

America's Children in Brief: Key National Indicators of Well-Being, 2016



America's Children in Brief: Key National Indicators of Well-Being, 2016



This year's America's Children in Brief: Key National Indicators of Well-Being continues more than a decade of dedication and collaboration by agencies across the Federal Government to advance our understanding of our Nation's children and what may be needed to bring them a better tomorrow. We hope you find this report useful. The Forum will be releasing its next full report in 2017.

Katherine K. Wallman, Chief Statistician, Office of Management and Budget

Introduction

Each year since 1997, the Federal Interagency Forum on Child and Family Statistics has published a report on the well-being of children and families. The Forum fosters coordination and collaboration among 23 federal agencies that produce or use statistical data on children and families, and seeks to improve federal data on children and families. The *America's Children* series provides accessible compendiums of indicators drawn across topics from the most reliable official statistics; it is designed to complement other more specialized, technical, or comprehensive reports produced by various Forum agencies. The *America's Children* series makes Federal data on children and families available in a nontechnical, easy-to-use format in order to stimulate discussion among data providers, policymakers, and the public.

Pending data availability, the Forum updates all 41 indicators annually on its website (<http://childstats.gov>) and alternates publishing a detailed report, *America's Children: Key National Indicators of Well-Being*, with a summary version, *America's Children in Brief*, which highlights selected indicators. The data in this report come from a variety of sources—featuring both sample and universe surveys—often with different underlying populations, as appropriate for the topic. Indicators are chosen because they are easy to understand, are based on substantial research connecting them to child well-being, cut across important areas of children's lives, are measured regularly so that they can be updated and show trends over time, and represent large segments of the population rather than one particular group. These indicators span seven domains: *Family and Social Environment*, *Economic Circumstances*, *Health Care*, *Physical Environment and Safety*, *Behavior*, *Education*, and *Health*. To provide a more in-depth perspective across report domains, this year's *America's Children in Brief* highlights selected indicators by race and ethnicity.

This report reveals that the adolescent birth rate declined across all race and Hispanic origin groups and the rate of immediate college enrollment increased among White, non-Hispanic; Black, non-Hispanic; and Hispanic high school completers. Poverty rates and percentages of children living in food-insecure homes remain higher for Black, non-Hispanic and Hispanic children than for their White, non-Hispanic counterparts. New this year is a supplemental poverty measure for White, non-Hispanic; Black, non-Hispanic; Hispanic; and Asian, non-Hispanic children. The *Brief* concludes with its usual *At a Glance* summary table displaying the most recent data for all 41 indicators.

For Further Information

The Forum's website (<http://childstats.gov>) provides additional information, including:

- Detailed data, including trend data, for indicators discussed in this *Brief* as well as other *America's Children* indicators not discussed here.
- Data source descriptions and agency contact information.
- *America's Children* reports from 1997 to the present and other Forum reports.
- Links to Forum agencies, their online data tools, and various international data sources.
- Forum news and information on the Forum's overall structure and organization.

Report Coverage

As usual, this year's *America's Children in Brief* highlights selected indicators; however, in addition, this *Brief* looks at these indicators by race and ethnicity. This focused perspective gives the reader both a snapshot of the overall well-being of America's children and a closer look at the differences among the country's race and Hispanic origin groups. The observed differences are not simply a result of the growing demographic diversity of the U.S. population in general and of children in particular; they also reflect the complex interactions among socioeconomic factors, regional influences, and personal circumstances.

Measuring Race and Ethnicity

The Forum strives to consistently report racial and ethnic data across indicators for clarity and continuity. However, data sources in *America's Children in Brief* reflect a variety of classifications and methodologies. In 1997, the Office of Management and Budget (OMB) issued revised standards for data on race and ethnicity (<http://www.whitehouse.gov/omb/fedreg/1997standards.html>). The number of racial categories expanded from four (White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander) to five (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander). Respondents were also given the opportunity to select multiple races. The standards continued to require data on ethnicity in two categories: Hispanic or Latino and Not Hispanic or Latino.

The data sources used in this report implemented these revised standards at different times, and some data sources can report more detailed data on race and ethnicity than others. Nevertheless, the 1997 OMB standards are used in this report wherever feasible. Where possible, data on children from racial groups that represent smaller percentages of the population are shown throughout the report. Where applicable and based on data availability, indicators show data trends over time as well as the most recent year of data.

Measuring Poverty

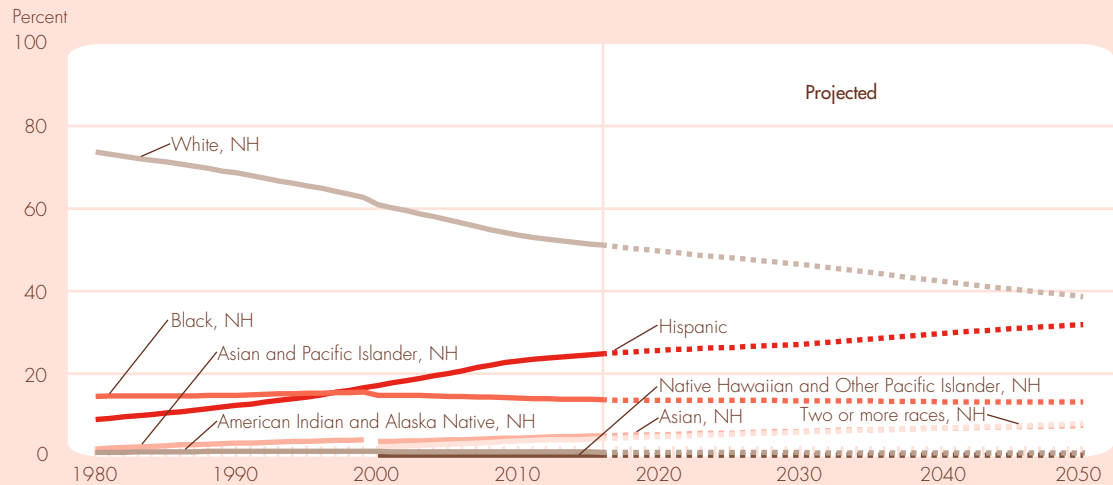
Many indicators in this report include data tabulated by family income or poverty status. Most of these poverty calculations are based on OMB's Statistical Policy Directive 14, the official poverty measurement standard for the United States. A family is considered to be living below the poverty level if its before-tax cash income is below a defined level of need called a poverty threshold. Poverty thresholds are updated annually and vary based on family size and composition. Wherever feasible, indicators present data by poverty status, using the following categories: families with incomes less than 100 percent of the poverty threshold, families with incomes between 100 and 199 percent of the poverty threshold (low income), and families with incomes at 200 percent or more of the poverty threshold (medium and high income). The Forum continues to work on reporting consistent data on family income and poverty status across indicators for clarity and continuity.

One indicator includes the supplemental poverty measure (SPM) officially introduced by the U.S. Census Bureau in 2011. The SPM does not replace the official poverty measure but serves as an additional indicator of economic well-being and provides a deeper understanding of economic conditions and policy effects. The SPM creates a more complex statistical picture, incorporating additional items such as tax payments, work expenses, and medical out-of-pocket expenditures in its family resource estimates. The resource estimates also take into account the value of noncash benefits including nutritional, energy, and housing assistance.

Demographic Background

Racial and ethnic diversity in the United States has increased dramatically in the last 35 years. This growth was first evident among children, a population projected to become even more diverse in the years to come.

Figure 1 Percentage of U.S. children ages 0–17 by race and Hispanic origin, 1980–2015 and projected 2016–2050



NOTE: The abbreviation NH refers to non-Hispanic origin. Each group represents the non-Hispanic population, with the exception of the Hispanic category itself. People of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately. Race data from 2000 onward are not directly comparable with data from earlier years.

SOURCE: U.S. Census Bureau, Population Division.

- In 2020, fewer than half of all U.S. children ages 0–17 are projected to be White, non-Hispanic, down from 74 percent in 1980 and 52 percent in 2015. By 2050, only 39 percent of all U.S. children are projected to be White, non-Hispanic.
- Hispanic children represented 25 percent of U.S. children in 2015, up from 9 percent in 1980. By 2020, they are projected to represent 26 percent of all U.S. children and 32 percent by 2050.
- In 2015, Black, non-Hispanic children represented 14 percent of all U.S. children, down from 15 percent in 1980. By 2020, they are projected to represent 14 percent of all U.S. children and 13 percent by 2050.
- Since 2000, Asian, non-Hispanic children have increased from 3.5 percent of all U.S. children to 5 percent in 2015. By 2020, they are projected to represent 5 percent of all U.S. children and 7 percent by 2050.
- In 2000, non-Hispanic children of two or more races represented 2 percent of all U.S. children. By 2015, they represented 4 percent of all U.S. children. By 2020, they are projected to represent 5 percent of all U.S. children and 8 percent by 2050.
- American Indian and Alaska Native, non-Hispanic children represented 0.9 percent of all U.S. children in 2015, up from 0.8 percent in 1980. By 2020, they are projected to represent 0.8 percent of all U.S. children and 0.7 percent by 2050.
- Between 2000 and 2015, the proportion of Native Hawaiian and Other Pacific Islander, non-Hispanic children remained unchanged at 0.2 percent of all U.S. children. The proportion is projected to remain unchanged at 0.2 percent between 2020 and 2050.

Bullets contain references to data in table POP3 on the childstats.gov website. Endnotes begin on page 46.

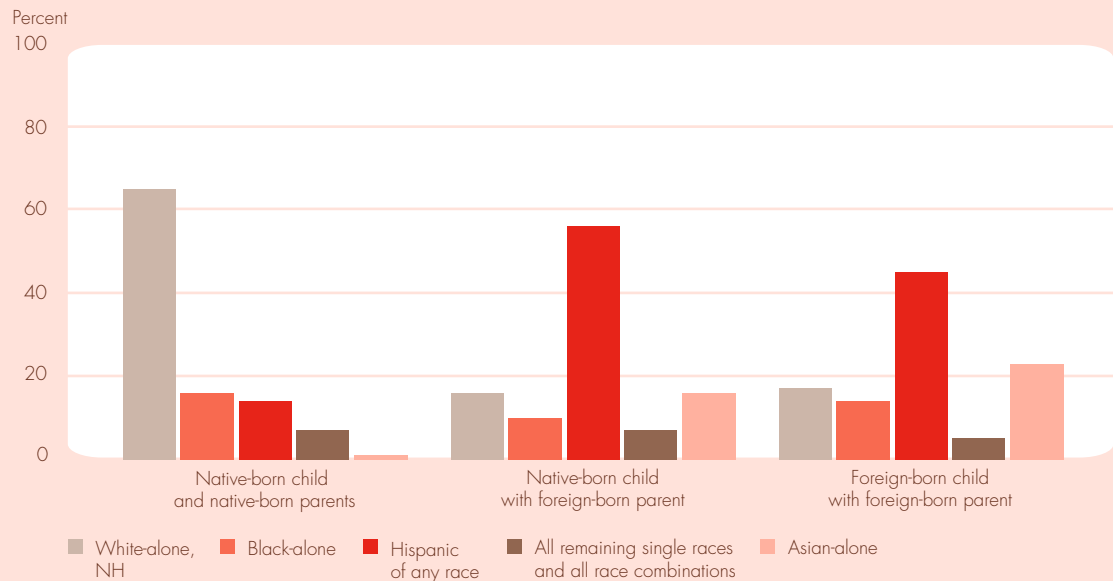


Family and Social Environment

Racial and Ethnic Composition of Children by Parental Nativity

The foreign-born population in the United States has grown since 1970. As a result, the population of children with foreign-born parents tends to be more diverse, in terms of race and Hispanic origin, than the population of children whose parents are native born. Potential language and cultural barriers confronting children and their foreign-born parents may make additional language resources necessary for children, both at school and at home.¹

Figure 2 Percentage of children ages 0–17 by parental and child nativity and race and Hispanic origin, 2015



NOTE: The abbreviation NH refers to non-Hispanic origin. Native-born parents means that all of the parents that the child lives with are native born, while foreign-born parent means that at least one of the child's parents is foreign born. Anyone with U.S. citizenship at birth is considered native born, which includes people born in the United States and in U.S. outlying areas, and people born abroad with at least one American parent. Only children who live with at least one parent are included. Persons under age 18 who were the respondent or spouse were not included. Since Hispanics may be of any race, the categories shown are not mutually exclusive, and percentages will add to more than 100 percent.

SOURCE: U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement.

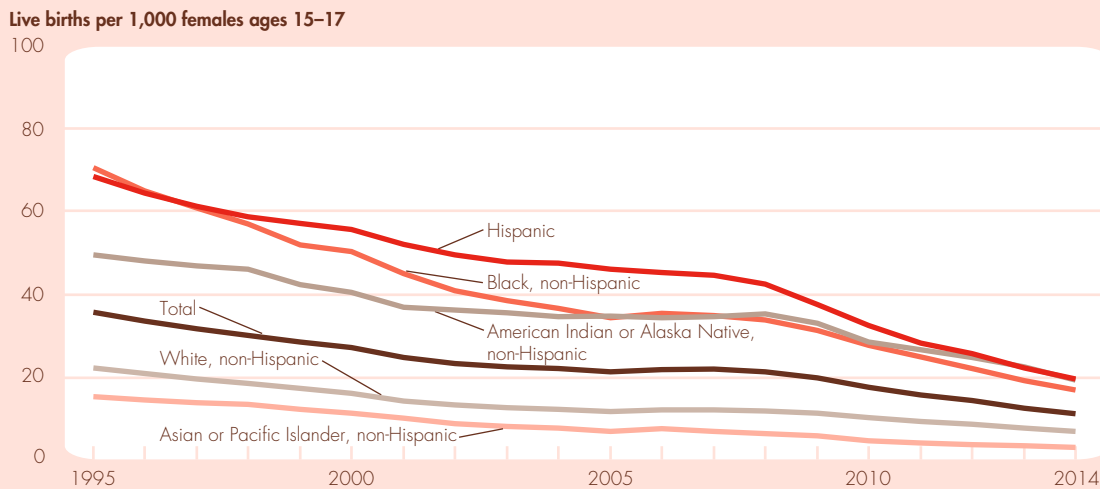
- In 2015, one quarter of all children in the United States had a parent who was foreign born. In contrast, about 71 percent of all children were native born and had native-born parents.
- Among native-born children with at least one foreign-born parent, the majority were Hispanic in 2015, a pattern that reflects the rise of immigration from Latin America over the past few decades.² In contrast, among native-born children with native-born parents, the majority were White, non-Hispanic in 2015.
- A growing share of immigrants are coming from Asia as well as Latin America.² In 2015, Asians made up just 1 percent of native-born children with native-born parents, but they made up a far larger proportion of the children whose parents were foreign born. Asians made up 16 percent of native-born children with a foreign-born parent and 23 percent of foreign-born children with a foreign-born parent.

