.0
Mexican American	13.2	13.2	14.0	17.8

"-" Indicates data not available

1 Obese is defined as body mass index (BMI) at or above the sex- and age-specific 95th percentile BMI cutoff points, while overweight is defined as between the 85th and 95th percentiles. This is based on the revised CDC Growth Charts, which are based on a nationally representative samples of children between 1963 and 1994. For more information, see Kuczmarski R. J., Ogden C. L., Guo S. S., et al. (2002) 2000 CDC growth charts for the United States: Methods and development. National Center for Health Statistics. Vital Health Stat 11(246). Available at http://www.cdc.gov/nchs/data/series/sr_11/sr11_246.pdf.

2 Totals include data for racial/ethnic groups not shown seperately.

"Sources: Data for 1999-2002 from Hedley, Allison, Ogden, Cynthia, Johnson, Clifford, Carroll, Margaret, Curtin, Lester and Katherine Flegal. "Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2002," JAMA, 291 (23): 2847-2850. Data for 2003-2006: Ogden, Cynthia, Carroll, and Flegal, Katherine. "High Body Mass Index for Age Among US Children and Adolescents, 2003-2006." JAMA, 299 (20): 2401-2405. Data for 2007-2008: Ogden C.L., Carroll, M.D., Curtin, L.R., Lamb, M. M., Flegal, K. M. (2010). Prevalence of high body mass index in US children and adolescents, 2007-2008, JAMA 303 (3). pp 242-249. Available at: http://jama.jamanetwork.com/article.aspx?articleid=185233. Data for 2009-2010: Ogden C.L., Carroll, M.D., Kit, B.K., Flegal, K.M., (2012). Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010, JAMA 307 (5). pp 483-490. Available at: http://jama.jamanetwork.com/article.aspx?volume=307&issue=5&page=483.

Percentage of Children Ages One Through Two Years Who Had Oral Health Problems in the Past 12 Months: 2011/12

	2011/12
Total	3.7
Sex	
Male	4.2
Female	3.2
Age	
One	2.7
Two	4.8
Family structure	
Two biological/adoptive parents	2.9
Single mother	5.5
Race/Hispanic origin	
White	2.3
Black	5.9
Hispanic	4.6
Other	6.0
Poverty level	
Poverty level and below	6.5
101 to 200% of poverty level	5.0
Above 200% of poverty level	1.6
Parental education	
Less than a high school degree	6.3
High school degree	2.8
More than a high school degree	3.0

Note: Oral health problems include toothaches, decayed teeth, or unfilled cavities

Source: Child Trends' analysis of the National Survey of Children's Health.

Percentage of Children Ages Two Through Five That Have Ever Been Diagnosed with Autism Spectrum Disorder

Total	1.6
Sex	
Male	2.4
Female	0.8
Race/Hispanic origin	
White	1.6
Black	1.7
Hispanic	1.4
Other	2.2
Poverty level	
Poverty level and below	2.1
101 to 199% of poverty level	1.8
200% of poverty level and above	1.3

Source: Child Trends' analysis of the National Survey of Children's Health.

Percentage of Children ages Two Through 17 with Autism Spectrum Disorder Who Were Diagnosed Before Age Three: 2011/12

Total	26.3
Sex	
Male	25.0
Female	32.1
Race/Hispanic origin	
White	24.4
Black	33.6
Hispanic	19.4
Other	42.4
Poverty level	
Poverty level and below	34.6
101 to 199% of poverty level	28.7
200% of poverty level and above	22.8
Family structure	
Two biological/adoptive parents	29.8
Single mother	27.2
Parental education	
Less than a high school degree	16.9
High school degree	30.1
More than a high school degree	26.7

Source: Child Trends' analysis of National Survey of Children's Health.

Percentage of Children Ages Birth Through Two with Special Health Care Needs: 2003, 2007 and 2011/12

	2003	2007	2011
Total	7.4	8.2	7.4
Sex			
Male	9.2	9.8	8.1
Female	5.7	6.5	6.7
Race/Hispanic origin			
White	7.3	9.1	7.5
Black	9.6	12.6	12.5
Hispanic	6.5	4.1	6.2
Other	8.2	8.0	5.0
Poverty level[1]			
Poverty level and below	9.6	8.9	8.2
101 to 199% of poverty level	7.1	7.4	8.1
200% of poverty level and above	6.7	8.2	6.7
Family structure			
Two biological/adoptive parents	6.9	7.0	5.9
Single mother	8.9	12.5	11.9
Other	11.6	20.8	19.5
Parental education			
Less than a high school degree	4.9	6.6	5.6
High school degree	8.7	7.6	8.3
More than a high school degree	7.3	8.7	7.4

Note: Special health care needs include needing prescription medications, needing elevated services, being limited in activities, needing specialized therapies, or having an emotional/developmental/behavioral problem, when the need is expected to persist for at least a year.
1 In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' analysis of National Survey of Children's Health.

Children Ages Six Months Through Two Years: Percentages Parents Report "Usually" or "Always" Exhibit Selected Characteristics of "Flourishing": 2011/12

	Child is affectionate and tender with parent	Child bounces back quickly when things don't go his or her way	Child smiles and laughs a lot	Child shows interest and curiosity in learning new things
Total	94.1	81.7	97.6	96.7
Race/Hispanic origin				
White	95.4	86.6	98.8	98.1
Black	91.3	69.8	97.1	94.2
Hispanic	94.7	79.3	95.6	95.0
Other	90.4	78.3	97.3	97.3
Poverty level				
Poverty level and below	92.6	72.4	96.4	93.7
101 to 199% of poverty level	93.6	81.2	96.4	97.0
200% of poverty level and above	95.1	87.1	98.8	98.2
Parental education				
Less than a high school degree	94.7	76.8	95.8	95.9
High school degree	94.3	81.2	98.9	96.5
More than a high school degree	94.6	85.4	97.8	97.8
Special health care needs (SHCN)				
No SHCN	94.2	82.4	97.7	97.3
SHCN	93.2	74.2	96.8	89.4

Source: Child Trends' analysis of National Survey of Children's Health.

Percent of Mothers Who Smoked During Pregnancy, Selected States, 1989-2010[1]

	1995	1996	1997	1998	1999	2000	2001	2002	2003[2]	2004[2]	2005[2]	2006[2]	2007[3]	2008[3]	2009[3]	2010[3]
All births	13.9	13.6	13.2	12.9	12.6	12.2	12.0	11.4	10.7	10.2	10.7	10.0	10.4	9.7	9.3	9.2
Age																
Under 15 years	7.3	7.7	8.1	7.7	7.8	7.1	6.0	5.8	5.3	4.1	4.8	3.3	3.4	3.2	2.7	2.9
15-19 years	16.8	17.2	17.6	17.9	18.1	17.8	17.5	16.7	15.4	14.2	15.2	13.6	14.2	13.1	12.6	12.4
20-24 years	17.1	16.8	16.6	16.5	16.7	16.8	17.0	16.7	16.1	15.5	16.4	15.0	15.9	15.0	14.5	14.4
25-29 years	12.7	12.3	11.8	11.4	11.0	10.5	10.3	9.9	9.4	9.2	9.9	9.6	10.2	9.7	9.4	9.3
30-34 years	11.4	10.9	10.0	9.3	8.6	8.0	7.6	7.1	6.5	6.1	6.1	5.8	5.9	5.6	5.5	5.7
35-39 years	12.0	11.7	11.1	10.5	9.9	9.1	8.6	7.8	6.8	6.3	6.2	5.6	5.4	4.9	4.5	4.5
40-54 years[4]	10.0	10.0	10.1	9.9	9.5	9.5	9.3	8.4	8.0	7.2	6.9	6.3	5.5	4.6	4.4	4.5
Race of mother																
White	17.1	16.9	16.5	16.2	15.9	15.6	15.5	15.0	14.3	13.8	13.9	13.3	16.3	15.5	14.6	13.9
Black	10.6	10.3	9.8	9.5	9.4	9.2	9.1	8.8	8.3	8.4	8.5	7.9	10.1	9.0	8.9	8.8
Asian or Pacific Islander[5]	3.2	3.1	2.9	2.9	2.7	2.6	2.6	2.3	2.0	2.0	2.1	2.0	1.5	1.4	1.3	1.2
American Indian or Alaska Native	21.1	21.7	21.2	20.7	20.6	20.5	20.5	20.1	18.6	18.6	18.1	16.8	24.4	19.5	18.4	19.0
Hispanic	4.3	4.3	4.1	4.0	3.7	3.5	3.2	3.0	2.7	2.6	2.9	2.6	2.1	2.1	2.0	2.0
Education of mother[6]																
0-8 years	11.0	10.3	9.9	9.5	8.9	7.9	7.2	6.8	6.2	5.5	6.2	5.8	-	-	-	-
Eighth grade or less	-	-	-	-	-	-	-	-	-	-	-	-	3.2	3.0	3.0	3.5
9-11 years	32.0	31.1	30.2	29.3	29.0	28.2	27.6	26.8	25.5	23.7	26.7	24.6	-	-	-	-
9th-12th grade, no diploma	-	-	-	-	-	-	-	-	-	-	-	-	18.9	17.9	17.5	18.1
12 years	18.3	18.0	17.5	17.1	17.0	16.6	16.5	16.0	15.2	14.9	15.7	14.6	-	-	-	-
High school diploma or GED	-	-	-	-	-	-	-	-	-	-	-	-	16.2	15.3	14.9	14.8
13-15 years	10.6	10.4	9.9	9.6	9.4	9.1	9.2	8.8	8.5	8.4	8.8	8.4	-	-	-	-
Some college or associate's degree	-	-	-	-	-	-	-	-	-	-	-	-	10.4	9.8	9.5	9.6
16 years or more	2.7	2.6	2.4	2.2	2.1	2.0	1.9	1.7	1.6	1.5	1.5	1.4	-	-	-	-
B.A. or more	-	-	-	-	-	-	-	-	-	-	-	-	1.4	1.2	1.2	1.1

"-": Data not available.

1 Excludes live births for whom smoking status of mother is unknown and data from states that did not require the reporting of mother's tobacco use during pregnancy on the birth certificate. Reporting area for tobacco use increased from 43 states and the District of Columbia (D.C.) in 1989 to 49 states and D.C. in 2002, and all 50 states and DC. in 2007.

2 Data are for the reporting areas that used the 1989 Revision of the U.S. Standard Certificate of Live Birth for prenatal care. Reporting areas that implemented the 2003 revision of the U.S. Standard Certificate of Live Birth are excluded because prenatal care data based on the 2003 revision are not comparable with data based on the 1989 revision. In 2003, 48 states and DC, representing 94 percent of births, used the 1989 revision. In 2004, 41 states and DC, representing 80 percent of births, used the 1989 revision. In 2005 it was 37 states and DC, representing 69 percent of births. In 2006 it was 32 states and DC, representing 65 percent of births. Although New York state began using the 2003 revision in 2004, New York City continued to use the 1989 revision, and is included in these estimates.

3 Data are for the reporting areas that used the 2003 Revision of the U.S. Standard Certificate of Live Birth for prenatal care. Reporting areas that did not yet implement the 2003 revision of the U.S. Standard Certificate of Live Birth are excluded because prenatal care data based on the 2003 revision are not comparable with data based on the 1989 revision. In 2007, 21 states, representing 53 percent of births, were using the 2003 revision. In 2008, 27 states, representing 65 percent of births, were. In 2009, 28 states, representing 66 percent of births were using the 2003 revision, and in 2010, 34 states, representing 76 percent of births, were using the 2003 revision. Although New York state began using the 2003 revision in 2004, New York City continued to use the 1989 revision until 2008, and is excluded for 2007.

4 Prior to 1997, data are for live births to mothers 45-49 years of age.

5 Maternal tobacco use during pregnancy was not reported on the birth certificates of California (except in 2001 and 2002) until 2007. California accounted for 32 percent of the births to Asian or Pacific Islander mothers in 1999. In 2006, California accounted for 29% of the births to Asian or Pacific Islander mothers and 28% of the births to Hispanic mothers.

6 Includes only mothers of age 20 or older. Data from states that did not require the reporting of mother's education on the birth certificate are not included.