Bullets contain references to data in table FAM4 on the childstats.gov website. Endnotes begin on page 46.

Adolescent Births

Childbirth during adolescence is often accompanied by long-term difficulties for the mother and her child. Compared with babies born to older mothers, babies born to adolescent mothers, particularly younger adolescent mothers, are at higher risk of low birthweight and infant mortality.^{3,4,5,6} They are more likely to grow up in homes that offer lower levels of emotional support and cognitive stimulation, and they are less likely to earn high school diplomas.⁷ For mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce employment prospects and earnings potential.⁷ Although adolescent birth rates for all racial and ethnic groups have generally been on a long-term decline since the late 1950s, birth rates continue to vary by race and ethnicity.^{8,9}

Figure 3 Birth rates for females ages 15–17 by race and Hispanic origin of mother, 1995–2014



NOTE: Race refers to mother's race. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected and reported separately. Data from states reporting multiple races were bridged to the single-race categories of the 1977 Office of Management and Budget Standards on Race and Ethnicity for comparability with other states.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

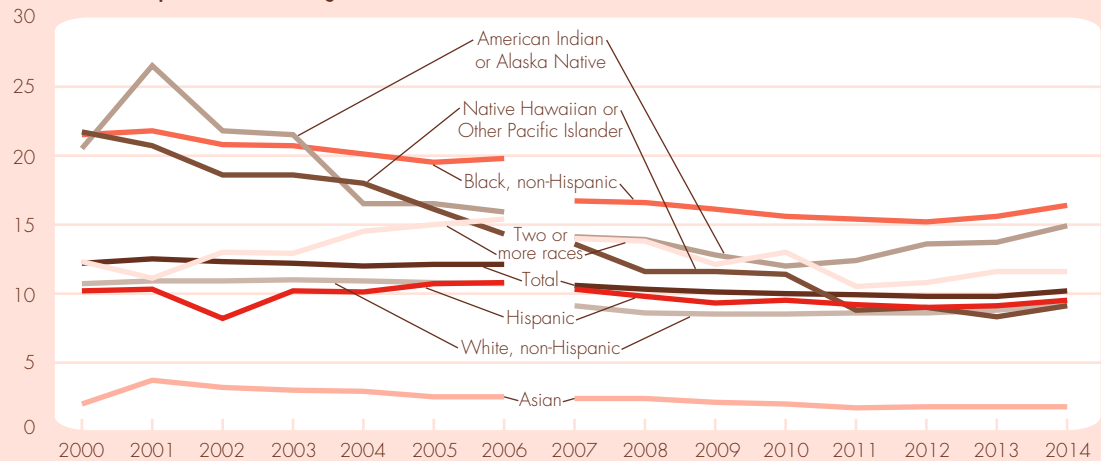
- In 2014, the adolescent birth rate was 19 births per 1,000 females for American Indian or Alaska Native, non-Hispanic and Hispanic adolescents; 17 for Black, non-Hispanic; 7 for White, non-Hispanic; and 3 for Asian or Pacific Islander, non-Hispanic adolescents ages 15–17.
- From 1995 to 2014, the total adolescent birth rate declined by 25 percentage points, from 36 per 1,000 to 11 per 1,000, a record low for the United States. This long-term downward trend was found for each racial and Hispanic origin group.
- The racial and ethnic disparity (the difference between the highest and lowest rates) in adolescent birth rates declined from 55 points in 1995 to 17 points in 2014. Yet, substantial racial and ethnic disparities remain. Adolescent birth rates among Hispanic; Black, non-Hispanic; and American Indian or Alaska Native, non-Hispanic adolescents remained higher than the rates for White, non-Hispanic and Asian or Pacific Islander, non-Hispanic adolescents throughout the entire period. Asian or Pacific Islander, non-Hispanic adolescents had the lowest birth rates.

Child Maltreatment

Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect). Maltreatment in general is associated with a number of negative outcomes for children, including lower school achievement, juvenile delinquency, substance abuse, and mental health problems.¹⁰ Certain types of maltreatment can result in long-term physical, social, and emotional problems, and even death. Child maltreatment rates vary by the race and ethnicity of the child.¹¹ Understanding these variations could potentially improve prevention and intervention efforts.

Figure 4 Rate of substantiated maltreatment reports of children ages 0–17 by race and Hispanic origin, 2000–2014

Victimization rate per 1,000 children ages 0–17



NOTE: The data in this figure are victimization rates based on the number of investigations and assessments by Child Protective Services that found the child to be a victim of one or more types of maltreatment. This is a duplicated count because an individual child may have been determined to have been maltreated on more than one occasion. Substantiated maltreatment includes the dispositions of substantiated, indicated, or alternative response victims. The number of states reporting may vary from year to year. States vary in their definitions of abuse and neglect. Data since 2007 are not directly comparable with prior years as differences may be partially attributed to changes in one state's procedures for substantiating maltreatment.

SOURCE: Administration for Children and Families, National Child Abuse and Neglect Data System.

- After several years of steady decreases, the national rate of substantiated child maltreatment reports increased in 2014 for the first time since 2007. Despite this recent increase, the 2014 rate of 10.2 per 1,000 children was lower than the 2007 rate of 10.6 per 1,000 children.
- The 2014 increase in national substantiated child maltreatment reports was apparent for victims of all races and ethnicities, except Asian children and children of two or more races. The victimization rates in those categories remained the same as in the previous year.
- From 2001 to 2014, Black, non-Hispanic and American Indian or Alaska Native children had the highest rates of substantiated child maltreatment reports (except in 2004 and 2010 when it was Native Hawaiian or Other Pacific Islander children and children of two or more races, respectively).
- In 2014, the victimization rates (per 1,000) were 16.4 for Black, non-Hispanic; 14.9 for American Indian or Alaska Native; 11.6 for two or more races; 9.5 for Hispanic; 9.2 for White, non-Hispanic; 9.1 for Native Hawaiian or Other Pacific Islander; and 1.8 for Asian children.

Bullets contain references to data in table FAM7.A on the childstats.gov website. Endnotes begin on page 46.

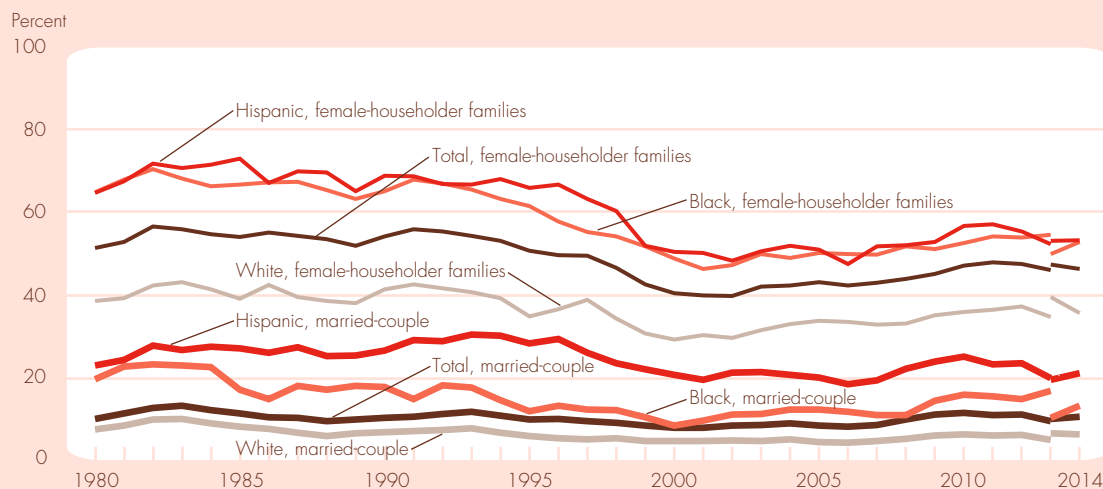


Economic Circumstances

Child Poverty

Children living in poverty are vulnerable to environmental, educational, health, and safety risks. Compared with their peers, children living in poverty, especially young children, are more likely to have cognitive, behavioral, and socioemotional difficulties. Additionally, throughout their lifetimes, they are more likely to complete fewer years of school and experience more years of unemployment.^{12,13,14,15} Child poverty rates in the United States vary considerably by race and Hispanic origin, a pattern that is important given the links between poverty and other economic and social outcomes.

Figure 5 Percentage of children ages 0–17 living in poverty by race and Hispanic origin and family structure, 1980–2014



NOTE: This indicator is based on the official poverty measure for the United States as defined in Office of Management and Budget Statistical Policy Directive 14. In 2014, the poverty threshold for a two-parent, two-child family was \$24,008. The income measure in the Current Population Survey (CPS) has been redesigned. The source for the traditional income is the portion of the 2014 CPS Annual Social and Economic Supplement (ASEC) sample (about 68,000 households) that received a set of income questions similar to those used in 2013. The source for the redesigned income is the portion of the 2014 CPS ASEC sample (about 30,000 households) that received the redesigned income questions. The 2014 CPS ASEC included redesigned questions for income that were implemented to a subsample of the 98,000 addresses using a probability split panel design. The redesigned income questions were used for the entire 2015 CPS ASEC sample. The proportion of children in male householder families (no spouse present) historically has been small. Selected data for this group are available as part of the detailed tables at <http://www.census.gov/hhes/www/poverty/data/index.html>.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- In 2014, 21 percent (15.5 million) of all U.S. children ages 0–17 lived in poverty.
- Overall, the poverty rate was much higher for Black, non-Hispanic and Hispanic children than for White, non-Hispanic children in 2014.¹⁶ Some 12 percent of White, non-Hispanic children lived in poverty, compared with 37 percent of Black, non-Hispanic children and 32 percent of Hispanic children.
- In 2014, children in married-couple families were much less likely to be living in poverty than children living in female-householder families (no spouse present). About 11 percent of children in married-couple families were living in poverty, compared with 46 percent in female-householder families.

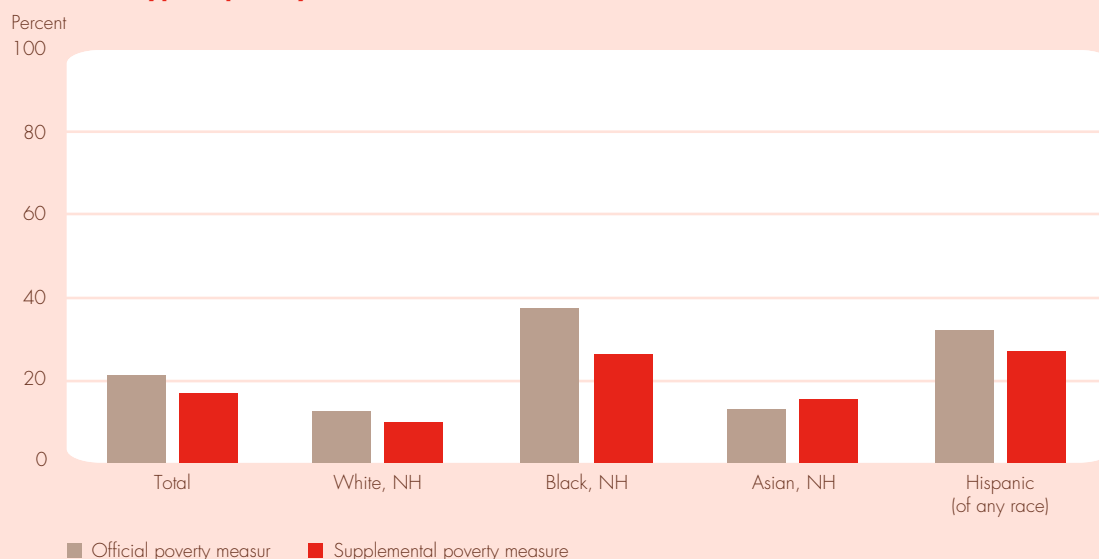
Bullets contain references to data in table ECON1.A on the childstats.gov website. Endnotes begin on page 46.

Supplemental Poverty Measure

Since the publication of the first official poverty estimates in 1964, there has been continuing debate about the best approach to measuring poverty in the United States. Recognizing that alternative estimates of poverty can provide useful information to the public as well as to the Federal Government, the U.S. Census Bureau publishes alternative poverty estimates using the new supplemental poverty measure (SPM). The SPM does not replace the official poverty measure but serves as an additional indicator of economic well-being and provides a deeper understanding of economic conditions and policy effects. The SPM is based on the suggestions of an interagency technical working group.^{17,18}

In contrast to the official poverty measure, which compares pre-tax cash income to a set of thresholds derived in the early 1960s, the SPM creates a more complex statistical picture by incorporating additional items such as tax payments, work expenses, medical out-of-pocket expenditures, and the value of noncash nutritional, energy, and housing assistance. Thresholds used in the new measure were derived by staff at the U.S. Bureau of Labor Statistics from Consumer Expenditure Survey expenditure data on basic necessities (food, shelter, clothing, and utilities) and are adjusted for geographic differences in the cost of housing.

Figure 6 Percentage of children ages 0–17 living in poverty by race and Hispanic origin and type of poverty measure, 2014



NOTE: These data refer to the civilian noninstitutionalized population. The abbreviation NH refers to non-Hispanic.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

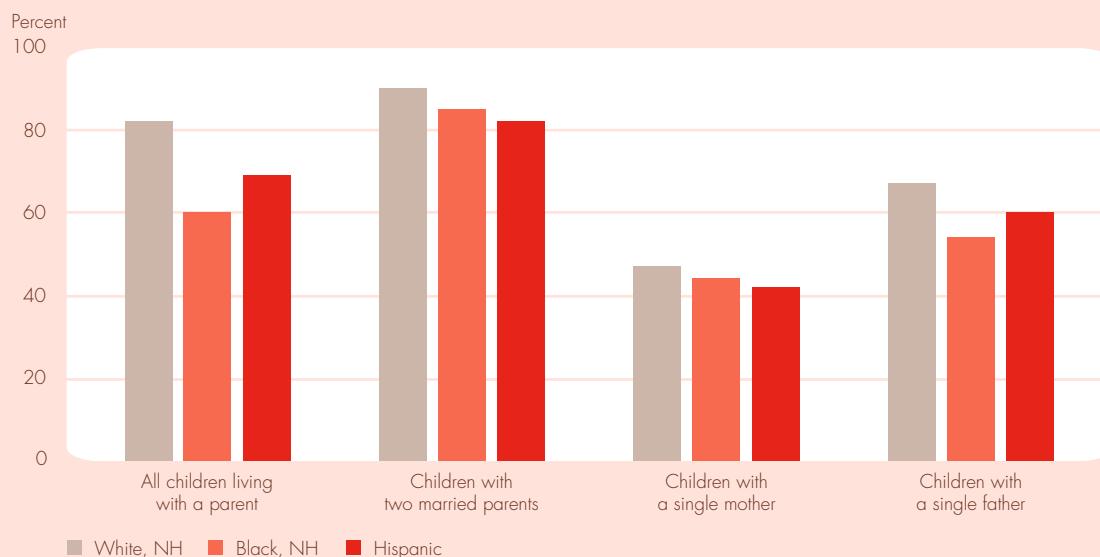
- For all children, the 2014 SPM rate was 17 percent, 4 percentage points lower than the official poverty rate of 21 percent.
- In 2014, the SPM rate was lower than the official poverty rate for White, non-Hispanic; Black, non-Hispanic; and Hispanic children.¹⁹ The difference between the two poverty rates for Asian, non-Hispanic children was not statistically significant.
- While the official poverty rate was higher for Black, non-Hispanic children than for Hispanic children in 2014, the difference between the SPM rates for these two groups was not statistically significant.
- The SPM rate was higher for Asian, non-Hispanic children than for White, non-Hispanic children in 2014. The difference in official poverty rates between these two groups was not statistically significant, however.

Bullets contain references to data in table ECON1.C on the childstats.gov website. Endnotes begin on page 46.

Secure Parental Employment

Secure parental employment is a major factor in the financial well-being of families. It is associated with higher family income and greater access to health insurance.²⁰ It also has been linked to a number of positive outcomes for children, including better health, education and social/emotional development.²¹ One measure of secure parental employment is the percentage of children whose resident parent or parents were employed full time throughout a given year. Since 2000, the percentage of children living with a securely employed parent has declined for all children, regardless of race and Hispanic origin.

Figure 7 Percentage of children ages 0–17 living with at least one parent employed year round, full time by family structure and race and Hispanic origin, 2014



NOTE: The abbreviation NH refers to non-Hispanic origin. Year-round, full-time employment is defined as usually working full time (35 hours or more per week) for 50 to 52 weeks. Children living with a single mother or single father includes some families in which both parents are present in the household but are unmarried partners.

SOURCE: Bureau of Labor Statistics, Current Population Survey, Annual Social and Economic Supplement.

- In 2014, White, non-Hispanic children were most likely to live with a parent who was securely employed (82 percent), meaning a parent who worked year round, full time. Hispanic children were less likely to have a securely employed parent (69 percent) and Black, non-Hispanic children were least likely (60 percent).

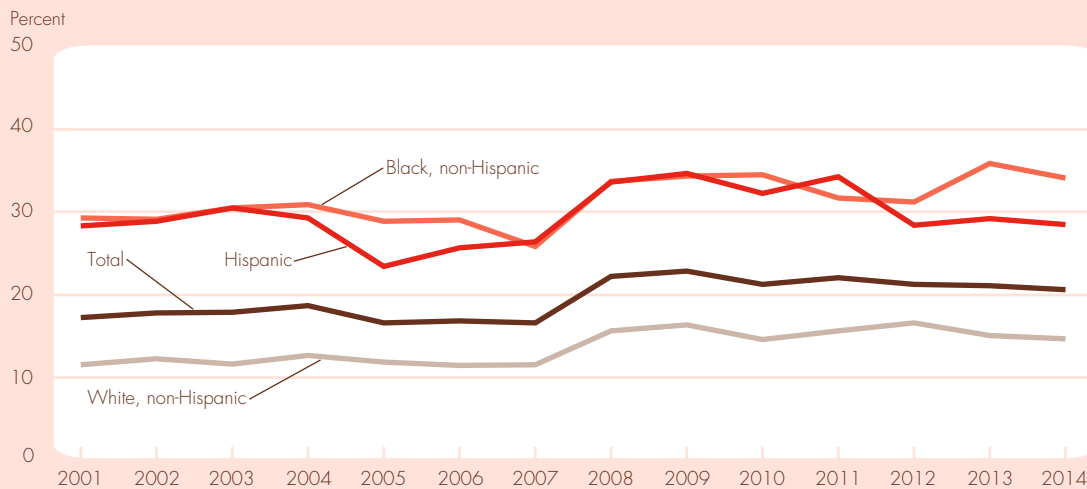
- The pattern varied by family structure. Children with two married parents were most likely to have a securely employed parent in 2014, regardless of race and Hispanic origin, while children with a single mother were least likely.

Bullets contain references to data in table ECON2 on the childstats.gov website. Endnotes begin on page 46.

Food Insecurity

A family's ability to provide for its children's nutritional needs is linked to the family's food security—that is, to its access at all times to adequate food for an active, healthy life for all household members.²² The food security status of households is based on self-reports of difficulty in obtaining enough food, reduced food intake, reduced diet quality, and anxiety about an adequate food supply. In some households classified as food insecure, only adults' diets and food intakes were affected, but in a majority of such households, children's eating patterns were also disrupted to some extent, and the quality and variety of their diets were adversely affected.²³ In a subset of food-insecure households—those classified as having very low food security among children—a parent or guardian reported that at some time during the year one or more children were hungry, skipped a meal, or did not eat for a whole day because the household could not afford enough food.²⁴

Figure 8 Percentage of children ages 0-17 in food-insecure households by race and Hispanic origin of household reference person, 2001-2014



NOTE: Food-insecure households are those in which either adults, children, or both were "food insecure," meaning that, at times, they were unable to acquire adequate food for active, healthy living because the household had insufficient money and other resources for food. Race and Hispanic origin are those of the household reference person. The revised 1997 Office of Management and Budget Standards for Data on Race and Ethnicity were implemented in 2003. Included in the total, but not shown separately, are American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, and "Two or more races." From 2003 onward, statistics for White, non-Hispanics and Black, non-Hispanics exclude persons who indicated "Two or more races." Data on race and Hispanic origin are collected separately.

SOURCE: U.S. Census Bureau, Current Population Survey Food Security Supplement; tabulated by Department of Agriculture, Economic Research Service and Food and Nutrition Service.

- In 2014, the percentages of children living in food-insecure households were substantially above the national average (21 percent) for Black, non-Hispanics (34 percent) and Hispanics (29 percent), while below the national average for White, non-Hispanics (15 percent).
- From 2001 to 2014, the percentage of children living in food-insecure households was 18 percent in 2001, 19 percent in 2004, 17 percent in 2007, then increased to 23 percent in 2008, and has remained above pre-Great Recession levels.
- Over the same period (from 2001 to 2014), compared with all households with children, the percentages of children living in food-insecure households declined more sharply for Hispanics between 2003 and 2005 following the end of the 2001 recession, and increased more sharply for Hispanics and Black, non-Hispanics in 2008 with the onset of the Great Recession.

Bullets contain references to data in table ECON3 on the childstats.gov website. Endnotes begin on page 46.

This page is intentionally left blank.

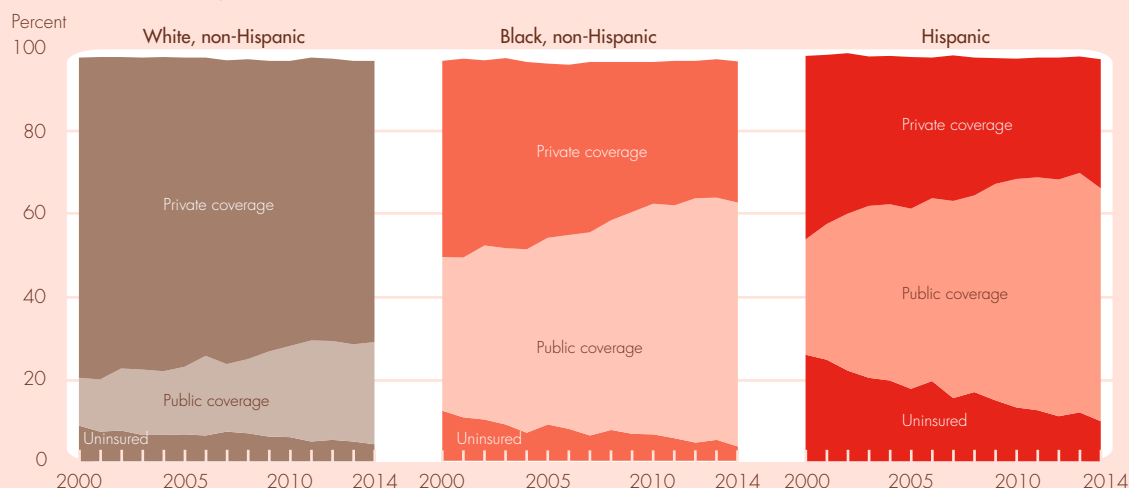


Health Care

Health Insurance Coverage

Health insurance is a major determinant of access to and utilization of health care.²⁵ Children with health insurance, whether public or private, have increased access and utilization compared to children without insurance. Further, insured children are more likely to have a regular and accessible source of health care.²⁶ The percentage of children who have health insurance is one indicator of the extent to which families can obtain preventive care or health care for a sick or injured child.^{27,28} The likelihood that children have health insurance, and the type of insurance among those insured, varies by race and ethnicity.²⁹

Figure 9 Percentage of children ages 0-17 by race and Hispanic origin and health insurance coverage at the time of interview, 2000-2014



NOTE: Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. A small percentage of children have coverage other than private or public health insurance.

SOURCE: National Center for Health Statistics, National Health Interview Survey.

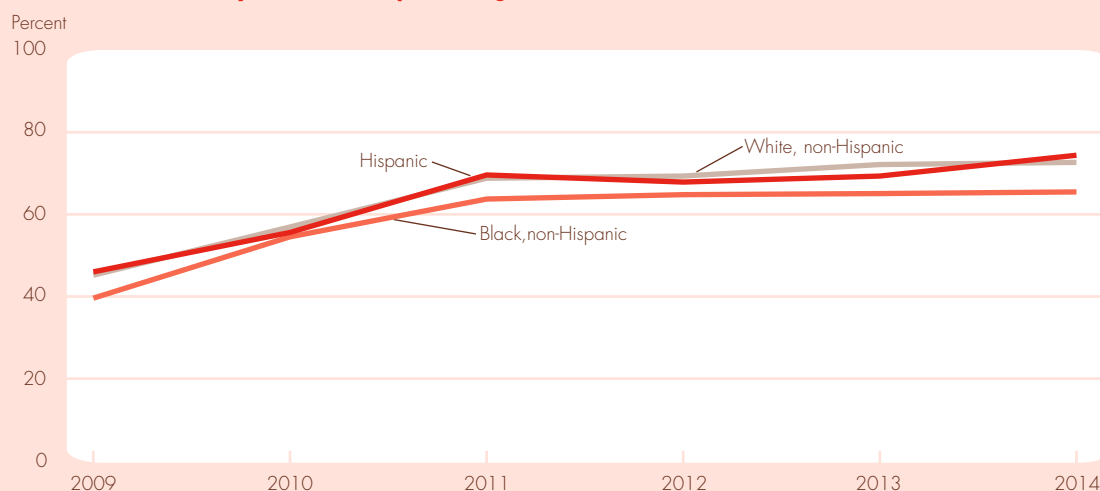
- In 2014, Hispanic children were more likely to be uninsured (10 percent) than White, non-Hispanic and Black, non-Hispanic children (4 percent each). White, non-Hispanic children were more likely to have private insurance (68 percent) compared to Hispanic (31 percent) and Black, non-Hispanic (34 percent) children. In 2014, Hispanic (57 percent) and Black, non-Hispanic (59 percent) children were more likely to have public coverage than White, non-Hispanic children (25 percent).
- For children in each racial and ethnic group—Black, non-Hispanic; Hispanic; and White, non-Hispanic—the percentage with public coverage increased and the percentage with no health insurance and with private health insurance declined from 2000 to 2014.
- Throughout 2000 to 2014, the percentage of uninsured children was higher among Hispanic children than among White, non-Hispanic and Black, non-Hispanic children. During that same period, Black, non-Hispanic children and Hispanic children were more likely than White, non-Hispanic children to have public coverage, and White, non-Hispanic children were more likely to have private insurance.
- From 2000 to 2014, the percentage of children overall with health insurance increased by 7 percentage points to 95 percent.³⁰ Although the percentage of children with private coverage declined by 13 percentage points during this period to 54 percent, public coverage increased by 20 percentage points to 38 percent.

Bullets contain references to data in table HC1 on the childstats.gov website. Endnotes begin on page 46.