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data, on CDC WONDER Online Database, November 2005. Accessed at http://wonder.cdc.gov

Percentage of Births That Are Preterm,[1] by Selected Characteristics, 1990-2011

	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
All preterm births (<37 wks. gestation)	10.6	11.0	11.0	11.4	11.6	11.8	11.6	11.9	12.1	12.3	12.5	12.7	12.8	12.7	12.3	12.2	12.0	11.7
Very preterm (<32 wks. gestation)	1.9	1.9	1.9	1.9	2.0	2.0	1.9	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.9
Moderately preterm (32-33 wks. gestation)	1.4	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.6	1.6	1.6	1.6	1.5	1.5	1.5
Late preterm (34-36 wks. gestation)	7.3	7.7	7.7	8.0	8.1	8.3	8.2	8.5	8.6	8.8	8.9	9.1	9.1	9.0	8.8	8.7	8.5	8.3
Mother's race/Hispanic origin[2]																		
White	8.5	9.4	9.5	9.9	10.2	10.5	10.4	10.8	11.0	11.3	11.5	11.8	11.7	11.5	11.1	10.9	10.8	10.5
Black	18.9	17.8	17.5	17.6	17.6	17.6	17.4	17.6	17.7	17.8	17.9	18.4	18.5	18.3	17.5	17.5	17.1	16.8
Hispanic	11.0	10.9	10.9	11.2	11.4	11.4	11.2	11.4	11.6	11.9	12.0	12.1	12.2	12.3	12.1	12.0	11.8	11.7
Asian or Pacific Islander	9.8	9.9	10.0	10.2	10.4	10.4	9.9	10.3	10.4	10.5	10.5	10.8	10.9	10.8	10.6	10.8	10.7	10.4
American Indian or Alaska Native	11.6	12.4	11.9	12.2	12.2	12.9	12.7	13.2	13.1	13.5	13.7	14.1	14.2	14.1	13.8	13.6	13.6	13.5
Plurality of birth																		
Singleton births	9.7	9.8	9.7	10.0	10.1	10.3	10.1	10.4	10.4	10.6	10.8	11.0	11.1	11.0	10.6	10.4	10.3	10.0
Twin	47.3	52.2	52.9	54.3	55.5	56.6	56.1	56.8	57.6	58.7	59.1	60.0	60.0	60.1	58.9	58.7	57.8	57.3
Triplet	86.7	90.6	91.0	92.1	91.1	91.3	90.9	91.4	91.3	92.3	92.1	92.7	91.5	93.7	92.9	94.2	93.9	93.4
Age of mother																		
Under 19 years	14.6	13.8	13.6	13.8	14.0	14.1	14.0	14.1	14.0	14.3	14.5	14.7	14.8	14.6	14.1	13.7	13.7	13.6
20 to 29 years	10.1	10.4	10.4	10.8	11.0	11.2	11.1	11.4	11.5	11.8	11.9	12.1	12.2	12.1	11.7	11.6	11.6	11.1
30 to 39 years	9.8	10.6	10.7	11.2	11.4	11.6	11.4	11.8	12.0	12.3	12.5	12.7	12.8	12.7	12.4	12.3	12.3	11.8
40 to 44 years	12.3	13.5	13.6	14.1	14.6	14.8	14.7	15.1	15.5	15.7	16.1	16.2	16.4	16.5	16.3	16.4	16.4	15.6
45 years or older	15.5	19.2	18.0	22.3	23.0	23.5	23.6	25.5	26.2	25.9	25.6	26.0	25.9	26.5	27.1	26.8	26.8	27.3

1 Excludes live births with unknown gestation period. Percent based on live births with known gestation period.
2 The race groups American Indian or Alaska Native and Asian or Pacific Islander include Hispanics.
Sources: Late and moderate preterm data for 1990-2005: March of Dimes (2013). Peristats online tool. Available at: http://www.marchofdimes.com/peristats/. All other data for 1990-1995, and 2010: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Available at http://www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. All other data for 1995-2009: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Data for 2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. National Vital Statistics Reports, 62(1). Hyattsville, MD: National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf.

Percentage of Children Ages Birth through Two with Housing Insecurity: 2011*

	Disruptive mobility	Crowded living
Total	4.7	16
Race/Hispanic origin		
White	2.7	7
Black	4.2	16
Hispanic	9.0	32
Income		
Poverty level and below	8.5	28
101 to 200% of poverty level	5.2	21
Above 200% of poverty level	2.3	7

*Data for disruptive mobility is for 2011 and 2012.
Note: Disruptive mobility is defined as moving more than two times per year of life, while crowded living is defined as having more than two household members per bedroom, or, if no bedrooms, more than one person per room.
Sources: Disruptive mobility: Child Trends' analysis of the National Survey of Children's Health. Crowded living: Child Trends' analysis of American Community Survey, Public Use Microdata Sample.

Number of Homeless Children Under Age Six: 2010

	Total children	Children unaccompanied by an adult
Total sheltered homeless	183,375	2,414
Age		
Infants	39,926	1,207
Ages 1-5	143,449	1,207
Location		
Principal cities	109,965	-
Suburban and rural	73,410	-
Transitional housing		
Infants	11,180	362
Ages 1-5	40,734	461
Emergency shelters		
Infants	30,426	888
Ages 1-5	108,989	805
Permanent supportive housing	27,615	1,125
Age		
Infants	4,857	309
Ages 1-5	22,758	816
Location		
Principal cities	18,357	-
Suburban and rural	9,257	-
Received HPRP housing assistance (Homeless-ness Prevention and Rapid Re-Housing Program)	101,727	1,069

'-' data are not available
Note: Estimates include all children that spent time in homeless shelters or permanent supportive housing over the course of the entire year. They do not include homeless children who spent time living in places not meant for human habitation, doubling-up, or staying in motels for extended periods, who are also considered homeless under the definitions of the HEARTH act.
Source: US Department of Housing and Urban Development, Office of Community Planning and Development. (2011) The 2010 Annual Homeless Assessment Report to Congress. Available at: http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf.

Percentage of Children Ages Birth Through Two in Food-Insecure Or Marginally Food-Secure Households, 2002-2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
In households with marginal food security[1]	-	-	-	12.3	12.1	12.6	12.5	15.0	14.8	15.1
Poverty										
Below 185% poverty	-	-	-	19.6	19.8	20.2	18.7	22.0	22.6	22.4
Above 185% poverty or income not reported	-	-	-	6.7	6.5	6.5	7.0	8.6	7.2	9.0
SNAP receipt										
Family received SNAP in past 12 months	-	-	-	21.3	20.8	22.4	20.2	25.3	25.8	23.2
Family did not receive SNAP in past 12 months	-	-	-	20.2	20.3	20.1	19.7	20.5	21.6	24.8
WIC receipt										
Family received WIC in past 30 days	-	-	-	23.6	23.6	21.9	20.7	23.9	27.0	26.2
Family did not receive WIC in past 30 days	-	-	-	18.1	18.0	20.0	19.2	21.2	20.4	22.5
Race/Hispanic origin										
Hispanic	-	-	-	17.2	15.3	14.7	16.7	19.6	20.3	20.7
White	-	-	-	10.0	9.7	10.6	10.1	12.3	11.4	11.7
Black	-	-	-	14.0	15.5	17.9	16.0	17.5	19.1	18.5
Age										
Less than one	-	-	-	14.0	13.5	13.4	13.3	15.3	15.2	14.3
One	-	-	-	12.1	12.1	11.4	12.1	15.0	15.2	16.8
Two	-	-	-	10.7	10.6	13.1	12.2	14.8	14.0	14.2
Family structure										
Two biological/adoptive parents	-	-	-	-	-	10.7	11.8	13.0	13.6	13.3
Single parent	-	-	-	-	-	17.8	13.7	20.6	17.3	21.0
Other	-	-	-	-	-	20.7	18.8	21.3	21.4	14.2

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Low food security[2]	14.2	14.1	14.1	13.1	13.4	13.5	16.5	16.8	16.0	16.5
Poverty										
Below 185% poverty	26.4	25.1	25.0	23.2	23.3	23.9	28.1	27.2	25.4	26.8
Above 185% poverty or income not reported	5.5	6.4	6.2	5.3	6.3	5.2	6.2	7.3	6.7	7.7
SNAP receipt										
Family received SNAP in past 12 months	37.2	35.5	34.5	30.9	32.7	36.4	38.0	33.9	33.1	34.4
Family did not receive SNAP in past 12 months	21.6	21.3	21.0	19.2	19.9	16.9	21.1	23.6	20.4	21.5
WIC receipt										
Family received WIC in past 30 days	35.1	31.3	31.2	28.6	28.9	29.7	31.2	32.0	32.1	31.2
Family did not receive WIC in past 30 days	19.4	21.0	20.2	18.7	19.9	18.9	23.7	23.2	20.5	23.9
Race/Hispanic origin										
Hispanic	21.8	23.9	21.1	15.9	19.7	22.3	24.2	23.5	23.4	24.0
White	10.1	8.7	9.8	10.2	9.2	8.8	11.6	11.6	9.5	11.4
Black	22.6	23.8	21.9	19.5	24.1	20.6	24.2	26.4	26.9	24.4
Age										
Less than one	13.7	13.5	13.9	12.6	13.7	12.8	15.5	15.9	16.5	17.4
One	13.9	15.0	13.6	13.7	12.4	14.3	16.7	17.4	14.3	17.1
Two	14.9	13.7	14.7	12.9	14.1	13.4	17.4	17.2	17.1	15.2
Family structure										
Two biological/adoptive parents	-	-	-	-	-	11.8	13.2	14.7	12.2	13.7
Single parent	-	-	-	-	-	19.5	25.5	24.0	26.7	24.4
Other	-	-	-	-	-	-	27.2	16.8	21.0	-

1 Marginal food security is when the household had one or two reported indications of food insecurity--typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diets or food intake.
2 Low food security is when the household reports of reduced quality, variety, or desirability of diet. There is little or no indication of reduced food intake.
3 Very low food security is when the household reports of multiple indications of disrupted eating patterns and reduced food intake.
Source: Child Trends' analysis of the Current Population Survey: Food Security Supplement.

continued on next page

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Very low food security[3]	3.8	3.8	3.8	4.0	4.6	4.4	6.6	6.7	5.6	5.3
Poverty										
Below 185% poverty	7.7	7.4	7.8	7.7	8.6	8.6	11.5	11.5	9.5	10.0
Above 185% poverty or income not reported	1.0	1.2	0.9	1.1	1.7	1.1	2.2	2.2	1.8	1.2
SNAP receipt										
Family received SNAP in past 12 months	12.0	13.1	13.1	12.3	14.0	14.3	16.7	15.4	13.1	14.7
Family did not receive SNAP in past 12 months	4.9	4.5	4.1	4.7	6.0	5.2	8.2	8.2	6.6	4.2
WIC receipt										
Family received WIC in past 30 days	9.5	9.6	9.0	9.7	10.0	11.7	14.7	13.3	11.7	13.1
Family did not receive WIC in past 30 days	4.8	4.9	5.1	4.9	7.1	5.7	8.1	9.1	7.4	5.7
Race/Hispanic origin										
Hispanic	7.6	6.4	5.0	4.8	5.6	6.7	9.5	9.6	8.0	8.1
White	1.6	2.1	2.7	2.7	3.6	2.5	4.1	4.2	3.5	2.8
Black	7.1	7.5	7.2	8.2	7.7	9.5	11.4	10.8	10.2	10.8
Age										
Less than one	2.9	3.1	3.7	4.1	4.3	5.5	6.3	6.5	5.0	4.2
One	3.8	4.0	4.6	4.4	4.8	3.9	8.1	6.8	6.4	4.8
Two	4.5	4.2	2.9	3.4	4.6	4.0	5.4	6.8	5.5	6.5
Family structure										
Two biological/adoptive parents	-	-	-	-	-	2.9	4.2	4.9	3.3	3.2
Single parent	-	-	-	-	-	9.6	14.5	12.1	12.2	11.3
Other	-	-	-	-	-	-	-	-	-	-

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Low or very low food security among children in household	-	-	-	7.4	8.4	8.4	11.0	9.9	9.3	8.8
Poverty										
Below 185% poverty	-	-	-	14.1	15.1	14.9	19.1	17.1	16.5	15.9
Above 185% poverty or income not reported	-	-	-	2.6	3.8	3.5	3.8	3.9	3.1	2.8
SNAP receipt										
Family received SNAP in past 12 months	-	-	-	18.6	20.5	23.3	27.7	22.5	21.4	21.0
Family did not receive SNAP in past 12 months	-	-	-	10.7	13.0	10.8	13.2	12.8	10.9	9.6
WIC receipt										
Family received WIC in past 30 days	-	-	-	15.8	19.9	20.2	21.2	18.7	20.5	20.1
Family did not receive WIC in past 30 days	-	-	-	10.7	11.8	11.5	15.7	14.5	11.4	10.5
Race/Hispanic origin										
Hispanic	-	-	-	10.9	12.8	15.0	17.8	16.6	17.3	14.9
White	-	-	-	4.8	5.7	4.5	6.4	5.8	4.3	4.7
Black	-	-	-	14.5	15.6	14.8	19.4	17.7	15.2	14.6
Age										
Less than one	-	-	-	7.0	7.7	8.4	10.0	8.6	8.9	7.6
One	-	-	-	7.7	8.8	8.9	11.4	9.8	8.8	9.4
Two	-	-	-	7.5	8.7	7.8	11.6	11.1	10.2	9.2
Family structure										
Two biological/adoptive parents	-	-	-	-	-	6.6	7.5	7.9	6.2	6.6
Single parent	-	-	-	-	-	13.9	22.0	15.8	19.1	15.3
Other	-	-	-	-	-	-	13.0	16.2	13.2	-

Percentage of Children Ages 4 Months Through Two Years With Developmental Risk according to Parental Report: 2011/12

	High risk	Moderate risk	High or moderate risk
Total	7.3	14.1	21.4
Sex			
Male	7.5	15.7	23.1
Female	7.2	12.4	19.6
Race/Hispanic origin			
White	3.2	12.6	15.8
Black	9.4	15.4	24.9
Hispanic	13.0	15.6	28.6
Other	9.6	15.9	25.5
Poverty level			
Poverty level and below	12.4	14.8	27.2
101 to 200% of poverty level	7.2	14.5	21.7
Above 200% of poverty level	4.6	13.5	18.1
Family structure			
Two biological/adoptive parents	6.4	13.2	19.6
Single mother	10.5	16.8	27.3
Parental education			
Less than a high school degree	15.6	14.3	29.9
High school degree	6.5	13.7	20.2
More than a high school degree	4.4	13.9	18.2

Note: Risk assessment is based on one or more age-specific parental concerns that are predictive of delay.
Source: Child Trends' analysis of National Survey of Children's Health.

Percentage of Children Ages Birth Through Two Who Had Adverse Experiences, by Type: 2011/12

Type of experience	
Has experienced socioeconomic hardship somewhat or very often	24.5
Has experienced parental divorce or separation	5.4
Has experienced parental death	0.6
Has experienced parental incarceration	2.9
Has witnessed parental domestic violence	2.2
Has witnessed or experienced violence in the neighborhood	1.4
Has lived with someone who was mentally ill or suicidal	3.9
Has lived with someone who had a substance abuse problem	3.5
Has experienced racial or ethnic discrimination	0.7

Source: Child Trends' analysis of National Survey of Children's Health.

Adverse Experiences[1] Among Children Ages Birth Through Two: 2011/12

	None	One	Two	Three or more
Total	68.4	24.3	4.4	2.9
Sex				
Male	66.1	26.4	4.3	3.2
Female	70.9	22.0	4.6	2.6
Age				
Less than one	72.3	23.8	2.5	1.4
One	69.6	22.4	4.1	3.9
Two	62.1	27.1	7.1	3.7
Family structure				
Two biological/adoptive parents	75.0	21.8	2.1	1.1
Single mother	42.7	35.4	13.9	8.0
Other	43.0	29.2	10.7	17.1
Race/Hispanic origin				
White	74.1	18.7	4.5	2.7
Black	57.0	31.5	7.9	3.6
Hispanic	60.9	32.6	3.6	2.9
Other	72.6	21.5	2.7	3.3
Poverty level (Socioeconomic hardship excluded)				
Poverty level and below	79.6	11.9	6.1	2.4
101 to 200% of poverty level	85.5	10.3	2.7	1.5
Above 200% of poverty level	92.1	6.2	0.7	1.0
Parental education				
Less than a high school degree	57.1	34.6	4.8	3.6
High school degree	66.7	24.8	4.7	3.8
More than a high school degree	75.5	18.1	4.2	2.3
Special health care needs				
No SHCN	70.1	23.4	4.0	2.5
SHCN	49.9	32.2	9.7	8.2

1 Adverse experiences include: frequent socioeconomic hardship, parental divorce or separation, parental death, parental incarceration, witnessing domestic violence, witnessing violence in the neighborhood, living with someone who is mentally ill or suicidal, living with someone who has problems with substance abuse, and racial or ethnic descrimination.
Source: Child Trends' analysis of National Survey of Children's Health.

Percentage of Children Ages Birth Through Five with Direct or Indirect Experience of Violence in the Past Year, by Type of Victimization: 2011

	0-1 years old	2-5 years old
Type of experience		
Physical assault	12.7	43.9
Sexual victimization	0.7	1.1
Maltreament	6.2	9.5
Witness violence[1]	7.5	14.4
Witness family assualt	5.7	6.8
Indirect exposure to violence[2]	0.2	3.0

"-": data not available
1 Includes witnessing family assault, assault in the community, shooting, or war.
2 Includes hearing about or seeing violence; excludes witnessing violence, household theft, and school threat of bomb or attack.
Source: Finkelhor, D., Turner, H., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. Published online before print. Available at: http://archpedi.jamanetwork.com/article.aspx?articleid=1686983

Vaccinations of Children 19-35 Months of Age: United States, 1994-2011 (Percentage)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Combined series (4:3:1:3)[1]	69	74	76	76	79	78	76	77	78	81	83	82	82	82	80	73	79	82
Race/Hispanic origin[2]																		
White	72	76	79	79	82	81	80	79	80	84	85	84	84	83	79	74	78	82
Black	67	70	74	73	73	74	70	71	71	75	76	81	79	80	76	69	78	79
Hispanic	62	68	71	73	75	75	73	77	76	79	81	81	82	78	78	75	80	82
Asian or Pacific Islander	60	76	78	71	79	77	-	-	-	-	-	-	-	-	-	-	-	-
Asian	-	-	-	-	-	-	75	76	83	81	84	82	80	82	85	73	78	88
American Indian or Alaska Native	82	69	82	73	78	75	72	75	NA	77	75	NA	80	85	79	77	80	72
Poverty status																		
Below poverty	61	67	69	71	74	73	71	72	72	76	78	79	78	79	75	71	76	79
At or above poverty	72	77	79	79	82	81	78	79	79	83	85	84	84	83	81	74	80	84
Location of residence																		
Central city	68	72	74	74	77	77	73	75	75	80	81	81	82	81	80	-	79	83
Remaining areas inside metropolitan statistical area	70	75	78	78	81	79	78	78	80	82	84	84	83	83	80	-	79	81
Outside metropolitan statistical area	70	75	77	77	81	80	79	79	77	81	82	81	83	81	77	-	78	81
Combined series (4:3:1:3:3:1)[6]	-	-	-	-	-	-	-	-	66	73	76	76	77	77	76	70	75	77
Race/Hispanic origin[2]																		
White	-	-	-	-	-	-	-	-	66	74	77	76	78	78	75	69	74	77
Black	-	-	-	-	-	-	-	-	62	68	71	76	74	75	73	67	75	75
Hispanic	-	-	-	-	-	-	-	-	66	71	76	76	77	78	78	73	77	77
Asian	-	-	-	-	-	-	-	-	74	76	80	77	76	79	82	70	74	83
American Indian or Alaska Native	-	-	-	-	-	-	-	-	NA	69	67	NA	74	83	77	73	77	72
Poverty status																		
Below poverty	-	-	-	-	-	-	-	-	62	70	73	74	74	75	72	68	74	74
At or above poverty	-	-	-	-	-	-	-	-	66	74	77	77	78	78	78	70	76	79
Location of residence																		
Central city	-	-	-	-	-	-	-	-	64	72	75	75	77	77	77	-	75	78
Remaining areas inside metropolitan statistical area	-	-	-	-	-	-	-	-	68	74	78	78	78	78	76	-	75	76
Outside metropolitan statistical area	-	-	-	-	-	-	-	-	61	70	74	74	75	76	74	-	75	77
Individual vaccines																		
DTP/DT/DTaP (4 doses or more)[3]	76	78	81	82	84	83	82	82	82	85	86	86	85	85	85	84	84	85
Polio (3 doses or more)	83	88	91	91	91	90	90	89	90	92	92	92	93	93	94	93	93	94
Measles-Mumps-Rubella	89	90	91	90	92	92	91	91	92	93	93	92	92	92	92	90	92	92
Hib (3 doses or more)[4]	86	91	91	93	93	94	93	93	93	94	94	94	93	93	91	84	90	94
Hepatitis B	37	68	82	84	87	88	90	89	90	92	92	93	93	93	94	92	92	91
Varicella (Chickenpox)[5]	-	-	-	26	43	58	68	76	81	85	88	88	89	90	91	91	90	91

continued on next page

"-" Indicates no data available; NA (Not Available) indicates that the sample size for this group was too small to produce reliable estimates.
1 The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib)
2 Persons of Hispanic origin may be of any race. These estimates for the years 2000-2011 have been revised to reflect the new OMB race definitions and only include those who are identified with a single race.
3 Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diptheria and tetanus toxoids and acellular pertussis vaccine
4 Haemophilus influenzae type b vaccine (Hib)
5 Data collection for Varicella began in July 1996
6 The 4:3:1:3::3:1 combined series measures the number of children who have received 6 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine (DTP), 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, 3 or more doses of Haemophilus influenzae type b vaccine (Hib), three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella.
Notes: Final estimates of data from the National Immunization Survey include an adjustment for children with missing immunization provider data. Poverty status is based on family income and family size using Bureau of the Census poverty thresholds. Children missing information about poverty status were omitted from analysis by poverty level. In 2000, 14.2 percent of all children, 17.9 percent of Hispanic, 12.1 percent of non-Hispanic white, and 16.1 percent of non-Hispanic black children were missing information about poverty status and were omitted.
Sources: Data for 1994 from: Eberhardt MS, Ingram DD, Makuc DM, et al. Health, United States, 2001, with Urban and Rural Healthbook. Hyattsville, Maryland: National Center for Health Statistics. 2001: Table 73. Data for 1995-2001 from: National Center for Health Statistics. (2003) Health United States, 2003 With Chartbook on Trends in the Health of Americans. National Center for Health Statistics. 2003. Table 71. Data for 2002 and 2003 and race estimates for 2000 and 2001 from: National Immunization Program (2003). Immunization Coverage in the U.S. Results from National Immunization Survey. Centers for Disease Control and Prevention. http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis. Data for 2003: National Immunization Program (2004). Immunization Coverage in the U.S.: Results from National Immunization Survey. Centers for Disease Control and Prevention. http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis. Data for 2004-2011 Centers for Disease Control and Prevention, National Immunization Program ,NIS data, tables, Jan-Dec . /www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

Percentage of Infants Whose Mothers Breastfeed: 2007

	Ever breastfed	Breastfed at 6 months	Breastfed at 12 months
Total	75	44	23
Sex of infant			
Male	75	43	22
Female	75	44	23
Birth order			
First born	75	44	24
Not first born	76	42	21
Race/Hispanic origin[1]			
White	76	45	23
Black	58	28	13
Hispanic	81	46	25
Asian or Pacific Islander	83	56	33
American Indian or Alaskan Native	74	42	21
Receiving WIC			
Yes	68	34	18
No, but eligible	78	48	31
No, and ineligible	85	54	28
Maternal age			
Less than 20	60	22	11
Ages 20 to 29	70	33	16
30 and older	79	51	27
Maternal education			
Less than high school	67	37	22
High school	66	31	15
Some college	77	41	21
College graduate	88	60	31
Maternal marital status			
Married	82	52	28
Unmarried2	61	26	12
Poverty income ratio[3]			
Poverty level and below	67	35	19
101% - 184% FPL	71	37	19
185% - 349% FPL	78	45	24
350% FPL and above	84	54	27

1 Asians, Pacific Islanders, American Indians, and Alaska Natives include Hispanics.
2 Includes widowed, seperated, divorced, deceased, and never married.
3 This equals the ratio of the self-reported family income to the federal poverty threshold value, taking into account the number of people in in the household.
Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.

Percentage of Children, Ages Birth through Three, Using Seat Belts or Other Restraints: Selected Years, 1994-2011

	1994	1996	1998	2000	2002	2004	2005	2006	2007	2008	2009	2010	2011
Infants (under 1 year)	88	85	97	95	99	98	98	98	98	99	98	99	98
Front-facing car seat	-	-	-	-	66	48	49	36	14	12	15	-	11
Rear-facing car seat	-	-	-	-	32	45	45	48	81	86	83	-	86
High-back booster seat	-	-	-	-	1	0	N/A	N/A	N/A	N/A	N/A	-	N/A
Belt or backless booster	-	-	-	-	1	4	1	11	N/A	N/A	N/A	-	N/A
No restraint observed	-	-	-	-	1	2	2	2	2	1	2	-	2
Toddlers (ages 1 through 3)	-	-	-	-	94	93	89	89	96	92	96	94	96
Front-facing car seat	-	-	-	-	62	62	66	67	73	72	76	-	75
Rear-facing car seat	-	-	-	-	4	6	6	3	3	2	3	-	7
High-back booster seat	-	-	-	-	16	2	5	4	9	11	11	-	9
Belt or backless booster	-	-	-	-	13	22	13	15	11	7	7	-	5
No restraint observed	-	-	-	-	6	7	11	11	4	8	4	-	4

Note: Before 2007 and in 2010, NHTSA published the child restraint use rates by age based on the data from the NOPUS. For the years 2007-2011, however, NHTSA's published estimates of child restraint use by age came from the National Survey of the Use of Booster Seats (NSUBS). Since information about age is obtained by interviews in NSUBS and through visual assessment in NOPUS, the former is more accurate.

Sources: Data for 1994-2000: Bondy, N. & Glassbrenner, D. (2001). National Occupant Protection Use Survey: 2000 Controlled Intersection Study. DOT HS 809 318. U.S. Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/809318.pdf. Data for 2002-2004: Glassbrenner, D. (2005). Child restraint use in 2004: Overall results. DOT HS 809 845. U.S Department of Transportation, National Highway Traffic Safety Administration. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/809845.pdf. Data for 2005-2006: Glassbrenner, D. & Ye, J. (2007). Child restraint use in 2006 - Overall results. DOT HS 810 737. U.S Department of Transportation, National Highway Traffic Safety Administration. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/810737.pdf. Data for 2007-2008: National Highway Traffic Safety Administration. (2009). Child restraint use in 2008:Use of correct restraint types. DOT HS 811 132. Available at http://www-nrd.nhtsa.dot.gov/Pubs/811132.pdf. data for 2009: National Highway Traffic Safety Administration. (2010). The 2009 National Survey of the Use of Booster Seats. DOT HS 811 377. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/811377.pdf. Data for 2010: National Highway Traffic Safety Administration. (2011). Occupant restraint use in 2010: Results from the National Occupant Protection Use Survey, Controlled Intersection Study. DOT HS 811 527. Available at: http://www-nrd.nhtsa.dot.gov/Pubs/811527.pdf. Data for 2011: Pickrell, T. M., & Ye, T. J. (2013, January). Occupant Restraint Use in 2011: Results from the National Occupant Protection Use Survey Controlled Intersection Study. (Report No. DOT HS 811 697). Washington, DC: National Highway Traffic Safety Administration.

Number of Infants in Foster Care, Rate per 1,000 Population, Percentage of Infants in Foster Care, Percentage of Infants in Population, 2000-2008

	Number of infants in care	Rate per thousand	Percent of infants in foster care	Percent of population
Total	40,755	10.2	100.0	100.0
Race and Hispanic Origin				
White	12,283	5.7	30.1	53.9
Black	16,028	29.2	39.3	13.7
Hispanic	8,459	8.9	20.8	23.7
Other/Missing	3,985	-	9.8	-
Child Health Status				
Excellent	15,234	-	37.4	-
Very Good	9,030	-	22.2	-
Good	8,845	-	21.7	-
Fair/Poor	7,645	-	18.8	-

Source: Population data from Child Trends calculations from Intercensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/intercensal/national/nat2010.html. Foster care data from Wulczyn, F., Ernst, M., & Fisher, P. (2011). Who are the infantes in out-of-home care? An epidemiological and developmental snapshot. Chicago, IL: Chapin Hall.