Immunization

Vaccination can prevent or lessen the severity of vaccine-preventable diseases and is regarded as one of the greatest public health achievements in the United States in the 20th century.³¹ For children ages 19–35 months, receipt of the combined seven-vaccine series (4:3:1:3*:3:1:4) is used to evaluate the proportion of children meeting the current vaccination guidelines. Data on vaccination coverage are used to identify groups at risk of vaccine-preventable diseases and to evaluate the effectiveness of programs designed to increase coverage. Black, non-Hispanic children generally have had lower vaccination coverage relative to their White, non-Hispanic counterparts; poverty status accounts for much of this difference in vaccination coverage.³²

Figure 10 Percentage of children ages 19–35 months vaccinated with combined seven-vaccine series by race and Hispanic origin, 2009–2014



NOTE: The 4:3:1:3*:3:1:4 combined series consists of four doses (or more) of diphtheria, tetanus toxoids, and pertussis (DTP) vaccines, diphtheria and tetanus toxoids (DT), or diphtheria, tetanus toxoids, and any acellular pertussis (DTaP) vaccines; three doses (or more) of poliovirus vaccines; one dose (or more) of any measles-containing vaccine; the full series of *Haemophilus influenzae* type b (Hib) vaccine (three or four doses, depending on product type); three doses (or more) of hepatitis B vaccines; one dose (or more) of varicella vaccine; and four doses (or more) of pneumococcal conjugate vaccine (PCV). The recommended immunization schedule for children is available at <http://www.cdc.gov/vaccines/schedules/index.html>. Estimating coverage estimates for this series began in 2009. The 2009 series estimates were affected by a temporary Hib vaccine shortage and the resulting interim Advisory Committee on Immunization Practices (ACIP) recommendation to defer the Hib booster dose for healthy children during December 2007 to June 2009, a time when most children ages 19–35 months in the 2009 National Immunization Survey would have received the Hib booster dose. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity.

SOURCE: Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases and National Center for Health Statistics, National Immunization Survey.

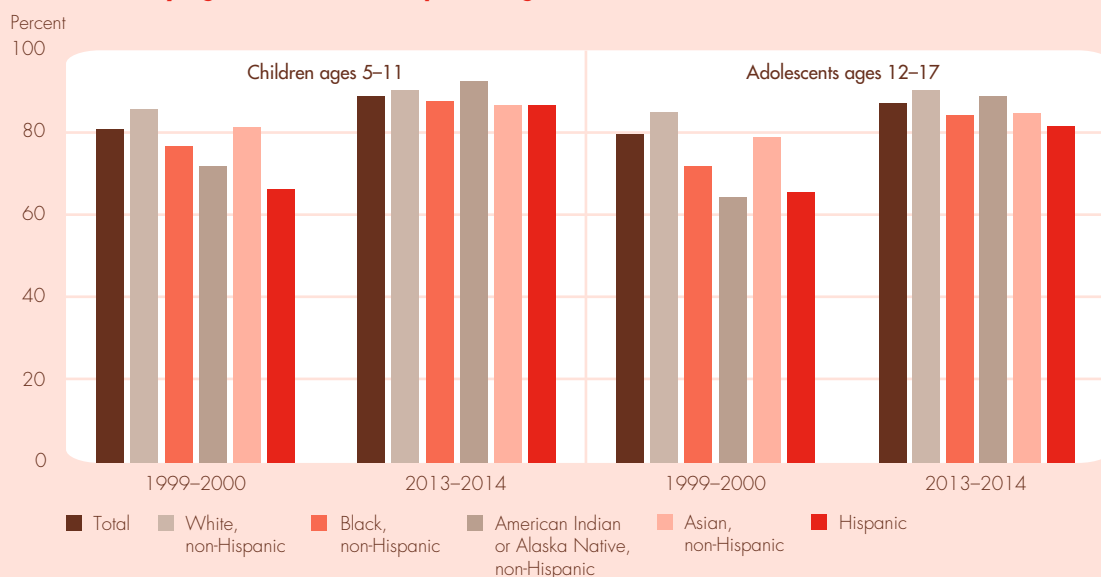
- In 2014, vaccination coverage for the combined seven-vaccine series (4:3:1:3*:3:1:4) was higher for Hispanic (74 percent) and White, non-Hispanic children (73 percent) than for Black, non-Hispanic children (65 percent) ages 19–35 months.
- Between 2009 and 2014, vaccination coverage among children ages 19–35 months receiving the combined vaccine series increased for White, non-Hispanic (from 45 to 73 percent); Black, non-Hispanic (from 40 to 65 percent); and Hispanic (from 46 to 74 percent) children.
- During that same period, the percentage of White, non-Hispanic children ages 19–35 months receiving the combined vaccine series was higher than the percentage of Black, non-Hispanic children, except for 2010, when coverage did not differ. Vaccination coverage for the combined series between White, non-Hispanic and Hispanic children was not significantly different.

Bullets contain references to data in table HC3.A on the childstats.gov website. Endnotes begin on page 46.

Oral Health

Oral health is an essential component of overall health.³³ Tooth decay is one of the most common chronic conditions among children. If untreated, decay may cause pain, infection, and problems with eating, speaking, and concentrating. Regular dental visits provide an opportunity for prevention, early diagnosis, and treatment of tooth decay and other oral and craniofacial diseases and conditions.³³ Low-income and minority children are at the greatest risk of inadequate access to oral health care.^{34,35} The prevalence of untreated tooth decay varies by race and ethnicity.

Figure 11 Percentage of children and adolescents ages 5–17 with a dental visit in the past year by age and race and Hispanic origin, 1999–2000 and 2013–2014



NOTE: In 1999–2000, children were identified as having a dental visit in the past year by asking respondents, “About how long has it been since your child last saw or talked to a dentist?” In 2013–2014, the question was “About how long has it been since your child last saw a dentist?” Respondents were instructed to include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity.

SOURCE: National Center for Health Statistics, National Health Interview Survey.

- During 2013–2014, 89 percent of children ages 5–11 had a dental visit in the past year, an 8 percentage point increase from 1999–2000. During 2013–2014, 87 percent of adolescents ages 12–17 had a dental visit in the past year, a 7 percentage point increase from 1999–2000.
- Between 1999–2000 and 2013–2014, the percentage of children and adolescents with a dental visit in the past year increased for all racial and ethnic groups, except Asian, non-Hispanic children and adolescents.
- Among children in 2013–2014, White, non-Hispanic children (90 percent) were more likely to have had a dental visit in the past year than Black, non-Hispanic (88 percent) and Hispanic (87 percent) children. The percentages of dental visits in the past year for American Indian or Alaska Native, non-Hispanic (93 percent) and Asian, non-Hispanic (87 percent) children were not different from those of other racial and ethnic groups.
- Among adolescents in 2013–2014, White, non-Hispanic adolescents (90 percent) were more likely to have had a dental visit in the past year than Black, non-Hispanic (84 percent); Asian, non-Hispanic (84 percent); and Hispanic (81 percent) adolescents. The percentage of dental visits in the past year for American Indian or Alaska Native, non-Hispanic adolescents (89 percent) was not significantly different from other racial and ethnic groups.

Bullets contain references to data in table HC4.A/B.BRIEF on the childstats.gov website. Endnotes begin on page 46.

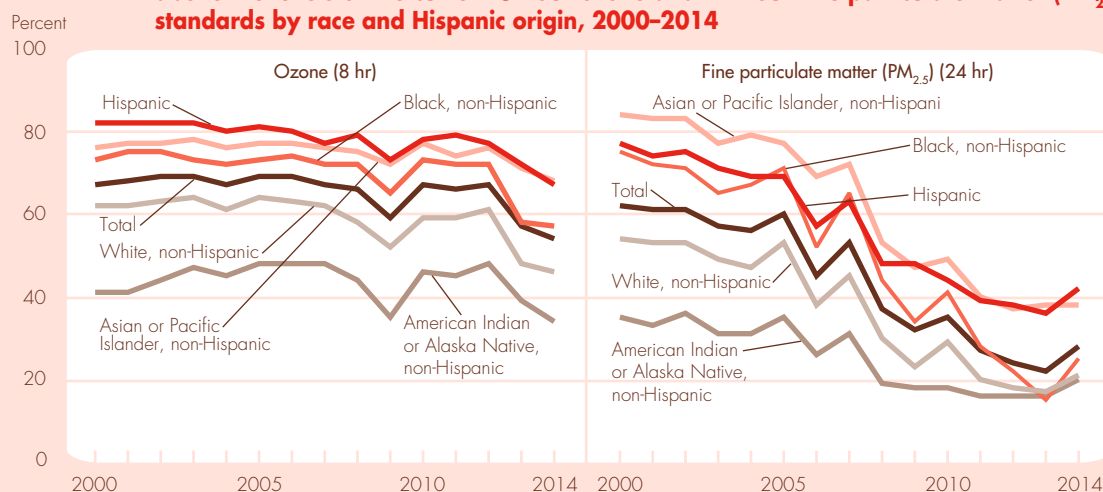


Physical Environment
and Safety

Outdoor Air Quality

One important children's environmental health measure is the percentage of children living in areas in which air pollution levels are higher than the allowable levels of the Primary National Ambient Air Quality Standards.³⁶ The Environmental Protection Agency sets these standards to protect public health, including susceptible groups such as children. Ozone and particulate matter (PM) are air pollutants associated with increased asthma episodes, and other respiratory illnesses in children, all of which can lead to increased emergency room visits and hospitalizations.^{37,38} PM, especially fine PM (PM_{2.5}), contains microscopic solids or liquid droplets that are so small that they can get deep into lungs and cause serious health problems. Studies indicate the possibility of race-related increases in risk for some health effects resulting from exposure to ozone and PM, although the understanding of potential differences by race is limited by the small number of studies and possibly confounded by other factors.^{37,38}

Figure 12 Percentage of children ages 0–17 living in counties with pollutant concentrations above the levels of the current 8-hour ozone and 24-hour fine particulate matter (PM_{2.5}) standards by race and Hispanic origin, 2000–2014



NOTE: Percentages are based on the number of children, by race and ethnicity, living in counties where measured air pollution concentrations were higher than the levels of the 8-hour ozone and 24-hour fine particulate matter (PM_{2.5}) Primary National Ambient Air Quality Standards, at least once during the year. The Environmental Protection Agency periodically reviews air quality standards and may change them based on updated scientific findings. The indicator is calculated with reference to the current levels of the air quality standards for all years shown. Measuring concentrations above the level of a standard is not equivalent to violating the standard. The level of a standard may be exceeded on multiple days before the exceedance is considered a violation of the standard. Data have been revised since previous publication in *America's Children*. Values have been recalculated based on updated data in the Air Quality System and the revised ozone air quality standard promulgated in October 2015. For more information on the air quality standard used in calculating these percentages, please see <http://www.epa.gov/criteria-air-pollutants/naaqs-table>.

SOURCE: Environmental Protection Agency, Office of Air and Radiation, Air Quality System.

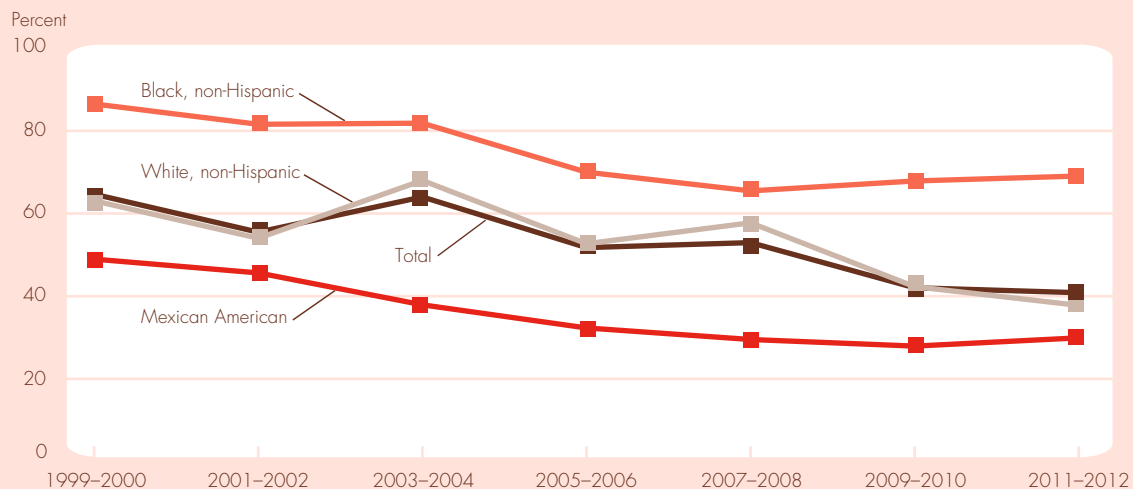
- In 2014, about 54 percent of all U.S. children lived in counties with measured pollutant concentrations above the level of the 8-hour ozone Primary National Ambient Air Quality Standard at least once during the year.
- In 2014, approximately 68 percent of Asian or Pacific Islander, non-Hispanic and 67 percent of Hispanic children lived in counties that exceeded the level of the allowable air quality standard for ozone, compared with 57 percent of Black, non-Hispanic; 46 percent of White, non-Hispanic; and 34 percent of American Indian or Alaska Native, non-Hispanic children.
- From 2000 to 2014, the percentage of children living in counties with measured ozone concentrations above the level of the current standard at least one day per year declined from 67 to 54 percent.
- In 2014, about 28 percent of all children lived in counties with measured concentrations of PM_{2.5} above the level of the 24-hour Primary National Ambient Air Quality Standard at least once during the year.
- In 2014, approximately 38 percent of Asian or Pacific Islander, non-Hispanic and 42 percent of Hispanic children lived in counties that exceeded the level of the allowable air quality standard for PM_{2.5} compared with 25 percent of Black, non-Hispanic; 21 percent of White, non-Hispanic; and 20 percent of American Indian or Alaska Native, non-Hispanic children.
- From 2000 to 2014, the percentage of children living in counties with measured PM_{2.5} concentrations above the level of the current standard at least one day per year declined from 62 to 28 percent.

Bullets contain references to data in table PHY1 on the childstats.gov website. Endnotes begin on page 46.

Secondhand Smoke

The U.S. Surgeon General has determined that there is no safe level of exposure to secondhand tobacco smoke.³⁹ Children who are exposed to secondhand smoke have an increased risk of adverse health effects, such as respiratory symptoms, lower respiratory tract infections, bronchitis, pneumonia, middle ear disease, and sudden infant death syndrome.^{39,40} Further, secondhand smoke can play a role in the development and exacerbation of asthma.^{39,40} Cotinine, a breakdown product of nicotine, is used as a marker for exposure to secondhand smoke in nonsmokers. Cotinine levels at or above 0.05 nanograms per milliliter (ng/mL) are often used as an indicator of secondhand smoke exposure in the previous 1 to 2 days. Previous research has found that the likelihood of exposure to secondhand smoke varies by the race and ethnicity of the child.⁴⁰

Figure 13 Percentage of children ages 4–11 with blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL) by race and Hispanic origin, 1999–2000 through 2011–2012



NOTE: Cotinine levels are reported for nonsmoking children only (based on an individual's cotinine level of less than 10 ng/mL). "Any detectable cotinine" indicates blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL). Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Beginning in 2007, the National Health and Nutrition Examination Survey allows for reporting of both total Hispanics and Mexican Americans; however, estimates reported here are for Mexican Americans to be consistent with earlier years.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- In 2011–2012, 69 percent of Black, non-Hispanic; 37 percent of White, non-Hispanic; and 30 percent of Mexican American children ages 4–11 had detectable levels of cotinine, indicating that they had been exposed to secondhand smoke (defined as cotinine levels at or above 0.05 ng/mL) in the previous day or two.
- From 1999–2000 through 2011–2012, the percentage of all children ages 4–11 with exposure to secondhand smoke declined by 24 percentage points. There were significant declines in secondhand smoke exposure for each racial and ethnic group—25 percentage points among White, non-Hispanic; 18 percentage points among Black, non-Hispanic; and 19 percentage points among Mexican-American children.
- Throughout the period, the percentage of Black, non-Hispanic children exposed to secondhand smoke was approximately 2 to 2½ times higher than that of Mexican American children. For most of the period, the percentage of Black, non-Hispanic children ages 4–11 with secondhand smoke exposure was also higher than that of White, non-Hispanic children. In 2003–2004 and 2007–2008, there were no significant differences between the secondhand smoke exposure rates of Black and White, non-Hispanic children.

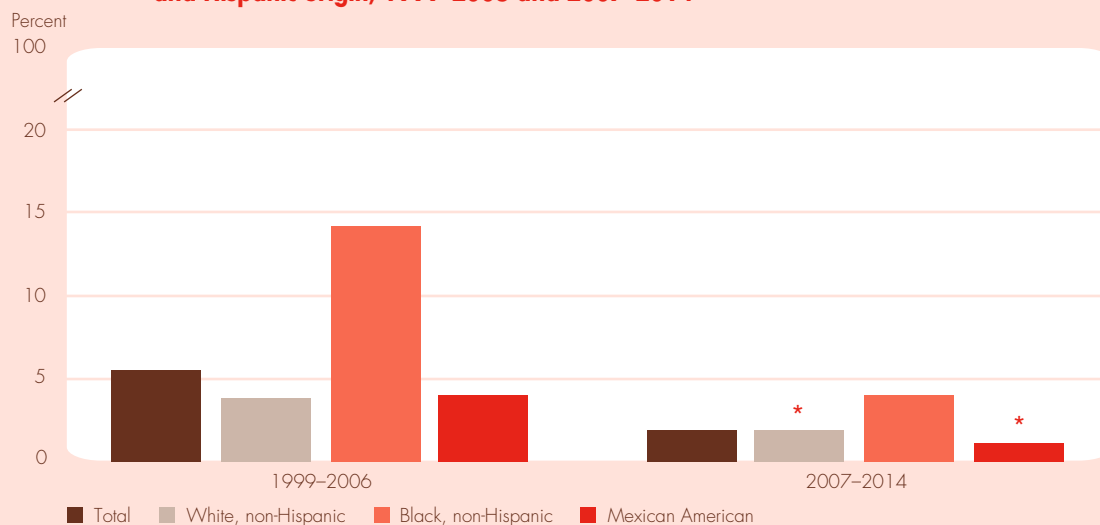
Bullets contain references to data in table PHY2.A on the childstats.gov website. Endnotes begin on page 46.

Lead in the Blood of Children

Lead is a major environmental health hazard for children. Childhood exposure to lead contributes to reduced IQ and academic achievement and behavioral problems.^{41,42} The chief sources of exposure for children are deteriorating lead-based paint in homes, water from leaded pipes, and consumer products.^{42,43,44} Young children are particularly vulnerable to lead because of their developing nervous systems and their hand-to-mouth behavior. A blood lead level of 5 micrograms per deciliter (µg/dL) is defined as “elevated” for purposes of identifying children for follow-up, but no level of lead exposure can be considered safe.^{42,43,45} Blood lead levels have declined since the 1970s, due largely to the removal of lead from gasoline and paint. Yet in 2005–2006, 15 percent of U.S. homes with young children had indoor lead hazards, including lead-based paint.^{46,47} Children with nutritional deficiencies or living in poverty or older housing are more likely to have elevated blood lead levels.^{42,43}

Figure 14

Percentage of children ages 1–5 with blood lead levels at or above 5 µg/dL by race and Hispanic origin, 1999–2006 and 2007–2014



* Estimate is considered unstable (relative standard error is greater than 30 percent but less than 40 percent).

NOTE: The Centers for Disease Control and Prevention currently uses 5 µg/dL as a reference level to identify children with elevated blood lead levels. Estimates are based on eight years of data to improve reliability of the estimates. Persons of Mexican American origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Beginning in 2007, the National Health and Nutrition Examination Survey allows for reporting of both total Hispanics and Mexican Americans; however, estimates reported here are for Mexican Americans to be consistent with earlier years.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- In 2007–2014, 1.9 percent of children ages 1–5 (approximately 390,000 children) had blood lead levels at or above 5 µg/dL. Among Black, non-Hispanic children ages 1–5, 4.0 percent had elevated blood lead levels, compared with 1.9 percent of White, non-Hispanic children and 1.1 percent of Mexican American children. In 2007–2014, Black, non-Hispanic children ages 1–5 were twice as likely as White, non-Hispanic children and three times as likely as Mexican American children to have elevated blood lead levels.
- Between 1999–2006 and 2007–2014, the percentage of all children ages 1–5 with blood lead levels at or above 5 µg/dL declined by approximately 4 percentage points. Black, non-Hispanic and Mexican American children also had large declines in the percentage with elevated blood lead levels between these two time periods, by 10 percentage points and 3 percentage points, respectively. However, the percentage of White, non-Hispanic children ages 1–5 with elevated blood lead levels was not statistically different between 1999–2006 and 2007–2014.
- In both 1999–2006 and 2007–2014, Black, non-Hispanic children were more likely to have elevated blood lead levels than White, non-Hispanic and Mexican American children.

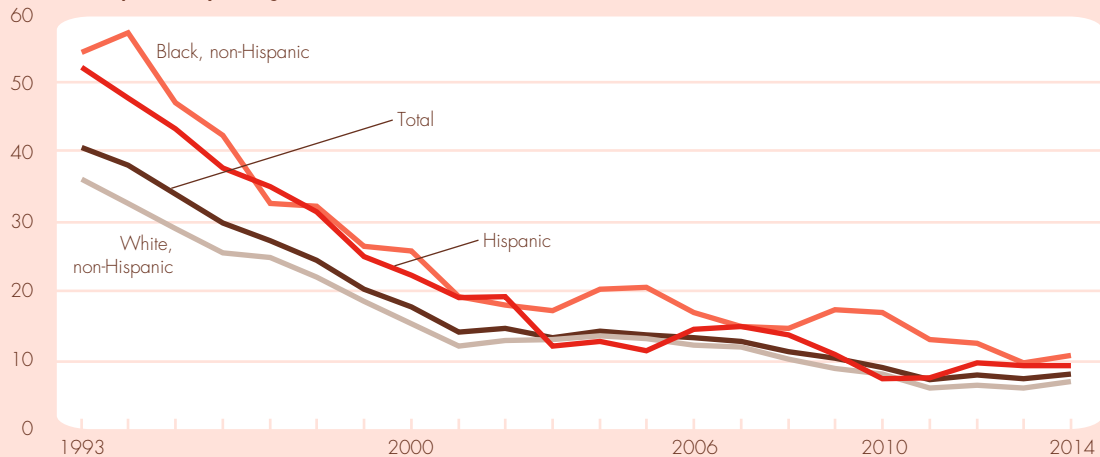
Bullets contain references to data in table PHY4.B on the childstats.gov website. Endnotes begin on page 46.

Youth Victims of Serious Violent Crimes

Violence frequently has dire and long-lasting impacts on young people who experience, witness, or feel threatened by it. In addition to causing direct physical harm to young victims, serious violence can adversely affect their mental health and development and increase the likelihood that they themselves will commit acts of serious violence. Examining violent victimization rates by race and ethnicity is important for understanding whether the risk for victimization differs for youth from different racial and ethnic backgrounds.^{48,49}

Figure 15 Serious violent victimization rates for youth ages 12–17 by race and Hispanic origin, 1993–2014

Youth victims per 1,000 youth ages 12–17



NOTE: Estimates from 1993 to 2013 are based on 3-year rolling averages centered on the year reported. For example, 1993 estimates were calculated by averaging 1992, 1993, and 1994 estimates. Estimates for 2014 are based on a 2-year average of 2013 and 2014 estimates. Serious violent victimizations include aggravated assault, rape, robbery, and homicide. Data on race and Hispanic origin are collected separately and persons of Hispanic origin may be of any race. Homicide data are collected using the FBI's Supplementary Homicide Reports (SHR), for which Hispanic origin is not available. Homicide is included in estimates among Black and White youth, but the victim may have been Hispanic. Homicide data were not available for 2014 at the time of publication. The 2013 homicide estimates are included in the 2014 victimization estimates. In 2013, homicides represented less than 1 percent of serious violent crime. Estimates exclude series victimizations, defined as victimizations that are similar in type but occur with such frequency that a victim is unable to recall each individual event or to describe each event in detail. In 2013–2014, about 2 percent of non-fatal serious violent victimizations committed against youth ages 12–17 were series victimizations. Due to methodological changes in the 2006 National Crime Victimization Survey, use caution when comparing 2006 criminal victimization estimates to those of other years. See *Criminal Victimization, 2007*, <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=764>, for more information.

SOURCE: Bureau of Justice Statistics, National Crime Victimization Survey and Federal Bureau of Investigation, Uniform Crime Reporting Program, Supplementary Homicide Reports.

- For all youth ages 12–17, the rate of serious violent victimization declined sharply from the early 1990s through the early 2000s and has declined more slowly since then. In 1993, youth ages 12–17 experienced 40 serious violent crimes per 1,000 youth, compared with 18 crimes per 1,000 youth in 2000 and 8 crimes per 1,000 youth in 2014.
- From 1993 to 2014, the rate at which White, non-Hispanic youth were victims of serious violent crimes decreased from 36 crimes per 1,000 youth to 7 crimes per 1,000 youth.
- Over the same period, the serious violent victimization rate for Black, non-Hispanic youth decreased from 54 crimes per 1,000 youth in 1993 to 11 crimes per 1,000 youth in 2014.
- Serious violent victimization rates decreased for Hispanic youth from 52 crimes per 1,000 youth in 1993 to 9 crimes per 1,000 youth in 2014.
- In 2014, there were no significant differences in the rates at which White, non-Hispanic, Black, non-Hispanic, and Hispanic youth ages 12–17 were victims of serious violent crimes.

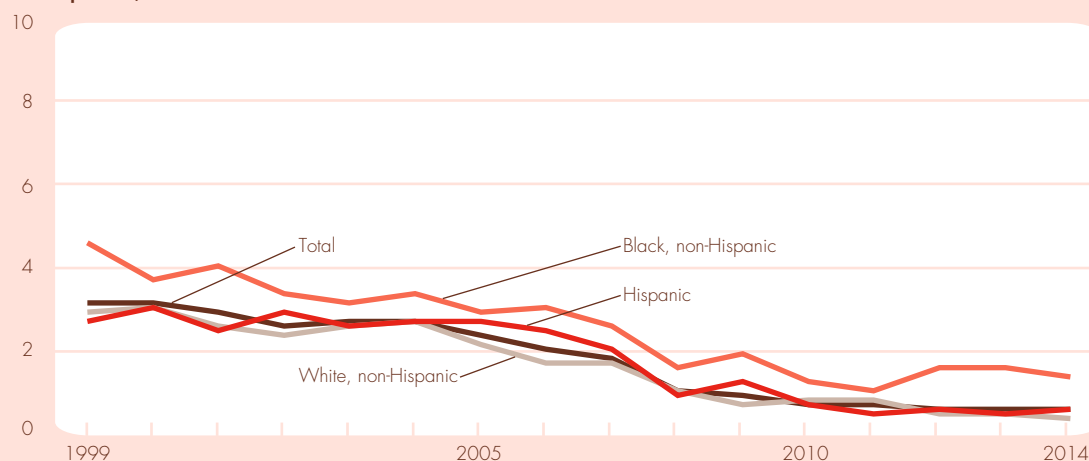
Bullets contain references to data in table PHY6.BRIEF on the childstats.gov website. Endnotes begin on page 46.