Percentage of Children Ages Birth Through Two, by Language Environment

	2006	2007	2008	2009	2010	2011
No one in the household 14 and older speaks English at home or speaks English 'very well'	8.9	8.9	8.6	8.4	8.4	8.0
English-only household	68.4	67.9	68.4	67.7	66.5	66.6
At least one Spanish speaker in household	21.1	21.6	21.2	21.5	22.3	22.0

Note: Categories are not mutually exclusive.
Source: Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.

Number of Adopted Children Ages Birth Through Two, and Percentage by Adoption Type and Race/Hispanic Origin, 2007

Total	101,931
Type	
Private	38
Foster	19
International	42
Relative/kin	14
Race/Hispanic origin	
Non-Hispanic white	29
Hispanic or not white	71

Source: Child Trends' analysis of the National Survey of Adoptive Parents.

Percentage of Children, Ages Birth through Two, Who Ate Meals with Their Families at least 4 Days in the Past Week: 2003, 2007, and 2011/12

	2003	2007	2011/12
Total	79.6	81.8	84.4
Race/Hispanic origin			
White	82.0	85.0	87.7
Black	74.0	70.9	76.5
Hispanic	75.9	81.6	81.5
Other	81.8	78.2	84.0
Poverty level[1]			
Poverty level and below	78.9	79.5	81.4
101 to 200% of poverty level	77.8	78.6	86.0
Above 200% of poverty level	80.7	84.2	85.4
Parental education			
Less than a high school degree	79.6	81.3	82.5
High school degree	78.5	81.2	85.4
More than a high school degree	80.2	82.7	85.2

1 In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' analysis of the National Survey of Children's Health

Percentage of Children, Ages Birth through Two, Who Had A Family Member Read, Sing, or Tell Them Stories In The Past Week, by Number of Days: 2011/12

	Everyday		4 to 6 days		None	
	Sing or tell stories	Read	Sing or tell stories	Read	Sing or tell stories	Read
Total	65.5	46.3	18.4	19.4	4.2	11.6
Race/Hispanic origin						
White	74.4	58.3	15.7	19.7	2.0	6.7
Black	61.8	40.5	23.2	19.3	3.5	9.7
Hispanic	48.4	25.7	22.9	19.5	8.5	21.0
Other	71.6	49.8	14.9	17.9	4.0	12.3
Poverty level						
Poverty level and below	51.9	32.1	21.7	17.9	7.1	16.8
101 to 200% of poverty level	62.3	43.3	19.6	21.2	5.5	11.8
Above 200% of poverty level	74.2	55.4	16.1	19.5	2.1	8.6
Parental education						
Less than a high school degree	49.9	27.9	21.7	15.6	9.1	22.8
High school degree	64.0	43.7	20.3	23.2	3.0	8.3
More than a high school degree	74.6	56.3	16.4	19.0	1.8	8.1

Source: Child Trends' analysis of the National Survey of Children's Health

Use of Television[1] and Electronic Devices[2] by Children Ages Birth Through Two, Percentages by Selected Characteristics, 2011/12

	An hour or more		None	
	Electronic devices	TV	Electronic devices	TV
Total	9.1	47.3	77.8	30.3
Sex				
Male	8.2	47.7	79.4	31.1
Female	10.0	46.9	76.1	29.5
Family structure				
Two biological/adoptive parents	7.7	45.0	78.7	32.5
Single mother	14.8	54.4	74.0	22.9
Other	15.2	65.4	72.1	17.1
Race/Hispanic origin				
White	5.6	44.3	80.1	33.2
Black	18.6	59.4	70.3	18.5
Hispanic	9.2	47.5	79.7	29.0
Other	14.3	49.2	71.3	30.7
Poverty level				
Poverty level and below	11.9	51.9	77.2	25.8
101 to 200% of poverty level	9.3	48.8	79.8	29.1
Above 200% of poverty level	7.5	44.2	77.3	33.2
Parental education				
Less than a high school degree	8.7	47.0	81.2	29.3
High school degree	10.9	50.2	76.1	28.6
More than a high school degree	7.6	45.1	77.4	31.9

1 Time in front of a television includes time watching tv or videos, or playing video games.
2 Usage of electronic devices includes usage of computers, cell phones, handheld video games, and other electronic devices.
Source: Child Trends' analysis of the National Survey of Children's Health

Parental Well-Being

Percentage Distribution of Children Ages Birth to 2, by Resident Parents' Age, by Child's Race and Hispanic Origin, Selected Years, 2007-2012

	2007	2008	2009	2010	2011	2012
Mother's age						
Less than 20	3.0	2.5	2.4	2.3	3.4	0.6
Ages 20-29	46.4	46.2	45.9	46.9	45.8	38.4
Ages 30-39	43.5	43.7	44.1	43.3	43.3	52.1
Ages 40-49	6.3	6.5	6.9	6.7	6.5	7.9
50 or older	0.7	1.0	0.8	0.8	1.0	1.0
White						
Less than 20	1.9	1.4	1.6	1.5	2.0	0.2
Ages 20-29	42.9	42.0	41.1	42.7	41.2	33.8
Ages 30-39	48.0	48.8	48.7	48.1	48.6	56.8
Ages 40-49	6.7	7.0	7.8	7.0	7.1	8.3
50 or older	0.5	0.8	0.9	0.7	1.2	1.0
Black						
Less than 20	5.0	5.1	4.1	3.1	5.3	0.5
Ages 20-29	49.8	53.6	57.6	58.9	54.8	43.3
Ages 30-39	38.5	31.2	31.4	30.5	33.4	46.2
Ages 40-49	5.0	8.3	6.4	6.9	5.2	8.7
50 or older	1.6	1.7	0.5	0.6	1.3	1.4
Hispanic						
Less than 20	5.0	3.8	3.6	3.8	5.6	1.4
Ages 20-29	54.6	53.1	52.0	51.4	51.5	45.3
Ages 30-39	33.7	37.5	38.3	38.4	36.4	46.4
Ages 40-49	6.2	4.7	5.4	5.4	5.6	6.2
50 or older	0.5	0.9	0.7	1.0	0.9	0.7

	2007	2008	2009	2010	2011	2012
Father's age						
Less than 20	0.5	0.6	0.3	0.6	0.7	0.3
Ages 20-29	31.5	32.2	31.3	30.3	30.2	24.5
Ages 30-39	50.7	50.1	51.9	51.3	51.2	54.9
Ages 40-49	14.9	14.5	13.7	15.6	15.3	17.3
50 or older	2.4	2.7	2.7	2.3	2.6	2.9
White						
Less than 20	0.3	0.4	0.2	0.4	0.5	0.5
Ages 20-29	29.9	29.8	29.2	28.9	27.3	22.9
Ages 30-39	53.3	52.8	54.7	54.8	55.4	58.0
Ages 40-49	14.7	14.6	13.4	14.1	14.4	16.2
50 or older	1.9	2.5	2.5	1.8	2.5	2.4
Black						
Less than 20	0.7	1.1	0.5	-	0.6	-
Ages 20-29	24.7	32.2	34.9	30.9	36.9	28.1
Ages 30-39	47.7	43.3	44.8	41.2	38.2	42.7
Ages 40-49	21.3	16.7	16.5	24.1	19.7	25.5
50 or older	5.7	6.8	3.4	3.8	4.7	3.7
Hispanic						
Less than 20	1.1	1.2	0.6	1.2	1.4	0.2
Ages 20-29	42.4	41.5	40.2	37.3	38.2	28.9
Ages 30-39	42.2	43.4	43.6	44.8	44.2	52.8
Ages 40-49	11.3	12.1	12.8	14.5	14.7	15.9
50 or older	3.0	1.8	2.7	2.3	1.6	2.3

Source: Child Trends' calculations using U.S. Census Bureau March Current Population Survey

Population of Children Ages Birth through Two, Percentages by Resident Parents' Education and Child's Race/Hispanic Origin: 2012

	Less than high school	High school diploma or equivalent	Some college, including vocational/technical	Bachelor's degree or higher
Mother's education	15.4	26.2	27.9	30.6
Race/ Hispanic origin				
White	6.3	19.9	30.3	43.6
Black	13.5	34.1	35.0	17.5
Hispanic	33.2	33.1	20.4	13.3
Mexican	40.9	32.2	17.9	9.0
Father's education	15.2	26.9	25.6	32.3
Race/ Hispanic origin				
White	6.6	24.2	28.1	41.1
Black	6.8	36.0	30.1	27.1
Hispanic	37.1	30.9	19.9	12.1
Mexican	39.5	33.3	17.6	9.5

Source: Child Trends' calculations using U.S. Census Bureau March Current Population Survey, 2012, public use data

Percentage of Births that are Unintended,[1] by Characteristics of the Mother, 2002 and 2006-10

	Total unintended		Mistimed births		Unwanted births	
	2002	2006-10	2002	2006-10	2002	2006-10
Total	34.9	37.1	20.8	23.3	14.1	13.8
Age						
15-19	78.4	77.2	56.9	57.9	21.4	19.3
20-24	44.0	50.1	26.9	33.6	17.2	16.5
25-29	27.0	28.3	16.3	15.8	10.4	12.4
30-34	-	22.5	-	11.9	-	10.5
Race/Hispanic origin						
White	28.8	30.7	18.1	21.4	10.7	9.3
Black	50.9	53.5	24.6	30.6	26.2	22.9
Hispanic[2]	43.3	42.9	26.5	24.8	16.8	18.1
Marital status (at birth)						
Ever married	-	25.3	-	16.4	-	8.9
Never married		59.6	-	36.5	-	23.1
Married	23.1	23.4	14.1	16.2	9.0	7.2
Unmarried	55.9	56.4	32.8	33.5	22.5	22.9
Not cohabiting	59.5	66.9	32.6	39.2	26.9	27.7
Cohabiting	51.3	50.7	33.2	30.3	18.1	20.4
Birth order						
First birth	36.1	38.6	27.6	29.9	8.5	8.8
Second birth	28.4	30.6	17.2	19.2	11.3	11.3
Third or higher order birth	41.4	42.9	14.8	19.9	26.6	23.0
Education at time of interview[3]						
Less than high school	41.8	41.1	22.7	17.9	19.1	23.2
High school or GED only	35.8	40.1	19.7	22.8	16.1	17.3
Some college	33.2	36.7	19.3	24.1	13.9	12.6
Bachelor's degree or more	14.5	16.7	8.5	12.6	6.0	4.0
Poverty at time of interview						
0-149% FPL	44.2	46.3	24.4	25.6	19.8	20.7
0-99% FPL	47.2	47.5	24.1	27.2	23.2	20.3
150-299% FPL	34.7	35.0	20.5	23.3	14.2	11.7
300%+ FPL	18.6	17.7	11.7	13.2	7.0	4.5

1 Births that are “unintended” are any births to the mother in the five years before the interview that she indicated were either “unwanted” or “mistimed.” An “unwanted” birth is one where the mother states that she never wanted a child, or did not want a child of that birth order (second, third, etc.). A “mistimed” birth is one where the mother states that the pregnancy occurred too soon.
2 Hispanics may be any race.
3 Refers only to births to mothers who were older than 20 at the time of the interview. "
Source: Mosher W.D., Jones J., Abma J.C. (2012). Intended and unintended births in the United States: 1982–2010. National health statistics reports; no 55. Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf.

Percentage of All Births to Mothers Receiving Late or No Prenatal Care, Selected Years 1970-2009[1]

	1970	1975	1980	1985	1990	1995	2000	2001	2002	2003[2]	2004[2]	2005[2]	2006[2]	2007[3]	2008[3]	2009[3]	2010[3]
Total	7.9	6.0	5.1	5.7	6.1	4.2	3.9	3.7	3.6	3.5	3.6	3.5	3.6	7.1	7.0	6.6	6.2
Race/Hispanic origin[4]																	
White	-	-	3.5	4.0	3.4	2.5	2.3	2.2	2.2	2.1	2.2	2.2	2.3	5.0	4.8	4.5	4.3
Black	-	-	9.7	10.9	11.2	7.6	6.7	6.5	6.2	6.0	5.7	5.6	5.7	11.7	11.3	10.6	10.2
Hispanic[5]	-	-	12.0	12.4	12.0	7.4	6.3	5.9	5.5	5.3	5.4	5.1	5.0	9.3	9.2	8.8	8.1
Asian or Pacific Islander	-	-	6.5	6.5	5.8	4.3	3.3	3.4	3.1	3.0	2.9	2.9	3.1	4.6	5.1	4.7	5.0
American Indian or Alaska Native	28.9	22.4	15.2	12.9	12.9	9.5	8.5	8.1	8.1	7.6	7.9	8.3	8.1	12.5	12.7	11.3	11.4
Age																	
Under 15 years	-	-	-	-	20.3	15.3	16.3	16.8	14.8	15.4	15.4	15.0	15.6	23.2	26.0	22.0	22.0
15-19 years	-	-	-	-	11.9	7.6	7.2	6.9	6.6	6.4	6.3	6.3	6.4	12.0	11.8	11.1	10.6
20-24 years	-	-	-	-	8.0	5.4	5.1	4.9	4.7	4.6	4.6	4.5	4.7	9.4	9.1	8.6	8.2
25-29 years	-	-	-	-	4.4	3.3	3.1	3.1	3.0	3.0	3.0	3.0	3.2	6.2	6.1	5.8	5.5
30-34 years	-	-	-	-	3.4	2.7	2.4	2.3	2.3	2.3	2.3	2.3	2.4	4.7	4.8	4.5	4.3
35-39 years	-	-	-	-	3.8	3.0	2.6	2.6	2.5	2.4	2.5	2.4	2.5	4.6	4.7	4.5	4.4
40 years and over	-	-	-	-	5.6	3.9	3.5	3.4	3.3	3.2	3.3	3.2	3.1	5.6	5.5	5.2	5.3

"-" Indicates data not available.