Child and Adolescent Injury and Mortality

Unintentional injuries are the leading cause of death for children and adolescents.^{50,51} In 2014, 35 percent of deaths among adolescents ages 15–19 and 30 percent of deaths among children ages 1–14 were due to unintentional injuries.⁵⁰ For both age groups, motor-vehicle-related (MVR) injury deaths are the leading type of unintentional injury death.⁵¹ Compared with younger children, adolescents have much higher death rates overall and from injuries, and are much more likely to die from injuries sustained in motor vehicle traffic crashes.⁵² In 2014, the reported MVR deaths rates for American Indian or Alaska Native children under age 20 were more than double the rates for White, non-Hispanic; Black, non-Hispanic; Asian or Pacific Islander, non-Hispanic; and Hispanic children under age 20.⁵³ Research has found that the race and ethnicity of Hispanic, American Indian or Alaska Native, and Asian or Pacific Islander decedents is often misclassified on death certificates, resulting in an under-estimate of death rates.⁵⁴ Therefore, death rates cannot be accurately reported for all racial and ethnic groups.^{54,55}

Figure 16 Motor-vehicle-related (MVR) death rates among children ages 1–14 by race and Hispanic origin, 1999–2014

Deaths per 100,000 children



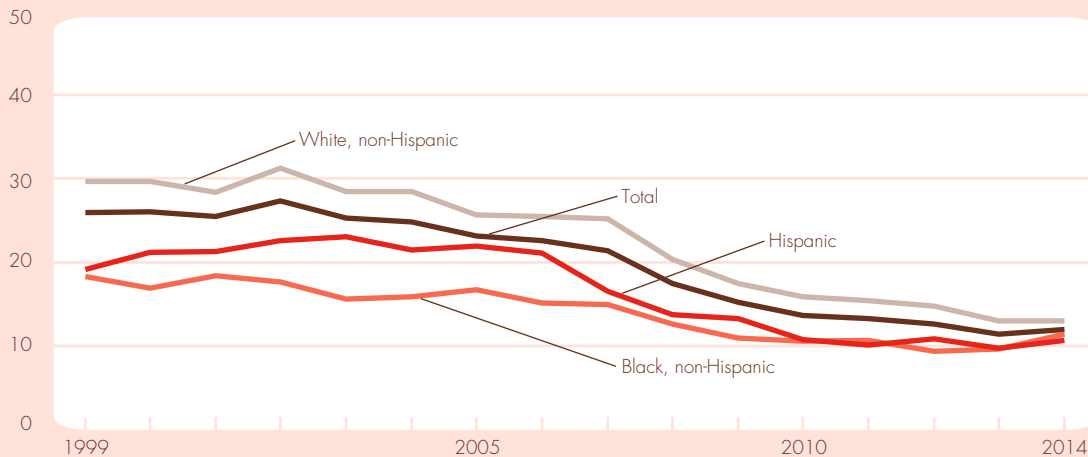
NOTE: Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1977 Office of Management and Budget Standards for Data on Race and Ethnicity.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2014, the MVR death rate for children ages 1–14 was 2.2 deaths per 100,000 population, representing 1,234 deaths. MVR death rates for Black, non-Hispanic (2.8); White, non-Hispanic (2.0); and Hispanic (2.2) children ranged from 2 to 3 deaths per 100,000 population.
- During most of 1999 to 2014, Black, non-Hispanic children had a higher MVR death rate than White, non-Hispanic children. Death rates for Black, non-Hispanic; White, non-Hispanic; and Hispanic children differed by 1 to 2 points throughout the period.

Figure 17 Motor-vehicle-related (MVR) death rates among adolescents ages 15–19 by race and Hispanic origin, 1999–2014

Deaths per 100,000 adolescents



NOTE: Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1977 Office of Management and Budget Standards for Data on Race and Ethnicity.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

- Among adolescents, the MVR death rate in 2014 was 11.9 deaths per 100,000 population, a total of 2,515 deaths. The MVR death rate for White, non-Hispanic (13.0) adolescents was higher than the rates for Black, non-Hispanic (11.4) and Hispanic (10.6) adolescents.
- Throughout 1999 to 2014, White, non-Hispanic adolescents had a higher MVR death rate than Black, non-Hispanic and Hispanic adolescents. This disparity in death rates declined from an 11 point difference in 1999 to about a 2 point difference in 2014.
- Between 1999 and 2014, the total MVR death rate for adolescents ages 15–19 declined from 26 deaths per 100,000 population to 12 deaths per 100,000 population. The MVR death rates for each racial and ethnic group declined throughout the period.

Bullets contain references to data in table PHY7/8.BRIEF on the childstats.gov website. Endnotes begin on page 46.

This page is intentionally left blank.

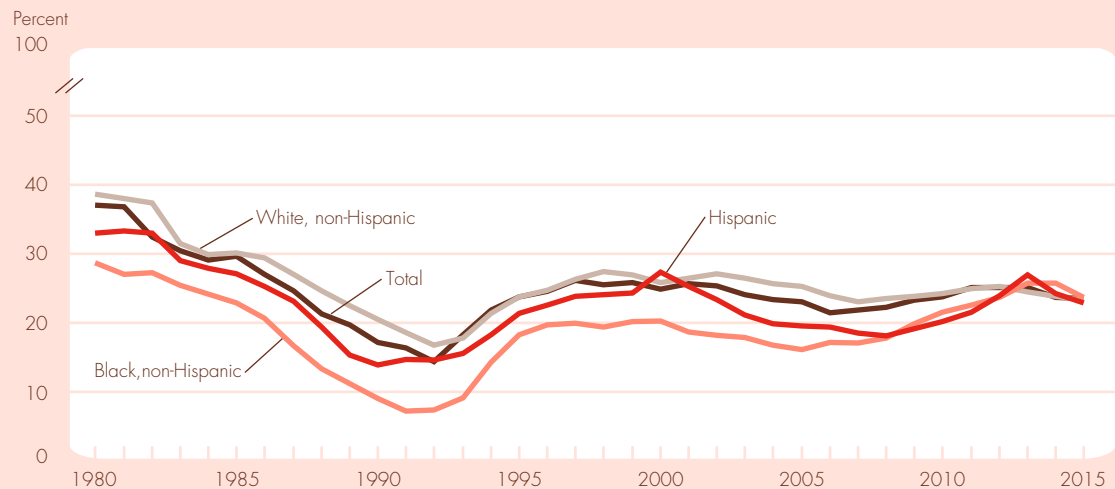


Behavior

Illicit Drug Use

The adolescent years can be a critical period for both substance use—including alcohol, tobacco, and illegal and prescription drugs—and the development of substance use disorders. When substance use disorders occur in adolescence, they may affect key developmental and social transitions, and they can interfere with normal brain maturation. Chronic and heavy marijuana use in adolescence, for example, has been shown to lead to a loss of IQ that is not recovered even if the individual quits using in adulthood.⁵⁶ The abuse of prescription and over-the-counter drugs can be addictive and puts users at risk of other adverse health effects, including overdose—especially when taken along with other drugs or alcohol. Impaired memory or thinking ability and other problems caused by drug use can derail a young person’s social and educational development and hold him or her back in life. Examining illicit drug use among adolescents by race and ethnicity can provide us with a fuller picture of who is at risk.

Figure 18 Percentage of 12th-grade students who reported using any illicit drugs in the past 30 days by race and Hispanic origin, 1980–2015



NOTE: Use of “any illicit drug” includes any use of marijuana, LSD, other hallucinogens, crack, other cocaine, or heroin, or any use of other prescription narcotics, amphetamines, barbiturates, or tranquilizers not under a doctor’s orders. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately.

SOURCE: National Institute on Drug Abuse, Monitoring the Future Survey.

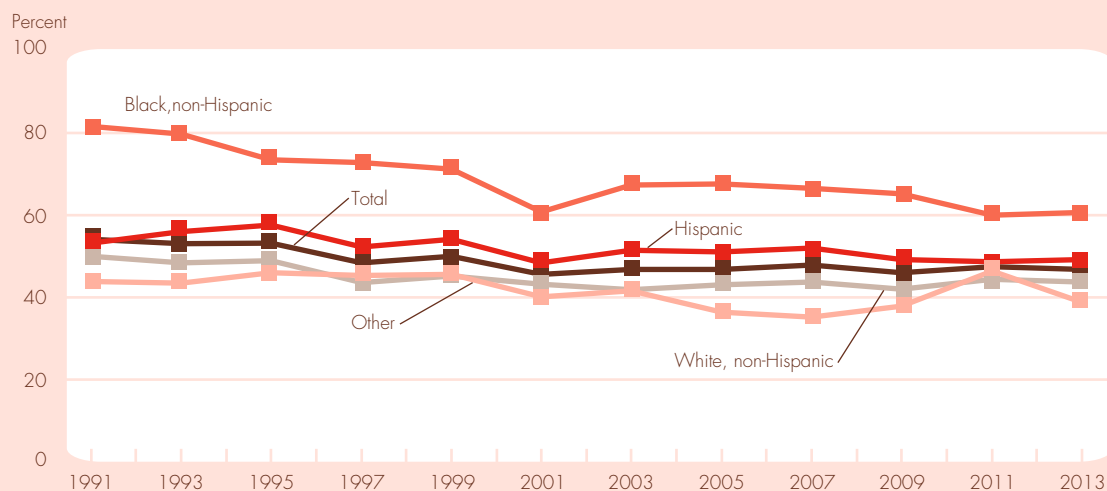
- Between 2014 and 2015, illicit drug use in the past 30 days remained stable at 8 percent among 8th-grade students and 24 percent among 12th-grade students. However, among 10th-grade students, illicit drug use declined from 19 percent to 17 percent.
- Among 12th-graders, 23 percent of both White, non-Hispanic and Hispanic students and 24 percent of Black, non-Hispanic students reported using illicit drugs in the past 30 days in 2015. Among 10th-grade students, the percentages were 16 percent for White, non-Hispanics and 20 percent for both Black, non-Hispanics and Hispanics. Among 8th-grade students, the percentages were 6 percent for White, non-Hispanic students; 9 percent for Black, non-Hispanic students; and 10 percent for Hispanic students.
- Over the past several decades, 12th grade White non-Hispanics and Hispanics reported similar rates of past month illicit drug use with rates consistently above those reported by Black non-Hispanics. Since 2012, there has been a narrowing of this gap and in 2015 there was no significant difference in the rate of past month illicit drug use reported by White non-Hispanics, Hispanics or Black non-Hispanics.

Bullets contain references to data in table BEH3 on the childstats.gov website. Endnotes begin on page 46.

Sexual Activity

Early sexual activity is associated with emotional⁵⁷ and physical health risks. Youth who engage in sexual activity are at risk of contracting sexually transmitted infections (STIs) and becoming pregnant. STIs, including HIV, can infect a person for a lifetime and have consequences including disability and early death. Delaying sexual initiation is associated with a decrease in the number of lifetime sexual partners,⁵⁸ and decreasing the number of lifetime partners is associated with a decrease in the rate of STIs.^{59,60} Additionally, teen pregnancy is associated with a number of negative risk factors, not only for the mother but also for her child (see also *Adolescent Births*).⁶¹ Examining sexual activity by race and ethnicity can help us determine who is at highest risk for negative emotional and physical consequences.

Figure 19 Percentage of high school students who reported ever having had sexual intercourse by race and Hispanic origin, selected years 1991–2013



NOTE: Data are based on the student's response to the question "Have you ever had sexual intercourse?" The revised 1997 Office of Management and Budget Standards for Data on Race and Ethnicity were implemented in 2005. Data on race and Hispanic origin are collected separately but are combined for reporting. Students were coded as "Other" if they (1) did not self-report as Hispanic, and (2) selected "American Indian or Alaska Native," "Asian," or "Native Hawaiian or Other Pacific Islander," or selected more than one response to a question on race.

SOURCE: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Youth Risk Behavior Surveillance System.

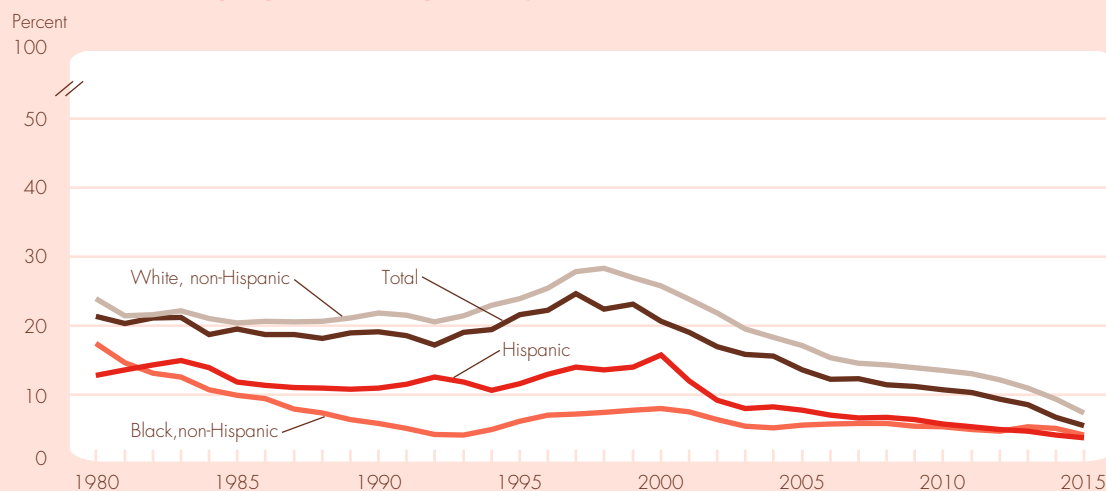
- In 2013, 47 percent of high school students in grades 9 through 12 reported ever having had sexual intercourse.
- The percentage of students who reported ever having had sexual intercourse declined from 1991 (54 percent) to 2001 (46 percent) and remained stable from 2001 to 2013.
- The percentage of students who reported ever having had sexual intercourse differed by race and Hispanic origin. In 2013, 61 percent of Black, non-Hispanic students reported ever having had sexual intercourse, compared with 49 percent of Hispanic students and 44 percent of White, non-Hispanic students.

Bullets contain references to data in table BEH4.A on the *childstats.gov* website. Endnotes begin on page 46.

Regular Cigarette Smoking

Smoking has serious long-term consequences, including the risk of smoking-related diseases and premature death, as well as the increased health care costs related to treating associated illnesses.⁶² Over 480,000 deaths are attributable annually to tobacco use, making tobacco more lethal than all other addictive drugs. Nearly 87 percent of smokers start smoking by age 18. Each day in the United States, approximately 2,300 young people under 18 years of age smoke their first cigarette, and an estimated 450 youth in that age group become daily cigarette smokers.⁶³ Smoking rates vary greatly by race and ethnicity. The high rate of use and the consequences of cigarette smoking underscore the importance of studying patterns of smoking among adolescents.