1 Data for 1970 and 1975 exclude births that occurred in states not reporting prenatal care. All years exclude live births for whom trimester when prenatal care began is unknown. All data are based on the National Vital Statistics System.

2 Data are for the reporting areas that used the 1989 Revision of the U.S. Standard Certificate of Live Birth for prenatal care. Reporting areas that implemented the 2003 revision of the U.S. Standard Certificate of Live Birth are excluded because prenatal care data based on the 2003 revision are not comparable with data based on the 1989 revision. In 2003, 48 states and DC, representing 94 percent of births, used the 1989 revision. In 2004, 41 states and DC, representing 80 percent of births, used the 1989 revision. In 2005 it was 37 states and DC, representing 69 percent of births. In 2006 it was 32 states and DC, representing 65 percent of births. Although New York State began using the 2003 revision in 2004, New York City continued to use the 1989 revision, and is included in these estimates

3 Data are for the reporting areas that used the 2003 Revision of the U.S. Standard Certificate of Live Birth for prenatal care. Reporting areas that did not yet implement the 2003 revision of the U.S. Standard Certificate of Live Birth are excluded because prenatal care data based on the 2003 revision are not comparable with data based on the 1989 revision. In 2007, 21 states, representing 53 percent of births, were using the 2003 revision. In 2008, 27 states, representing 65 percent of births, were. In 2009, 28 states, representing 66 percent of births were using the 2003 revision, and in 2010, 34 states, representing 76 percent of births, were using the 2003 revision. Although New York State began using the 2003 revision in 2004, New York City continued to use the 1989 revision until 2008, and is excluded for 2007.

4 Totals for Asians, Pacific Islanders, American Indians, and Alaska Natives include Hispanics before 1995.

5 Trend data for Hispanics, whites, and blacks are affected by expansion of the reporting area for an Hispanic-origin item on the birth certificate and by immigration. These two factors affect numbers of events, composition of the Hispanic population, and maternal and infant health characteristics. The number of states in the reporting area increased from 22 in 1980, to 23 and the District of Columbia (DC) in 1983-87, 30 and DC in 1988, 47 and DC in 1989, 48 and DC in 1990, 49 and DC in 1991-92, and 50 and DC in 1993 and later years.

Sources: Data for 1970-1990: Eberhart, M. S., Ingram, D. D., Makuc, D. M., et al. (2001). Urban and rural health chartbook: Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. Table 6. Available at: http://www.cdc.gov/nchs/hus/previous.htm. Data for 1995-2010: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

Maternal Mortality Rate[1] (per 100,000 live births), 2010[2]

Total	16.9
Birth certificate format[3]	
States using 2003 birth certificate	17.7
States using 1989 birth certificate	14.1
Race/Hispanic origin	
White	13.9
Black	37.8
Hispanic	11.3
Age of mother	
Younger than 25	9.9
25-34	14.4
35-44	32.0
45 or older	763.8

1 The maternal mortality rate indicates the likelihood of a pregnant woman dying of maternal causes. The number of live births used in the denominator is an approximation of the population of pregnant women who are at risk of a maternal death. “Maternal deaths” are defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." Included in these deaths are ICD–10 codes A34, O00-O95, and O98-O99.
2 Trends over time cannot be evaluated until such time as all states provide data in the same format.
3 Alabama, Alaska, Arizona, Arkansas, Connecticut, Hawaii, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, New Jersey, North Carolina, Rhode Island, Virginia, West Virginia, and Wisconsin used the 1989 certificate in 2010.
Source: Child Trends' analysis of data from CDC WONDER, available at: http://wonder.cdc.gov/

Secure Parental Employment: Percentage of Children Ages Birth Through Two Living with at Least One Parent Employed Full-Time, All Year,[1] 2007-2012

	2007	2008	2009	2010	2011	2012
All children living with parent(s)	74.7	74.2	71.7	67.3	66.6	72.4
Race/Hispanic origin						
White	81.7	81.1	78.7	74.6	75.9	78.5
Black	52.5	54.4	50.6	51.9	43.6	50.5
Hispanic	71.4	68.8	66.7	59.7	59.3	66.0
Poverty status						
Below poverty	-	-	-	-	-	24.9
At or above poverty	-	-	-	-	-	82.3
With two parents working full-time all year	19.6	19.4	18.3	17.6	17.8	17.2
Children living in families maintained by two parents	86.4	86.1	83.8	79.0	79.0	82.4
Race/Hispanic origin						
White	87.9	88.4	86.1	82.4	83.4	84.9
Black	84.3	84.5	79.8	81.0	69.4	77.0
Hispanic	83.2	80.3	78.7	70.7	71.4	78.3
Poverty status						
Below poverty	-	-	-	-	-	44.7
At or above poverty	-	-	-	-	-	88.9
With both parents working full-time all year	25.0	25.0	23.8	23.0	23.2	22.1

	2007	2008	2009	2010	2011	2012
Children living in families maintained by single mothers[2]	30.1	30.4	28.9	27.8	24.1	24.9
Race/Hispanic origin						
White	29.7	26.2	27.2	26.6	25.7	23.3
Black	31.9	34.0	29.7	28.9	22.4	24.3
Hispanic	28.0	27.2	29.4	27.0	22.8	25.7
Poverty status						
Below poverty	-	-	-	-	-	9.4
At or above poverty	-	-	-	-	-	41.1
Children living in families maintained by single fathers[2]	63.6	63.4	53.4	50.8	50.1	58.0
Race/Hispanic origin						
White	79.0	66.3	60.8	53.8	47.6	54.9
Black	35.2	61.1	29.0	37.0	41.5	64.4
Hispanic	56.7	54.6	53.3	50.7	65.5	61.8
Poverty status						
Below poverty	-	-	-	-	-	10.4
At or above poverty	-	-	-	-	-	75.0

1 Full-time, all-year employment is defined as usually working full time (35 hours or more per week) for 50-52 weeks.
2 Includes some families with cohabitating partners who are not biological, adoptive, or step parents.
Source: Child Trends' analysis of Current Population Survey, March Supplement.

Parents of Children Ages Birth Through Two Who Reported Two or More Depressive Symptoms[1] During the Past 30 Days, 2001-2011

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Parents living with another parent	3.3	2.8	2.9	3.1	3.0	3.6	4.0	2.3	2.9	4.1	3.3
Gender											
Male	2.4	2.5	3.0	2.4	3.1	3.6	4.9	-	2.9	4.2	2.4
Female	4.3	3.3	2.8	3.9	2.9	3.5	3.1	-	2.9	4.1	4.2
Poverty status											
At or above poverty	3.5	2.2	2.2	2.6	2.4	2.7	3.8	-	2.0	3.1	2.0
Below poverty	-	-	-	-	-	-	-	-	6.8	9.4	9.9
Single parents	10.7	8.5	9.3	7.3	14.7	4.9	6.1	10.5	8.8	7.9	8.8

1 Depressive symptoms include the following: felt sad, hopeless, worthless, restless, or that everything was an effort all of the time or most of the time during the past 30 days
Source: Child Trends' analysis of National Health Interview Survey data.

Percentage of Parents of Children Ages Birth through Two Who Report Drinking Heavily at Least Once a Month,[1] 2001-2011

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Parents in two-parent families	8.4	8.9	9.6	7.2	8.4	8.1	8.8	9.8	8.7	10.3	9.7
Gender											
Male	15.0	14.9	17.3	12.8	14.2	15.4	14.0	17.7	19.6	17.6	16.7
Female	1.7	3.1	2.3	1.8	2.6	-	3.7	-	-	3.1	2.9
Single parents	6.2	7.9	5.0	4.6	5.1	4.3	6.5	5.1	8.1	7.5	5.7

1 Heavy drinking is defined as drinking five or more alcoholic drinks on one occasion
Source: Child Trends' analysis of National Health Interview Survey data.

Current Smoking[1] Among Resident Parents of Children Ages Birth Through Two, by Family Structure, 2001-2011

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Single parents	31.2	32.5	29.1	34.4	30.1	27.3	28.4	33.8	28.6	28.0	30.2
Race/Hispanic origin											
White	44.3	44.6	49.1	53.8	54.7	42.1	48.6	56.0	44.1	46.7	48.7
Black	21.0	30.1	15.3	19.7	13.9	20.8	22.8	24.8	27.2	21.2	21.0
Hispanic	25.9	15.1	18.7	20.6	16.9	-	9.5	-	11.3	12.0	13.0
Poverty status											
At or above poverty	30.1	27.9	27.4	27.7	24.9	23.2	27.4	30.6	22.3	22.7	30.4
Below poverty	30.8	39.0	33.0	42.0	29.8	31.4	31.7	40.8	35.0	33.0	31.4
Parents living with another parent	20.1	20.0	20.0	17.3	18.5	18.6	16.3	19.9	17.5	18.0	18.4
Gender											
Male	21.5	25.5	25.3	21.4	22.8	23.3	18.3	25.1	22.1	20.7	22.7
Female	18.7	14.7	14.8	13.2	14.1	13.8	14.3	14.5	13.2	15.4	13.4
Race/Hispanic origin											
White	23.7	21.9	22.4	21.0	20.9	22.5	18.9	23.3	22.2	21.1	19.7
Black	13.5	19.9	20.9	14.6	17.5	16.5	19.6	17.7	-	19.6	21.9
Hispanic	13.3	12.7	12.8	7.8	11.7	11.9	9.7	12.9	11.2	11.4	13.3
Poverty status											
At or above poverty	18.9	19.2	18.0	15.9	17.2	17.4	14.3	18.5	16.2	16.2	15.1
Below poverty	32.1	28.1	32.8	25.7	29.6	26.1	29.5	25.0	24.1	29.9	31.5

1 Current smokers are defined as those who have ever smoked 100 cigarettes and currently smoke every day or some days.
Source: Child Trends' analysis of National Health Interview Survey data.

Percentage of Children Ages Birth through Two Whose Parents Report Frequent Stress from Parenting[1]

	2003	2007	2011/12
Total	6.9	7.8	7.1
Sex			
Male	6.7	8.4	7.3
Female	7.1	7.2	6.9
Age			
Less than one	4.2	4.0	5.5
One	7.1	8.9	7.7
Two	9.6	10.7	8.5
Family structure			
Two biological/adoptive parents	6.1	7.3	6.0
Single mother	10.2	9.8	12.2
Race/Hispanic origin			
White	4.2	5.0	3.5
Black	10.0	9.8	9.3
Hispanic	11.7	12.8	13.2
Other	8.6	8.2	6.8
Poverty level[2]			
Poverty level and below	11.7	12.3	13.5
101 to 200% of poverty level	8.2	9.4	5.6
Above 200% of poverty level	4.4	5.2	4.3
Parental education			
Less than a high school degree	15.9	13.3	14.0
High school degree	7.6	7.7	6.7
More than a high school degree	5.2	5.8	4.5
Special health care needs			
No SHCN	6.1	7.2	6.9
SHCN	13.8	14.8	9.6

1 Children qualify as having stressed parents if their parents responded "Usually" or "Always" to one or more of the following statements about their feelings during the past 30 days: "child was much harder to care for than other children"; "often bothered a lot by their child's behavior"; and/or "angry with child"
2 In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' analysis of National Survey of Children's Health

Neighborhood and Family

Percentage of Children Ages Birth through Four Who Live in Concentrated Poverty Areas,[1] 2007-2011

	Category III[2]	Category IV[3]	Total in poverty areas
Total children	23.7	5.1	28.9
Race/Hispanic origin[4]			
White	14.2	1.4	15.6
Black	39.1	14.6	53.7
Asian	14.0	2.2	16.2
American Indian or Alaska Native	38.6	12.6	51.2
Hispanic	36.8	8.1	44.9

Note: Race categories are not mutually exclusive.
1 Concentrated poverty areas are defined as census tracts where 20 percent or more of the population has incomes below the poverty line.
2 Category III poverty areas are defined as census tracts where between 20 and <40 percent of of the population has incomes below the poverty line.
3 Category IV poverty areas are defined as census tracts where between 40 percent or more of of the population has incomes below the poverty line.
4 Hispanics may be any race. Estimates for all races, except white, may include Hispanics.
Source: Child Trends' analysis of the American Community Survey, available at American Factfinder: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml.

Parent Report of Unsafe Neighborhoods,[1] Among Children ages Birth though Two: 2003, 2007 and 2011/12

	2003	2007	2011/12
Total	15.8	13.7	12.8
Gender			
Male	15.3	13.5	13.8
Female	16.2	14.0	11.8
Race/Hispanic origin			
White	8.2	8.3	6.9
Black	30.4	23.8	20.5
Hispanic	26.2	21.2	20.6
Other	17.9	13.4	12.6
Poverty level[2]			
Poverty level and below	26.4	21.2	21.3
101 to 200% of poverty level	20.5	17.7	15.9
Above 200% of poverty level	9.4	8.9	6.9
Parental education			
Less than a high school degree	28.1	21.3	18.8
High school degree	24.7	17.1	14.0
More than a high school degree	10.3	9.5	9.0
People in neighborhood help each other out			
Definitely agree	6.7	6.3	5.7
Somewhat agree	14.4	15.6	12.5
Somewhat disagree	29.4	22.8	29.4
Definitely disagree	47.7	38.6	38.0

1 Children in unsafe neighborhoods refers to children whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"
2 In 2003, income categories were the following: below poverty, 100 to 199% of poverty level, and 200% of poverty and above.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Percentage of All Births that were to Unmarried Women, by Race and Hispanic Origin, Selected Years, 1960-2011

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Births	5.3	7.7	10.7	14.3	18.4	18.9	19.4	20.3	21.0	22.0	23.4	24.5	25.7	27.1	28.0	29.5	30.1	31.0	32.6	32.2	32.4	32.4	32.8	33.0	33.2
Race/Hispanic origin																									
White	-	-	-	-	9.6	10.0	10.5	11.0	11.5	12.4	13.5	14.3	15.2	16.1	16.9	18.0	18.5	19.5	20.8	21.2	21.5	21.5	21.9	22.1	22.1
Black	-	-	-	-	57.3	-	-	-	-	62.1	-	-	-	-	66.7	68.2	68.4	68.9	70.7	70.0	70.0	69.4	69.3	69.1	68.7
Hispanic	-	-	-	-	23.6	24.5	25.6	27.5	28.3	29.5	31.6	32.6	34.0	35.5	36.7	38.5	39.1	40.0	43.1	40.8	40.7	40.9	41.6	42.2	42.7

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
33.5	34.0	34.6	35.8	36.8	38.5	39.7	40.6	41.0	40.8	40.7
22.5	23.0	23.6	24.5	25.4	26.6	27.8	28.7	29.0	29.3	29.0
68.6	68.4	68.5	69.3	69.5	70.7	71.6	72.3	72.8	72.4	72.3
42.5	43.5	45.0	46.4	47.9	49.9	51.3	52.6	53.2	52.8	53.3

1 Data for estimates before 1980 are based on the race/ethnicity of the child, from 1980 on estimates are based on the race/ethnicity of the mother. Before 1980 data for the mother's marital status was estimated for the United States from data for registration areas in which marital status of mother was reported. For 1980 on, data for States in which the mother's marital status was not reported were inferred from other items on the birth certificate and included with data from the reporting States.
2 Excludes data for New Hampshire and Oklahoma which did not report Hispanic origin on the birth certificate
3 Includes births to Aleuts and Eskimos"
Sources: Data for non-Hispanic whites and for Hispanics in 1980 and 1985, Asian and Pacific Islanders 1980-2001, and American Indian and Alaskan Native 1970-2001 from: National Center for Health Statistics. Health, United States 2002 With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland. 2002. Table 9; All other data for 1960-1998 from Ventura SJ, Bachrach CA. Nonmarital childbearing in the United States, 1940-1999. National Vital Statistics Reports; vol 48 no 16. Hyattsville, Maryland: National Center for Health Statistics. 2000. Table 4; Data for 1999-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm Preliminary data for 2011: Hamilton, B. E., Martin, J. A., Ventura, S. J. (2012). Births: Preliminary data for 2011. National Vital Statistics Reports, 61 (5). Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf

Birth Rates (Births per 1,000) for Females Ages 10-19, Selected Years 1960-2011

	1960	1970	1980	1990	1991	1996	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
15-to-19-year-olds	89.1	68.3	53.0	59.9	61.8	53.5	45.0	42.6	41.1	40.5	39.7	41.1	41.5	40.2	37.9	34.2	31.3
Race/Hispanic origin																	
White	-	-	41.2	42.5	43.4	37.6	30.3	28.6	27.4	26.7	26.0	26.7	27.2	26.7	25.7	23.5	21.7
Black	-	-	-	116.2	118.2	91.9	73.1	67.7	63.7	61.8	59.4	61.9	62.0	60.4	56.7	51.5	47.3
Hispanic	-	-	82.2	100.3	104.6	94.6	84.4	80.6	78.4	78.1	76.5	77.4	75.3	70.3	63.6	55.7	49.6
Asian or Pacific Islander1	-	-	26.2	26.4	27.3	23.5	19.3	17.7	16.4	16	15.4	15.3	14.8	13.8	12.6	10.9	10.2
American Indian[1]	-	-	82.2	81.1	84.1	68.2	54.7	51	49.2	47.4	46	47.0	49.4	47.4	43.8	38.7	36.1
Live-birth order[2]																	
First births	-	-	-	-	-	-	36.1	34.0	33.2	32.9	32.5	33.7	34.2	33.5	31.7	28.0	25.7
Second births	-	-	-	-	-	-	8.2	7.5	7.1	7.0	6.8	7.0	7.1	6.8	6.3	5.4	4.8
10-to-14-year-olds	0.8	1.2	1.1	1.4	1.4	1.2	0.8	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.4	0.4
Race/Hispanic origin																	
White	-	-	0.4	0.5	0.5	0.4	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Black	-	-	-	5.0	4.9	3.6	2.1	1.9	1.6	1.6	1.6	1.5	1.4	1.4	1.1	1.0	0.9
Hispanic	-	-	1.7	2.4	2.4	2.4.	1.5	1.4	1.3	1.2	1.3	1.2	1.2	1.1	1.0	0.8	0.7
Asian or Pacific Islander[1]	-	-	0.3	0.7	0.8	0.6	0.2	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.1	0.1	0.1
American Indian[1]	-	-	1.9	1.6	1.6	1.6	0.9	0.8	0.9	0.8	0.8	0.7	0.7	0.7	0.6	0.5	0.5
15-to-17-year-olds	43.9	38.8	32.5	37.5	38.6	33.3	24.5	23.1	22.2	21.8	21.1	21.6	21.7	21.1	19.6	17.3	15.4
Race/Hispanic origin																	
White	-	-	22.4	23.2	23.6	20.6	14.0	13.1	12.4	12	11.5	11.8	11.9	11.6	11.0	10.0	9.0
Black	-	-	-	84.9	86.1	64.8	44.8	40.6	38.2	36.4	34.1	35.2	34.6	33.6	31.0	27.4	24.6
Hispanic	-	-	52.1	65.9	69.3	64.2	51.9	49.3	47.6	47.3	45.8	45.1	44.1	42.2	37.3	32.3	28.0
Asian or Pacific Islander[1]	-	-	12.0	16.0	16.3	14.7	10.1	8.8	8.5	8.4	7.7	8.2	7.4	7	6.3	5.1	4.6
American Indian[1]	-	-	51.5	48.5	51.9	42.7	30.3	28.9	28	26.7	26.3	26.0	26.2	25.9	23.7	20.1	18.2
18-to-19-year-olds	166.7	114.7	82.1	88.6	94.0	84.7	75.5	72.2	69.6	68.7	68.4	71.2	71.7	68.2	64.0	58.2	54.1
Race/Hispanic origin																	
White	-	-	67.7	66.6	70.6	64.0	54.7	52	50	48.6	48.0	49.4	50.4	48.6	46.2	42.5	39.9
Black	-	-	-	157.5	162.2	134.1	115.8	109.5	103.4	101.5	100.2	105.0	105.2	100.0	93.5	85.6	78.8
Hispanic	-	-	126.9	147.7	155.5	140.0	131.3	127.1	124.8	124.8	124.4	128.7	124.7	114.0	103.3	90.7	81.5
Asian or Pacific Islander[1]	-	-	46.2	40.2	42.2	36.8	31.9	29.9	27.3	26.6	26.4	25.4	24.9	22.9	20.9	18.7	18.1
American Indian[1]	-	-	129.5	129.3	134.2	113.3	93.1	85.6	82.3	80.1	78.1	81.0	86.4	80.4	73.6	66.1	61.6

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- indicates no data available
1 Totals for Asians, Pacific Islanders, and American Indians include Hispanics.
2 Rates for first and second births are based on all women ages 15 to 19.
Sources: Data for 1960: Martin, J.A., Hamilton, B.E., Ventura, S.J., Menacker, F., and Park, M.M. (2002). Births: Final data for 2000. National Vital Statistics Reports, 50. Hyattsville, Maryland: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_05.pdf. Data for 1960 and for white and Hispanic birth rates in 1980 from: National Center for Health Statistics. Health, United States, 2009. Table 4. http://www.cdc.gov/nchs/hus.htm. Data for 1986-2010 by race and age, and all data for 2011: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., & Mathews T. J. (2013). Births: Final data for 2011. National Vital Statistics Reports, 62(1). Hyattsville, MD: National Center for Health Statistics. Available at ttp://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf. Birth order for 2001 from: Hamilton, B.E., Sutton, P.D., and Ventura, S.J. (2003). Revised birth and fertility rates for the 1990s and new rates for Hispanic populations, 2000 and 2001: United States. National Vital Statistics Reports, 51(12). Hyattsville, Maryland: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_12.pdf. Birth order data for 2002: Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Menacker, F., and Munson, M.L. (2003). Births: Final data for 2002. National Vital Statistics Reports, 52(10). Hyattsville, Maryland: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_10.pdf. Birth order data for 2003: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2005). Births: Final data for 2003. National Vital Statistics Reports, 54(2). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf. Birth order data for 2004: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2006). Births: Final data for 2004. National Vital Statistics Reports, 55(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_01.pdf. Bbirth order data for 2005: Hamilton, B.E., Martin, J.A., and Ventura, S.J. (2007). Births: Final data for 2005. National Vital Statistics Reports, 56(6). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf. Birth order data for 2006: Martin, J.A., Hamilton, B.E., Sutton, P.D., et al. (2009). Births: Final data for 2006. National Vital Statistics Reports, 57(7). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf. Birth order data for 2007: Hamilton, B.E., Martin, J.A., and Ventura, S.J. (2009). Births: Final data for 2007. National Vital Statistics Reports, 58(24). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_24.pdf. Birth order data for 2008: Martin, J. A., Hamilton, B. E., Sutton, P. D., and Ventura, S. J. (2010). Births: Final data for 2008. National Vital Statistics Reports, 59(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_01.pdf. Birth order data for 2009: Martin, J. A., Hamilton, B. E., Ventura, S. J., et al. (2011) Births: Final data for 2009. National Vital Statistics Reports, 60(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01.pdf. Birth order data for 2010: Martin J. A., Hamilton B. E., Ventura S. J., Osterman, M. J. K., Wilson E. C., and Mathews T. J. (2012). Births: Final data for 2010. National Vital Statistics Reports, 61(1). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf.

Percentage of Children Ages Birth Through Two, by Family Structure, 2012

	Two biological, step-, or adoptive parents	Single mother	Single father	No parent present
Total	73.4	21.8	1.9	2.9
Race/Hispanic origin				
White	82.9	13.0	1.8	2.3
Black	42.0	50.2	1.9	5.9
American Indian and Alaskan Native	45.7	35.3	5.7	13.4
Asian	91.6	6.1	1.6	0.7
Hispanic	70.2	25.5	1.8	2.5
Poverty level				
Poor (<100 FPL)	46.4	45.7	2.0	5.9
Near poor (100-199 FPL)	71.3	22.8	3.1	2.8
Not poor (200 FPL or more)	87.9	9.3	1.4	1.3

Note: Single mother and father includes cases where the parent is cohabiting and there has been no formal adoption.
Source: Child Trends' analysis of Current Population Survey, March Supplement.

Percentage of Children Ages Birth Through Two, by Family Structure, 2007-2012

	2007	2008	2009	2010	2011	2012
Two biological, step-, or adoptive parents	76.2	75.2	74.6	74.1	74.4	73.4
Single mother	19.6	19.9	20.4	21.1	20.8	21.8
Single father	1.6	2.1	1.9	1.8	1.8	1.9
No parent present	2.5	2.8	3.1	3.0	3.1	2.9

Source: Child Trends' analysis of Current Population Survey, March Supplement.

Percentage of Children Ages Birth Through Two, by Family Structure, 2011/12

	Cohabitating parents	Married parents	Single parent or other
Total	**16.4**	**64.2**	**19.5**
Age			
Less than one	17.7	64.9	17.4
One	14.2	65.2	20.6
Two	17.3	62.1	20.6
Race/Hispanic origin			
White	10.4	78.4	11.2
Black	14.5	31.8	53.7
Hispanic	29.7	49.5	20.8
Other	13.0	71.0	16.0
Poverty level			
Poverty level and below	29.9	32.8	37.2
101 to 200% of poverty level	17.6	61.7	20.8
Above 200% of poverty level	8.5	82.3	9.2
Parental education			
Less than a high school degree	29.2	47.2	23.7
High school degree	18.2	59.6	22.3
More than a high school degree	9.2	75.4	15.3
Special health care needs			
No SHCN	16.5	65.4	18.2
SHCN	14.9	51.2	34.0
Adverse experiences			
None	12.9	75.0	12.1
One	25.4	48.1	26.5
Two	17.9	25.7	56.4
Three or more	16.7	19.1	64.2

Source: Child Trends' analysis of the National Survey of Children's Health.

Percentage of Children Ages Birth through Two Who Live in Households Headed by Grandparents, 2006-2011

	2006	2007	2008	2009	2010	2011
Total	13.9	14.0	14.9	15.9	16.8	16.4
Race/Hispanic origin						
White	9.3	9.2	10.2	10.5	11.5	11.0
Black	22.5	22.3	23.2	24.5	25.0	23.9
Asian	17.9	18.7	17.7	20.4	21.9	21.8
American Indian and Alaska Native	27.2	26.3	31.8	30.6	33.6	30.2
Pacific Islander	26.3	23.3	39.6	16.8	22.7	16.4
Two or more races	17.5	16.8	17.7	17.8	17.0	17.9
Hispanic	17.8	18.1	18.7	20.9	21.5	21.6
Other	16.0	16.8	12.7	15.5	18.6	11.9
Income						
Poor	13.7	14.2	13.7	15.0	15.7	15.9
Low income	17.0	16.8	18.3	20.1	21.8	21.1
Not poor	12.9	12.8	14.0	14.7	15.3	14.8

Source: Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.