Figure 20 Percentage of 12th-grade students who reported smoking cigarettes daily in the past 30 days by race and Hispanic origin, 1980–2015



NOTE: Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately.

SOURCE: National Institute on Drug Abuse, Monitoring the Future Survey.

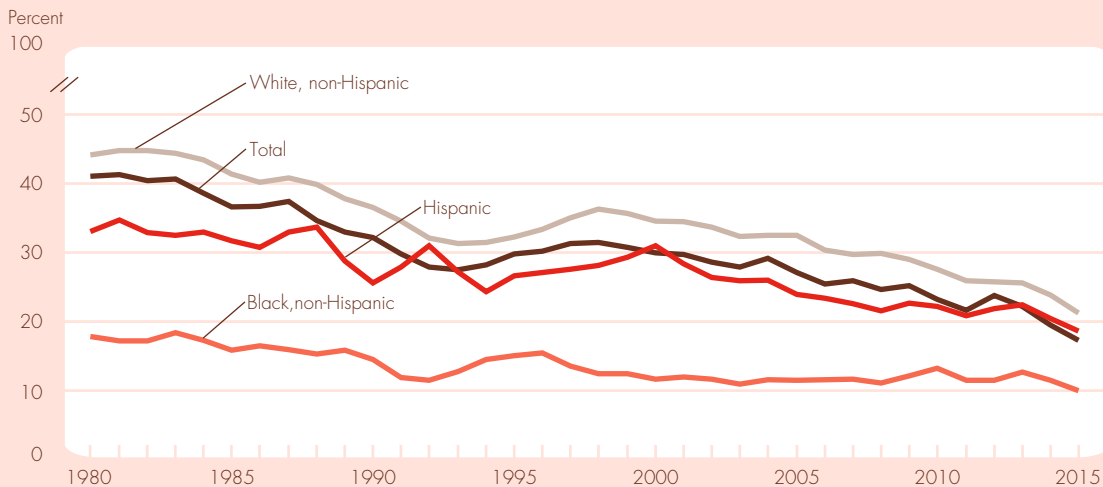
- In 2015, the percentage of 8th-, 10th-, and 12th-grade students who reported smoking cigarettes daily in the past 30 days has continued to be the lowest since data collection began in 1980. In 2015, 1 percent of 8th-grade students, 3 percent of 10th-grade students, and 6 percent of 12th-grade students—down from 9 percent, 16 percent, and 22 percent, respectively, in 1995—reported smoking in the past 30 days.
- In 2015, among 12th-graders, an estimated 7.3 percent of White, non-Hispanic students reported daily cigarette use in the past month—this is nearly twice as many as the 4 percent of Black, non-Hispanic and 3.7 percent of Hispanic students that reported regular cigarette use.
- Since 2000, the largest decline in regular cigarette use among 12th-graders was a 76 percent drop reported by Hispanic students—from 16 to 4 percent. Among Whites, there was a 70 percent decline in the same time period—from 26 to 7 percent. Among Black, non-Hispanics, the rate of regular cigarette use dropped by 50 percent—from 8 percent to 4 percent.

Bullets contain references to data in table BEH1 on the childstats.gov website. Endnotes begin on page 46.

Alcohol Use

Alcohol is the most common illicit substance used during adolescence. Heavy use is associated with negative outcomes such as problems in school and the workplace, being involved in fights, criminal activities, or motor vehicle crashes, resulting in injuries as well as death.⁶⁴ Binge drinking, defined here as five or more alcoholic beverages in a row or during a single occasion in the previous two weeks, is a common pattern of alcohol abuse. Early onset of binge drinking may be especially problematic, potentially increasing the likelihood of negative outcomes including alcohol use disorder. While overall trends of binge drinking continue to decline among adolescents, examining alcohol use by race and ethnicity can help us to better understand who is at greatest risk for negative consequences.

Figure 21 Percentage of 12th-grade students who reported having five or more alcoholic beverages in a row in the past two weeks by race and Hispanic origin, 1980–2015



NOTE: Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately.

SOURCE: National Institute on Drug Abuse, Monitoring the Future Survey.

- In 2015, the percentages of 10th-, and 12th-grade students who reported binge drinking were the lowest since the survey began in 1980.
- In 2015, 5 percent of 8th graders reported binge drinking—down from 11 percent in 1991, the first year the survey reported on 8th and 10th grade alcohol use. Among, 10th graders, there was a decline from 21 percent in 1991 to 11 percent in 2015.
- Twelfth graders were first surveyed in 1980 and have also reported a long-term decline from 41 percent in 1980 to 17 percent in 2015.
- Among 12th grade students, 21 percent of White, non-Hispanics and 19 percent of Hispanics reported binge drinking. This was two times the rate of Black, non-Hispanic 12th-graders that reported binge drinking (10 percent) in 2015.
- Among 12th graders, long-term trends of reported binge drinking have declined among White, non-Hispanics; Black, non-Hispanics; and Hispanics. Since 1980, reported use among White, non-Hispanics declined from 44 percent in that year to 21 percent in 2015. Among Black, non-Hispanics, binge drinking dropped from 18 percent in 1980 to 10 percent in 2015 and among Hispanics binge drinking decreased from 33 percent in 1980 to 19 percent in 2015.

Bullets contain references to data in table BEH2 on the childstats.gov website. Endnotes begin on page 46.

This page is intentionally left blank.

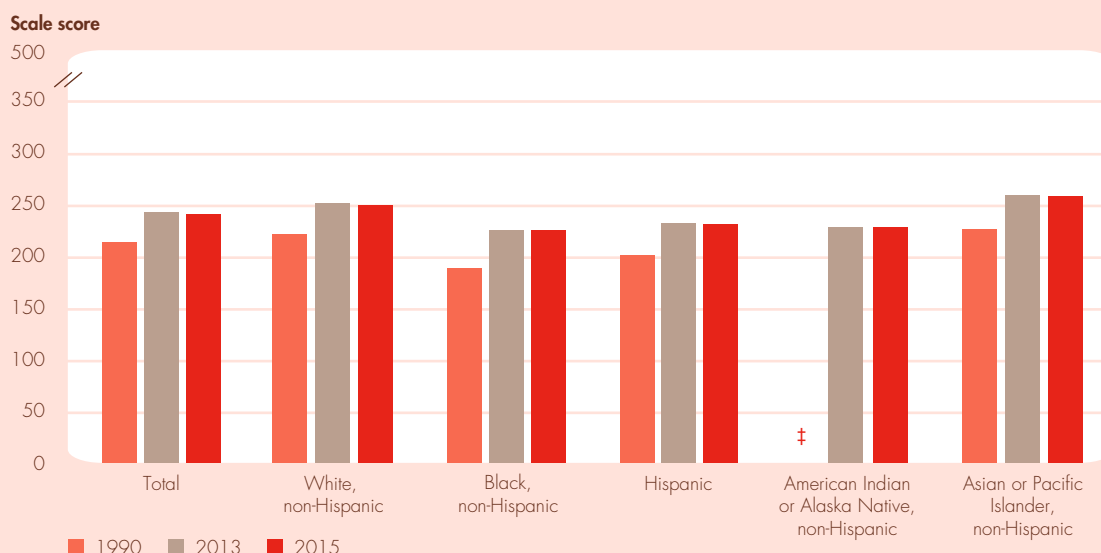


Education

Mathematics and Reading Achievement

The extent of children's knowledge, as well as their ability to think, learn, and communicate, affects their likelihood of becoming productive adults and active citizens. Mathematics and reading achievement test scores measure students' skills in these subjects and are good indicators of overall achievement in school. Students with lower levels of academic achievement tend to have less favorable education outcomes. In addition, differences in academic performance between groups of students, or achievement gaps, have long been documented for students from different racial and ethnic backgrounds.

Figure 22 Average mathematics scale scores for 4th-grade students by race and Hispanic origin, 1990, 2013, and 2015



† Reporting standards not met (too few cases for a reliable estimate).

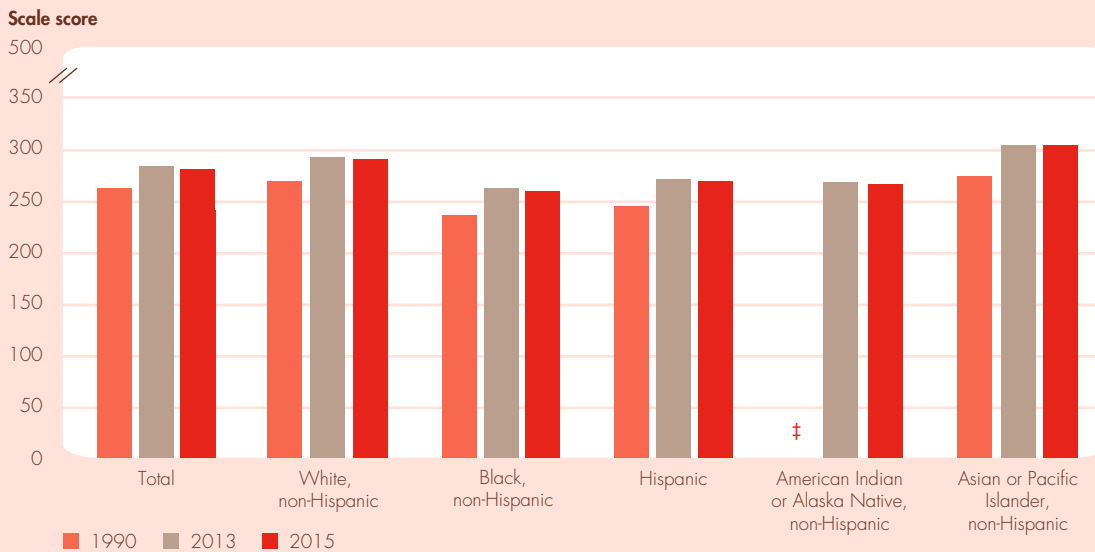
NOTE: To assess progress in mathematics and reading, the National Assessment of Educational Progress (NAEP) measures trends in the academic performance of U.S. students, including those in public and private schools. Testing accommodations (e.g., extended time, small group testing) for children with disabilities and English language learners were not permitted in 1990. Data on race and Hispanic origin are collected separately and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Race categories exclude persons of Hispanic ethnicity.

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress.

- At grade 4, the average mathematics scores for non-Hispanic White, Black, and Asian or Pacific Islander students were all higher in 2015 than in 1990; this finding also held for Hispanic students.
- In 2015 and in all previous assessment years, the average mathematics score for White, non-Hispanic 4th-grade students was higher than the scores for their Black, non-Hispanic and Hispanic peers. However, there has been some narrowing of racial and ethnic achievement gaps for 4th-grade students over time. For example, the White-Black mathematics achievement gap at grade 4 narrowed from 32 points in 1990 to 24 points in 2015.
- Despite increases over time, in 2015, for the first time, the average mathematics scale score for 4th-grade students was lower than in the previous assessment year, 2013 (240 versus 242).
- The 2015 average mathematics score for 4th-grade students (240) translates into a *Basic* level of proficiency,⁶⁵ but patterns in mathematics achievement varied among racial and ethnic groups. For example, the average mathematics score for 4th-grade Asian or Pacific Islander students (257) was higher than the scores for their counterparts. The score for White, non-Hispanic students (248) at grade 4 was also higher than the scores for non-Hispanic students who were Black (224) and American Indian or Alaska Native (227), as well as Hispanic students (230).

Figure 23

Average mathematics scale scores for 8th-grade students by race and Hispanic origin, 1990, 2013, and 2015



† Reporting standards not met (too few cases for a reliable estimate).

NOTE: To assess progress in mathematics and reading, the National Assessment of Educational Progress (NAEP) measures trends in the academic performance of U.S. students, including those in public and private schools. Testing accommodations (e.g., extended time, small group testing) for children with disabilities and English language learners were not permitted in 1990. Data on race and Hispanic origin are collected separately and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Race categories exclude persons of Hispanic ethnicity.

SOURCE: U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress.

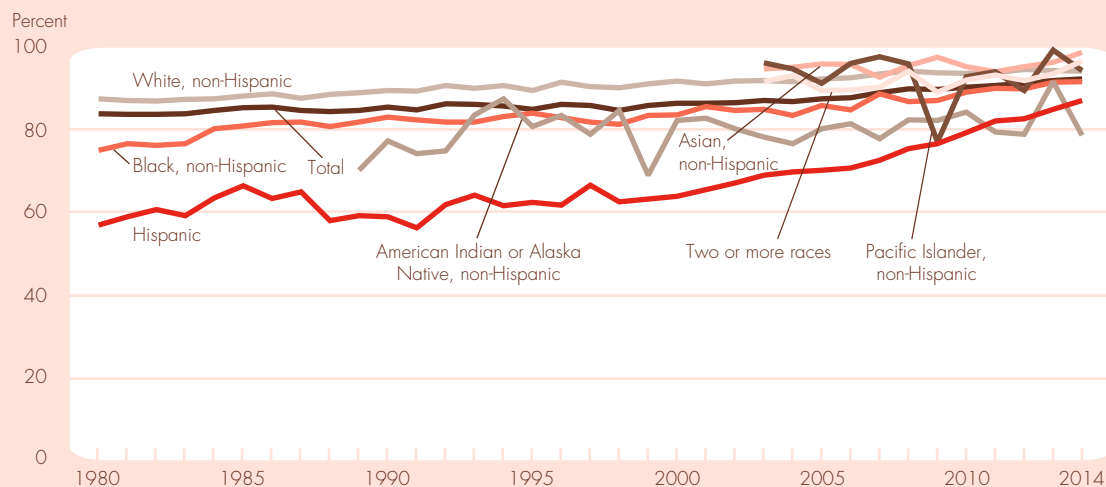
- At grade 8, the average mathematics scores for non-Hispanic White, Black, and Asian or Pacific Islander students were all higher in 2015 than in 1990; the same was true for Hispanic students.
- In 2015 and in all previous assessment years, the average mathematics scores for White, non-Hispanic students at grade 8 have been higher than the scores for their Black, non-Hispanic and Hispanic peers. At grade 8, the 2015 achievement gaps between White, non-Hispanic and Black, non-Hispanic students and between White, non-Hispanic and Hispanic students were not statistically different from the gaps in 1990.
- As was the case for 4th-grade students, in 2015, the average mathematics score for 8th-grade students was lower than the average score for the previous assessment year for the first time (282 in 2015 versus 285 in 2013). Nonetheless, the 8th-grade average mathematics score in 2015 was higher than in 1990 (263).
- At grade 8, the average mathematics score in 2015 (282) aligned with a *Basic* level of proficiency.⁶⁵ However, mathematics performance varied among students. The average mathematics score at grade 8 was higher for Asian or Pacific Islander, non-Hispanic students (306) than for their peers in the other racial and ethnic groups. In addition, the average 8th-grade mathematics score was higher for White, non-Hispanic (292) students than for non-Hispanic students who were Black (260) and American Indian or Alaska Native (267) as well as Hispanic students (270).