Public/Private Supports

Working During Pregnancy, and Maternal Leave-Taking, by Race/Hispanic Origin, 2006-10

	Percentage of women that worked during pregnancy	Percentage of working women that took maternity leave	Average length of leave among women who took leave	Percentage of women who took leave and no portion was paid	Percentage of women who took leave and 9 or more weeks were paid
Total	64.6	67.1	10.1	37.2	17.2
White	70.8	69.7	10.1	35.2	17.5
Black	65.5	61.3	10.0	36.3	19.2
Hispanic	49.4	62.3	9.5	45.2	13.0
Other	58.2	69.4	10.9	40.5	20.0

Source: Child Trends' analysis of the National Survey of Family Growth.
Note: Data refer to the woman's last pregnancy that resulted in a live birth and was not put up for adoption; within the past five years.

Infants and Toddlers Served by Early Head Start and Migrant and Seasonal Head Start, Program Years 2008-2012

	2008	2009	2010	2011	2012
Total served	112,420	108,108	146,275	173,981	176,386
Infants	30,366	28,522	42,361	49,581	49,114
Toddlers	82,054	79,586	103,914	124,400	127,272
Percent of eligible population served[1]	3.9	3.5	4.7	5.8	-
Infants	3.1	2.8	4.0	5.0	-
Toddlers	4.4	3.8	5.1	6.2	-

1 Head Start guidelines require that at least 90% of children enrolled live at or below 100% FPL. The other 10% do not have income restrictions. The figures here are based on the number of infants and toddlers living below 100%FPL.
Sources: Head Start Data: HHS/ACF/OHS. (2012). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Eligiblity data: Child Trends' analysis of the Current Population Survey, March Supplement. Down-loaded from: http://www.census.gov/cps/data/cpstablecreator.html.

Average Annual Pay[1] of Child Care Workers: 2000-2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Annual pay													
Child care workers	$16,350	$16,890	$17,310	$17,400	$17,830	$18,180	$18,820	$19,670	$20,350	$20,940	$21,110	$21,320	$21,310
Preschool teachers[2]	$20,100	$20,940	$21,730	$22,190	$23,940	$25,150	$25,900	$25,800	$26,610	$27,450	$29,200	$30,150	$30,750
Kindergarten teachers[2]	$40,230	$41,100	$42,040	$42,380	$44,000	$45,250	$47,040	$47,750	$49,770	$50,380	$51,550	$52,350	$53,030

1 Data are are not adjusted for inflation.
2 These figures do not include special education teachers
Source: Bureau of Labor Statistics. {various years} Occupational employment and wages. Available at: http://www.bls.gov/schedule/archives/all_nr.htm#OCWAGE.

Infants and Toddlers Served by Head Start Programs, School Years 2008-2012

	2008	2009	2010	2011	2012
Total served	112,420	108,108	146,275	173,981	176,386
Infants	30,366	28,522	42,361	49,581	49,114
Toddlers	82,054	79,586	103,914	124,400	127,272
Percent of eligible population served[1]	3.9	3.5	4.7	5.8	-
Infants	3.1	2.8	4.0	5.0	-
Toddlers	4.4	3.8	5.1	6.2	-

1 Head Start guidelines require that at least 90% of children enrolled live at or below 100% FPL. The other 10% do not have income restrictions. The figures here are based on the number of infants and toddlers living below 100%FPL.
Sources: Head Start Data: HHS/ACF/OHS. (2012). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Eligiblity data: Child Trends' analysis of the Current Population Survey, March Supplement. Downloaded from: http://www.census.gov/cps/data/cpstablecreator.html.

Percentage of Children with Employed Mothers, Ages Birth through Four, by Primary Type of Care Arrangement, Selected Years, 1993-2011

	1993	1995	1997	1999	2002	2005	2010	2011
Parental care[1]	22.1	24.1	23.5	22.5	21.5	22.8	24.8	24.4
Race/Hispanic origin[2]								
White	24.5	25.7	26.2	23.9	23.5	25.6	24.9	24.7
Black[3]	11.8	13.2	13.1	15.8	15.2	15.9	19.8	17.4
Hispanic	18.0	23.9	19.9	23.5	18.2	18.5	25.4	29.4
Asian[3]	-	-	-	17.7	21.7	14.6	30.1	26.9
Poverty status								
Below 100% federal poverty level (FPL)	24.4	27.7	25.8	19.0	25.1	29.4	22.3	26.1
100-199% FPL	28.4	27.1	28.9	27.2	24.6	24.6	31.9	31.0
200% FPL and above	19.8	22.7	21.4	21.5	20.0	20.8	23.1	21.3
Family type								
Two married parents	26.2	26.7	27.4	26.2	24.6	25.7	27.7	27.2
Mother only	3.4	15.3	11.5	12.7	12.8	15.4	17.5	
Age of child								
Less than 1 year	17.5	24.2	27.6	28.3	25.7	25.6	28.9	27.5
1-2 years	22.5	26.2	24.2	24.0	24.0	22.8	24.9	23.1
3-4 years	21.0	21.9	21.2	18.9	17.5	21.7	23.0	24.4
Mother's highest level of education								
Less than high school graduate	23.2	27.2	23.3	17.4	24.1	28.6	29.5	21.9
High school graduate/GED	22.9	24.5	23.7	27.0	23.1	21.7	27.4	25.4
Vocational/technical or some college	23.7	25.3	25.3	21.3	23.1	23.0	27.5	27.5
College graduate	19.0	21.5	21.3	21.3	17.7	21.9	20.4	21.7

	1993	1995	1997	1999	2002	2005	2010	2011
All regular non-parental care[4]	76.8	82.1	72.1	74.3	69.1	69.4	68.1	67.2
Race/Hispanic origin[2]								
White	74.8	79.3	69.7	73.4	66.4	67.3	67.6	66.8
Black[3]	86.2	102.9	81.5	80.4	79.0	76.7	71.8	73.4
Hispanic	79.8	76.2	74.3	70.6	71.3	70.6	71.5	61.9
Asian[3]	-	-	-	79.3	71.8	75.5	61.6	66.8
Poverty status								
Below 100% federal poverty level (FPL)	74.5	81.7	68.7	77.2	65.2	61.4	66.8	63.9
100-199% FPL	67.5	77.0	65.9	69.5	65.3	66.1	60.5	61.6
200% FPL and above	79.2	83.8	74.7	75.1	72.5	72.5	71.7	70.7
Family type								
Two married parents	72.7	77.8	67.5	70.1	64.8	65.9	63.8	63.8
Mother only	91.7	94.9	85.7	85.1	81.6	78.5	84.1	
Age of child								
Less than 1 year	75.5	80.8	67.0	68.0	63.0	67.5	62.3	65.1
1-2 years	77.4	79.8	73.7	75.2	68.6	70.3	70.8	72.0
3-4 years	76.5	85.0	72.7	75.2	74.5	69.4	67.6	62.9
Mother's highest level of education								
Less than high school graduate	76.0	80.3	70.2	79.6	65.1	57.6	63.0	58.2
High school graduate/GED	76.0	82.1	70.6	70.9	66.9	70.6	67.3	66.3
Vocational/technical or some college	75.0	79.9	70.8	74.1	69.2	71.5	64.1	66.1
College graduate	79.8	84.7	75.5	75.6	72.2	68.6	73.0	70.4

"—" Not available.

1 Parental care includes care only during mother's working or school hours.

2 For race and Hispanic-origin data in this table: From 1995 to 2002, following the 1977 Office of Management and Budget (OMB) standards for collecting and presenting data on race, the Survey of Income and Program Participation (SIPP) asked respondents to choose one race from the following: White, Black, American Indian or Alaskan Native, or Asian or Pacific Islander. The Census Bureau also offered an "Other" category. Beginning in 2004, following the 1997 OMB standards for collecting and presenting data on race, the SIPP asked respondents to choose one or more races from the following: White, Black or African American, Asian, American Indian or Alaska Native, or Native Hawaiian or Other Pacific Islander. The Census Bureau also offered an "Other" category. All race groups discussed in this table from 2004 onward refer to people who indicated only one racial identity within the racial categories presented. People who responded to the question on race by indicating only one race are referred to as the race-alone population. The use of the race-alone population in this table does not imply that it is the preferred method of presenting or analyzing data. Data from 2004 onward are not directly comparable with data from earlier years. Data on race and Hispanic origin are collected separately. Persons of Hispanic origin may be of any race.

3 All data for Asians and Blacks include Hispanics, except for in 1995.

4 Non-parental care includes care in home by a relative or non-relative, and center-based care. It does not include self-care, having no regular arrangement, or school. Data may include slight over-estimates, due to ties in calculating the primary type of care.

5 Care in home by a relative includes sibling, grandparent, or other relative care, in either the child or the caregiver's home.

6 Care in home by a non-relative includes care by a non-relative in the child's home and home-based day care.

7 Center-based programs include day care centers, nursery schools, preschools, and Head Start programs. It does not include kindergarten or elementary school.

Sources: Child Trends' calculations based on US Census Bureau. Who's minding the kids? Child care arrangements: Detailed tables {various years}. Survey of Income and Program Participation (SIPP) Data on Child Care. Available at http://www.census.gov/hhes/childcare/data/sipp/index.html.

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	1993	1995	1997	1999	2002	2005	2010	2011
Care in home by a relative[5]	25.3	23.4	27.1	30.1	25.8	27.4	27.2	27.3
Race/Hispanic origin[2]								
White	20.9	21.0	22.6	24.9	20.7	22.5	23.4	24.2
Black[3]	37.2	30.6	38.5	37.9	35.6	31.8	30.7	35.0
Hispanic	38.8	27.2	37.7	38.7	36.7	40.9	41.7	36.2
Asian[3]	-	-	-	58.9	29.1	36.2	21.1	25.3
Poverty status								
Below 100% federal poverty level (FPL)	35.8	33.4	36.6	38.2	35.4	29.9	36.0	33.1
100-199% FPL	25.6	29.7	27.6	39.0	29.1	34.4	32.5	30.0
200% FPL and above	22.5	19.8	25.2	25.7	24.6	24.6	23.8	25.0
Family type								
Two married parents	21.3	20.7	22.4	25.1	23.3	23.6	22.7	23.9
Mother only	40.2	31.2	41.4	43.2	33.6	37.2	38.8	
Age of child								
Less than 1 year	28.0	26.8	30.7	32.3	31.5	32.5	29.0	30.4
1-2 years	28.7	24.2	29.1	30.5	27.6	27.7	30.3	31.1
3-4 years	21.1	21.2	23.7	28.7	24.6	25.2	23.3	21.8
Mother's highest level of education								
Less than high school graduate	36.2	35.6	37.4	47.1	28.3	32.5	38.4	36.1
High school graduate/GED	30.2	28.5	30.2	34.4	30.4	37.1	33.3	34.3
Vocational/technical or some college	22.7	21.7	27.8	29.9	29.1	29.9	28.7	29.8
College graduate	16.8	16.2	19.3	19.1	17.8	16.6	20.8	20.3

	1993	1995	1997	1999	2002	2005	2010	2011
Care in home by a non-relative[6]	21.6	31.2	22.3	21.1	18.2	16.8	14.7	14.0
Race/Hispanic origin[2]								
White	22.8	31.6	23.7	23.9	20.3	18.7	16.6	16.2
Black[3]	15.7	33.0	14.7	13.4	14.9	13.8	12.1	7.7
Hispanic	19.7	26.5	23.2	20.0	14.1	14.7	12.6	11.3
Asian[3]	-	-	-	8.5	16.6	11.1	12.5	15.4
Poverty status								
Below 100% federal poverty level (FPL)	18.9	18.5	16.3	19.3	13.2	12.3	13.4	11.8
100-199% FPL	17.2	23.7	19.5	15.4	14.6	10.5	10.5	9.4
200% FPL and above	23.3	35.3	24.4	23.5	20.3	19.8	16.5	16.4
Family type								
Two married parents	21.4	31.7	23.3	22.1	18.0	17.0	14.9	14.4
Mother only	22.0	29.3	19.0	18.7	18.8	16.4	15.5	
Age of child								
Less than 1 year	28.3	38.3	22.7	19.7	16.5	18.4	16.8	19.5
1-2 years	24.4	31.0	24.0	24.0	19.7	18.6	16.3	14.5
3-4 years	16.0	28.5	20.4	18.9	17.4	14.5	12.1	11.2
Mother's highest level of education								
Less than high school graduate	19.5	23.0	19.3	14.2	18.0	12.5	15.5	10.0
High school graduate/GED	19.2	25.4	20.7	15.7	15.4	13.7	13.0	12.3
Vocational/technical or some college	20.2	30.0	18.5	23.6	15.9	16.2	10.8	14.1
College graduate	27.0	40.2	29.6	26.6	23.3	20.6	19.2	15.6

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	1993	1995	1997	1999	2002	2005	2010	2011
Center-based program[7]	29.9	27.5	22.7	23.1	25.1	25.2	26.2	25.9
Race/Hispanic origin[2]								
White	31.1	26.7	23.4	24.6	25.4	26.1	27.5	26.4
Black[3]	33.3	39.3	28.3	29.1	28.5	31.1	29.0	30.7
Hispanic	21.3	22.5	13.4	11.9	20.5	15.0	17.2	14.4
Asian[3]	-	-	-	11.9	26.1	28.2	28.0	26.1
Poverty status								
Below 100% federal poverty level (FPL)	19.8	29.8	15.8	19.7	16.6	19.2	17.3	19.0
100-199% FPL	24.7	23.6	18.8	15.1	21.6	21.2	17.5	22.2
200% FPL and above	33.4	28.7	25.1	25.9	27.6	28.1	31.4	29.3
Family type								
Two married parents	30.0	25.4	21.8	22.9	23.5	25.3	26.2	25.5
Mother only	29.5	34.4	25.3	23.2	29.1	24.9	29.9	
Age of child								
Less than 1 year	24.3	24.6	20.6	20.7	21.3	24.0	24.2	26.4
1-2 years	39.4	35.3	28.6	27.6	32.5	29.7	32.2	29.9
3-4 years								
Mother's highest level of education								
Less than high school graduate	20.3	21.7	13.5	18.3	18.8	12.6	9.1	12.1
High school graduate/GED	26.6	28.2	19.7	20.8	21.1	19.8	21.0	19.7
Vocational/technical or some college	32.1	28.2	24.5	20.6	24.2	25.4	24.6	22.2
College graduate	36.0	28.3	26.6	29.9	31.1	31.4	33.0	34.5

Number and Percentage of Eligible Infants and Toddlers Served by a Child Care Subsidy Program: 1999-2011

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
Total infants and toddlers served	429,900	471,900	507,900	505,500	472,900	469,400	488,900	495,600	494,900	486,800	499,900	511,800	464,200
Infants	82,700	87,400	108,800	104,600	87,600	86,900	104,800	106,200	102,400	97,400	96,500	95,400	81,100
Toddlers	347,200	384,500	399,000	400,900	385,300	382,400	384,100	389,400	392,500	389,400	403,500	416,300	383,000
Percent of eligible infants and toddlers served[1]	-	9.6	11.2	10.8	10.1	9.7	9.5	10.0	9.1	8.0	8.4	9.5	9.2

*Data for 2011 are preliminary and may be modified at a later date.
1 Eligibility for subsidy differs across states. The data presented here is based on infants and toddlers living at or below 185% FPL, as this is the eligibility criteria for most social services.
Sources: Data for child care subsidies: ACF 801 administrative data (total number of children served multiplied by the % in each age range). Office of Child Care, Administration for Children and Families, Department of Health and Human Services. Child care and development fund statistics. Available at: http://www.acf.hhs.gov/programs/occ/resource/ccdf-statistics. Eligibility data: Child Trends analysis of the Current Population Survey, December Food Security Supplement.

Number of States that Have Selected Quality Measures for Child Care

	Number of states
Compliant with NAEYC-recommended staff to child ratios	
Infants (1:3 to 1:4)	35
Toddlers (1:4-1:6)	15a
Compliant with NAEYC-recommended group sizes	
Infants (6-8 children)	22
Toddlers (8-12 children)	7a
NACCRA-recommended comprehensive background check required for all child care center staff with regular contact with children[b]	10
Requires all health and safety measures recommended by NACCRRA[c]	34
Requires staff to put infants to sleep on their backs	42
Conducts annual health and safety inspections	44
Requires that child care centers include program activities across all developmental domains[d]	22
State (or jurisdictions within a state) has a quality rating system[e]	35

a Figure provided for 18 month olds.
b NACCRRA recommended Comprehensive background check includes checking FBI records and state criminal records, the state child abuse registry and the child sex offender registry. 30 states require a FBI record check, 28 state criminal record checks, 17 sex offender registry checks, and 44 child abuse registry checks.
c Health and safety requirements recommended by NACCRRA address the following topics: immunizations, positive guidance and discipline, handwashing, fire drills, medication safety, illness/accidents, back to sleep for infants, safety storage of hazardous materials, safe playgrounds, and emergency preparation plans.
d These program activities are not necessarily targeted to infants and toddlers. Developmental domains include: physical, language/literacy, cognitive/intellectual, social, emotional, physical, and cultural. Following is a breakdown of the number of states that require child care centers to offer activities related to each of these developmental domains: physical (47), language/literacy (42), cognitive/intellectual (40), social (39), emotional (39), physical, and cultural (25).
e Personal communication with the QRIS National Learning Network on January 7, 2013.
Sources: 2011 NACCRRA Quality Matters (http://www.naccrra.org/about-child-care/quality-matters) and personal communication with the QRIS National Learning Network.

Current Health Insurance Status[1] of Children Ages Birth Through Two, 2008-2011

	2008	2009	2010	2011	% change, 2008 to 2011
Public insurance	37.1	42.3	44.9	45.6	23
Age					
Less than one	39.7	44.7	46.5	46.7	17
One	36.8	41.9	44.6	45.9	25
Two	34.7	40.5	43.7	44.5	28
Race/Hispanic origin					
White	24.9	29.1	31.2	31.7	27
Black	57.2	63.7	67.7	67.8	19
Hispanic	53.7	60.0	62.5	64.2	20
Asian	19.5	23.4	24.9	25.6	32
American Indian or Alaska Native	51.2	59.6	60.8	60.0	17
Poverty level					
Between 0 and 99% of FPL	76.2	83.1	84.1	85.9	13
Between 100 and 199% FPL	54.1	59.3	62.3	62.8	16
200% or more of FPL	14.1	15.8	16.8	16.6	17
Not specified	69.9	77.8	76.0	79.9	14
Private insurance	57.4	54.8	52.5	52.2	-9
Age					
Less than one	56.3	54.1	52.3	52.4	-7
One	56.9	54.6	52.1	51.4	-10
Two	59.1	55.6	53.0	52.8	-11
Race/Hispanic origin					
White	72.0	69.6	67.4	67.3	-6
Black	38.3	35.0	31.1	31.2	-19
Hispanic	35.2	33.0	31.3	30.7	-13
Asian	75.9	73.9	72.7	72.2	-5
American Indian or Alaska Native	28.0	25.6	25.2	28.1	0
Poverty Level					
Between 0 and 99% of FPL	15.0	12.5	11.9	11.1	-26
Between 100 and 199% FPL	38.0	36.7	34.0	34.5	-9
200% or more of FPL	82.8	82.5	81.8	82.1	-1
Not specified	20.6	17.4	17.4	14.6	-29

	2008	2009	2010	2011	% change, 2008 to 2011
No insurance	8.1	6.4	6.0	5.5	-32
Age					
Less than one	6.8	5.0	4.7	4.3	-36
One	8.7	6.8	6.6	6.0	-31
Two	8.8	7.3	6.6	6.1	-30
Race/Hispanic origin					
White	5.7	4.7	4.7	4.4	-23
Black	7.8	5.4	4.8	4.8	-39
Hispanic	13.4	10.4	9.2	8.2	-39
Asian	5.8	5.3	5.1	4.8	-17
American Indian or Alaska Native	23.0	18.1	19.3	16.5	-28
Poverty Level					
Between 0 and 99% of FPL	12.2	8.1	7.6	6.8	-44
Between 100 and 199% FPL	12.2	9.5	8.7	8.1	-34
200% or more of FPL	4.7	4.2	3.8	3.6	-23
Not specified	12.8	10.0	10.4	9.1	-29

1 Health insurance status is the coverage the child had on the day of the survey.
Source: Child Trends' analysis of American Community Survey, PUMS data.

Percentage of Children and Parents who Received One or More Home Visits During Pregnancy or Before Age Three, 2011/12

Total	13.5
Gender	
Male	14.4
Female	12.6
Race/Hispanic origin	
White	12.9
Black	18.0
Hispanic	13.3
Other	13.2
Poverty level	
Poverty level and below	18.8
101 to 200% of poverty level	14.6
Above 200% of poverty level	10.2
Family structure	
Two biological/adoptive parents	12.0
Single mother	19.8
Parental education	
Less than a high school degree	12.5
High school degree	14.6
More than a high school degree	12.8

Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Number of Infants and Children, Ages Birth Through Four, Served by WIC, Fiscal Years 2008 and 2012

	2008	2009	2010	2011	2012*
Total infants and children served	6,551,318	6,939,384	7,037,186	6,863,682	6,814,092

*2012 are preliminary data
Source: USDA. (2013).Monthly Data: Agency Level, Participation and Program Costs by Category per person. Available at: http://www.fns.usda.gov/pd/wicmain.htm.

Child Recipients of Food Stamps /SNAP Benefits, Ages Birth Through 4 Years, 1997-2011

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Child recipients under 5 (in thousands)[1]	4,046	3,509	3,025	2,846	2,878	3,224	3,541	3,967	4,277	4,243	4,345	4,656	5,403	6,317	6,780
Ages 0-1	-	1,327	1,177	1,132	1,150	1,305	1,396	1,550	1,681	1,718	1,745	1,945	2,182	2,419	2,511
Ages 2-4	-	2,181	1,847	1,714	1,728	1,919	2,145	2,417	2,597	2,525	2,600	2,711	3,221	3,898	4,269
Child recipients under 5 as a percent of:															
Total child population	20.6	17.9	15.4	14.4	14.8	16.3	17.8	19.6	21.3	20.8	20.9	22.1	25.4	31.5	34.0
Children in poverty	91.5	82.4	79.2	78.8	76.3	82.3	84.5	93.0	104.1	100.5	98.6	99.5	103.7	121.7	135.4

1 The number of child participants includes only the participating States and D.C. (the territories are not included). Data from 1980 to 1983 includes participants of the Family Food Assistance Program (FFAP) which was largely replaced by the Food Stamp program in 1975. From 1980 to 1983 the number of FFAP participants averaged only 88,000.
Sources: Data for number of participants: Department of Agriculture, Food and Nutrition Service. (2012). Research: Supplemental nutrition assistance program studies: SNAP household characteristics reports. Available at: http://www.fns.usda.gov/ORA/menu/Published/SNAP/SNAPPartHH.htm. Data for population and poverty population: Child Trends analysis of the Current Population Survey, March Supplement.

Percentage of Children, Ages 10 Months Through Two Years, Who Received a Screener for Developmental Delay[1]

	2007	2011/12
Total	23.0	38.5
Gender		
Male	21.9	38.5
Female	24.2	38.5
Race/Hispanic origin		
White	22.0	38.1
Black	27.3	38.3
Hispanic	21.7	38.3
Other	27.2	41.0
Poverty level		
Poverty level and below	23.9	37.6
101 to 200% of poverty level	24.4	36.6
Above 200% of poverty level	22.0	39.8
Family structure		
Two biological/adoptive parents	21.7	38.6
Single mother	28.0	38.5
Parental education		
Less than a high school degree	21.5	36.9
High school degree	22.7	38.8
More than a high school degree	23.4	39.4
Special health care needs		
Has SHCN	33.5	43.5
No SHCN	21.8	37.8

1 Using a standardized developmental screening tool.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Percentage of Children, Ages Birth Through Two, Who Had a Preventive Medical Visit, and Who Had a Preventive Dental Visit, in the Past 12 Months, 2011/12

	Medical	Dental[1]
Total	90.9	24.7
Age		
Less than one	90.9	-
One	92.5	17.4
Two	89.2	32.9
Sex		
Male	91.7	24.8
Female	90.2	24.5
Race/Hispanic origin		
White	94.2	21.3
Black	88.7	32.9
Hispanic	85.5	29.7
Other	92.6	20.6
Poverty level		
Poverty level and below	83.6	30.9
101 to 200% of poverty level	90.5	23.6
Above 200% of poverty level	95.0	21.5
Family structure		
Two biological/adoptive parents	92.1	24.0
Two parent stepfamily	87.6	30.1
Single mother	97.8	28.6
Parental education		
Less than a high school degree	84.5	31.4
High school degree	90.0	26.8
More than a high school degree	94.7	21.4
Special health care needs		
Has SHCN	96.7	33.2
No SHCN	90.5	23.9

1 Preventive dental visits are measured for children who are one or two years old, who have teeth.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Number and Percentage of Infants and Toddlers Served by Early Intervention Services (Part C), 1995-2012

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total served	177,281	186,527	196,337	187,355	206,108	232,810	245,775	268,735	274,747	284,536	299,042	305,392	321,925	342,985	348,604	342,821	343,000	337,000
Infants	29,786	31,496	34,375	31,089	35,793	36,570	38,338	41,657	39,205	40,905	42,190	43,370	45,371	45,272	44,341	41,069	-	-
Toddlers	147,495	155,031	161,962	156,266	170,315	196,240	207,437	227,078	235,542	243,631	256,852	262,022	276,554	297,713	304,263	301,752	-	-
Percent of population served	1.5	1.6	1.7	1.7	1.8	2.0	2.1	2.3	2.3	2.4	2.5	2.5	2.7	2.8	2.9	2.9	2.9	2.8
Infants	0.8	0.8	0.9	0.8	0.9	0.9	1.0	1.1	1.0	1.0	1.1	1.1	1.1	1.1	1.1	1.0	-	-
Toddlers	1.9	2.0	2.1	2.1	2.3	2.6	2.7	2.9	3.0	3.1	3.2	3.3	3.5	3.7	3.7	3.7	-	-

Sources: Data for 1995-2010: Danaher, J., Goode, S., & Lazara, A. (2011). Part C updates (12th edition). Chapel Hill, NC: The National Early Childhood Technical Assistance Center. Available at: http://ectacenter.org/~pdfs/pubs/partcupdate2011.pdf. Data for 2011-2012: Lazara, A., Danaher, J., & Goode, S. (2013). Part C Infant and Toddler Program: Federal appropriations and national child count 1987-2013. Chapel Hill, NC: The National Early Childhood Technical Assistance Center. Available at: http://www.ectacenter.org/~pdfs/growthcomppartc.pdf. Population data: Child Trends' calculations from Intercensal and postcensal population estimates from the Census Bureau, available at: http://www.census.gov/popest/data/national/totals/2012/index.html and http://www.census.gov/popest/data/intercensal/index.html.