Bullets contain references to data in table ED2.A/B, and data on reading achievement can be found in table ED2.C. All tables are available on the childstats.gov website. Endnotes begin on page 46.

High School Completion

Attainment of a high school diploma or its equivalent is an indicator that a person has acquired the basic academic skills needed to function in today's society. The percentage of young adults ages 18–24 with a high school diploma or an equivalent credential is a measure of the extent to which young adults have completed a basic prerequisite for many entry-level jobs and for higher education. Persons with higher levels of education tend to have better economic outcomes than their peers with lower levels of education.⁶⁶

Figure 24 Percentage of young adults ages 18–24 who have completed high school by race and Hispanic origin, 1980–2014



NOTE: From 1980 to 1991, high school completion was measured by the completion of 4 years of high school rather than the actual attainment of a high school diploma or equivalent. Diploma equivalents include alternative credentials obtained by passing exams such as the General Educational Development (GED) test. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Race categories exclude persons of Hispanic ethnicity.

SOURCE: U.S. Census Bureau, Current Population Survey, School Enrollment Supplement.

- In 2014, 92 percent of young adults ages 18–24 had completed high school with a diploma or an alternative credential, such as a General Educational Development (GED) certificate. The high school completion rate has increased from 84 percent in 1980.
- The high school completion rate for Black, non-Hispanic young adults increased from 75 percent in 1980 to 92 percent in 2014. Among White, non-Hispanic young adults, this rate increased from 87 percent in 1980 to 94 percent in 2014. While the high school completion rate for Hispanic young adults has consistently been lower during this period than for their White, non-Hispanic and Black, non-Hispanic peers, the rate for Hispanic young adults increased 30 percentage points between 1980 and 2014, from 57 percent to 87 percent.
- High school completion rates increased between 2003 (when separate data became available for all race groups) and 2014 for Asian, non-Hispanic young adults (from 95 to 99 percent) and non-Hispanic young adults of two or more races (from 92 to 97 percent). During this period, the completion rates also increased for young adults who were Hispanic (from 69 to 87 percent); Black, non-Hispanic (from 85 to 92 percent); and White, non-Hispanic (from 92 to 94 percent). In contrast, 2014 completion rates for non-Hispanic American Indian or Alaska Native (79 percent) and Pacific Islander young adults (99 percent) were not statistically different from the rates in 2003.
- In 2014, the high school completion rate was higher for non-Hispanic young adults who were White (94 percent), Asian (99 percent), and of two or more races (97 percent) than for those who were Black, non-Hispanic (92 percent); Hispanic (87 percent); and American Indian or Alaska Native, non-Hispanic (79 percent). The completion rate was also higher for Black, non-Hispanic young adults than for their Hispanic and American Indian or Alaska Native, non-Hispanic peers.

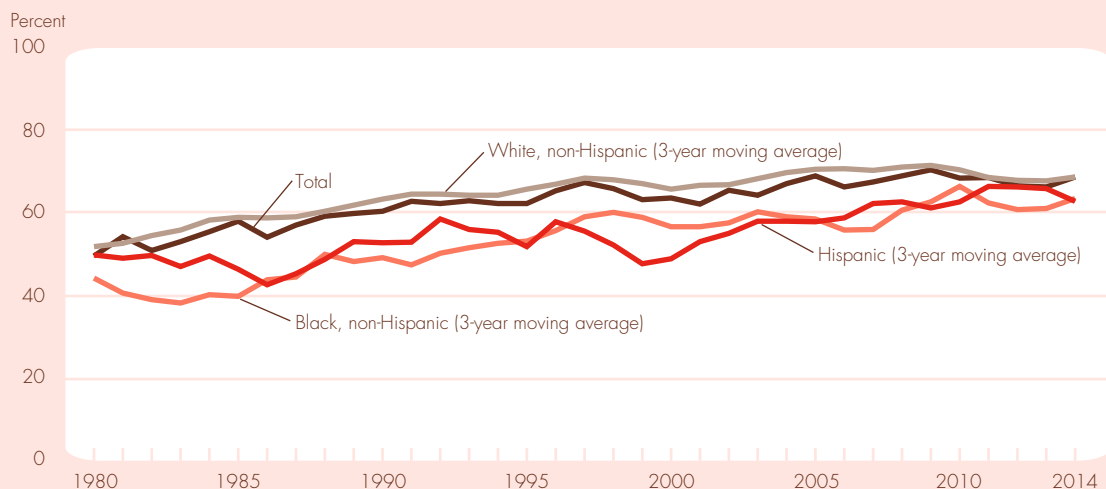
Bullets contain references to data in table ED4 on the childstats.gov website. Endnotes begin on page 46.

College Enrollment

A college education generally enhances a person's employment prospects and increases his or her earning potential.⁶⁶ The percentage of high school completers who enroll in college in the fall immediately after high school is one measure of the accessibility and perceived value of a college education by high school completers.⁶⁷ Research shows that high school completers who delay enrollment in postsecondary education are less likely to persist in their education and to attain a postsecondary credential.⁶⁸

Figure 25

Percentage of high school completers who were enrolled in college the October immediately after completing high school by race and Hispanic origin, 1980–2014



NOTE: Enrollment in college, as of October of each year, is for individuals ages 16–24 who completed high school during the preceding 12 months. High school completion includes General Educational Development (GED) certificate recipients. Data have been revised since previous publication in *America's Children*. Due to some short-term data fluctuations associated with small sample sizes, moving averages are used to produce more stable estimates for racial and ethnic groups. A 3-year moving average is the weighted average of the estimates for the year prior to the reported year, the reported year, and the following year. For 2014, a 2-year moving average is used, reflecting an average of the 2013 and 2014 estimates. Beginning in 2003, those in a given racial category represent those reporting only that race. Data from 2003 onward are not directly comparable with data from earlier years. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. Persons of Hispanic origin may be of any race.

SOURCE: U.S. Census Bureau, Current Population Survey, School Enrollment Supplement.

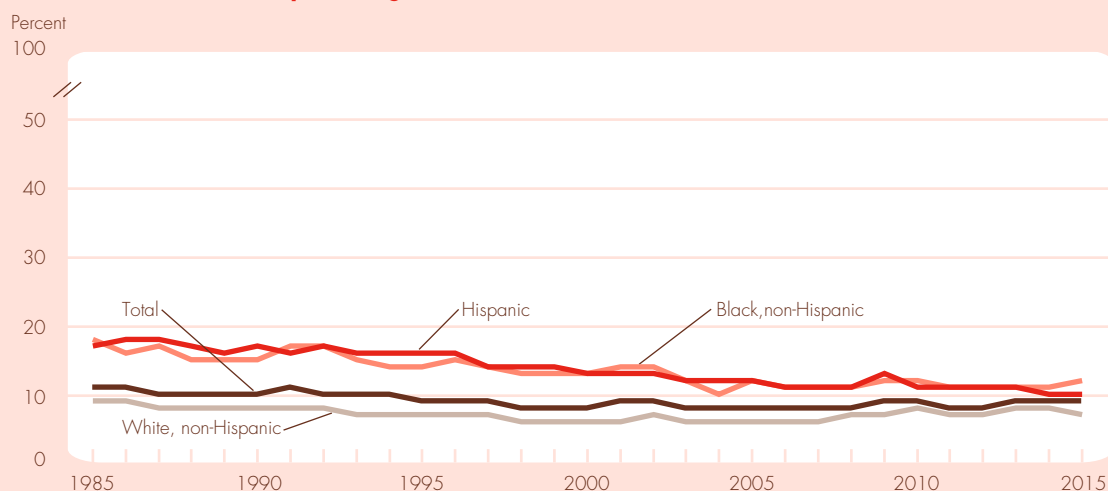
- In 2014, 68 percent of high school completers enrolled in a 2-year or 4-year college in the fall immediately after high school. Between 1980 and 2014, the rate of immediate college enrollment trended upward nearly 20 percentage points, from 49 percent to 68 percent.
- In 1980, some 52 percent of White, non-Hispanic high school completers immediately enrolled in college; this rate increased to 68 percent in 2014.⁶⁹
- The immediate college enrollment rate for Black, non-Hispanic high school completers increased from 44 percent in 1980 to 63 percent in 2014.
- The immediate college enrollment rate for Hispanic high school completers also increased, from 50 percent in 1980 to 62 percent in 2014.
- In 2014, the immediate college enrollment rates for White, non-Hispanic high school completers (68 percent); Black, non-Hispanic high school completers (63 percent); and Hispanic high school completers were not statistically different (62 percent), due in part to large standard errors for Black, non-Hispanic and Hispanic high school completers. In 1980, the immediate college enrollment rate was higher for White, non-Hispanic high school completers (52 percent) than for their Black, non-Hispanic peers (44 percent).

Bullets contain references to data in table ED6 on the childstats.gov website. Endnotes begin on page 46.

Youth Neither Enrolled in School nor Working

Youth ages 16–19 who are neither enrolled in school nor working are detached from these core activities, both of which play an important role in one’s transition from adolescence to adulthood. If this detachment lasts for several years, it can hinder a youth’s opportunity to build a work history that contributes to future higher wages and employability.⁷⁰ The percentage of youth who are not enrolled in school and not working is one measure of the proportion of young people who are at risk of limiting their future prospects. Analysis done by the Congressional Research Service finds that a greater share of minority youth, particularly Black males, are disconnected, and that their rates of disconnection have been higher over time. Disconnected youth are also twice as likely to be poor as their connected peers.⁷⁰

Figure 26 Percentage of youth ages 16–19 who are neither enrolled in school nor working by race and Hispanic origin, 1985–2015



NOTE: Data relate to the labor force and enrollment status of persons ages 16–19 in the civilian noninstitutionalized population during an “average” week of the school year. School refers to both high school and college. Data on race and Hispanic origin from 2003 onward are collected separately and combined for reporting according to 1997 Office of Management and Budget (OMB) Standards for Data on Race and Ethnicity. For data prior to 2003, 1977 OMB Standards were used. Data from 2003 onward are not directly comparable with data from earlier years. Beginning in 2003, those in each racial category represent those reporting only one race. Persons of Hispanic origin may be of any race.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

- In 2015, 9 percent of youth ages 16–19 were neither enrolled in school nor working. This figure was unchanged from 2014 and little different over the past 20 years.
- The percentage of Black, non-Hispanic youth and Hispanic youth neither enrolled in school nor working has declined since 1985.
- Black, non-Hispanic youth had a higher rate of detachment from work and school, at 12 percent, than Hispanic youth (10 percent) and White, non-Hispanic youth (7 percent) in 2015.
- For youth ages 16–17, the rate of detachment was less than half the rate of older youth ages 18–19. In 2015, 5 percent of both Black, non-Hispanic youth and Hispanic youth ages 16–17 were neither enrolled in school nor working, compared with 4 percent of White, non-Hispanic youth in this age group.
- Older youth, ages 18–19, had a higher rate of detachment from work and school at 13 percent. Black, non-Hispanic youth in this age group saw a detachment rate of 19 percent in 2015, compared with 16 percent for Hispanic youth and 11 percent for White, non-Hispanic youth. These figures were either the same as or almost unchanged from 2014.

Bullets contain references to data in table ED5.A on the childstats.gov website. Endnotes begin on page 46.

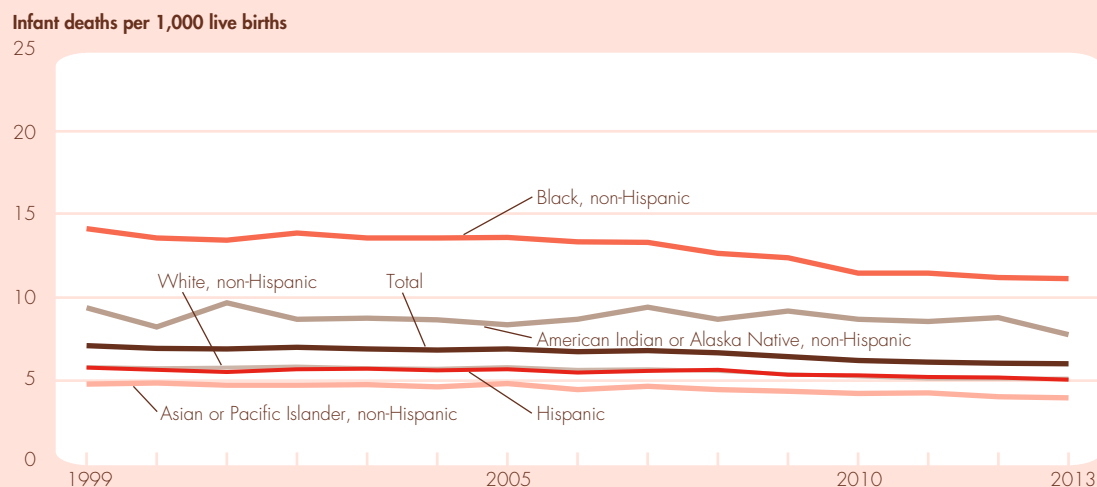


Health

Infant Mortality

Infant mortality is defined as the death of an infant before his or her first birthday. Infant mortality is related to the underlying health of the mother, public health practices, socioeconomic conditions, and availability and use of appropriate health care for infants and pregnant women.⁷¹ Despite medical advances and public health efforts, the mortality rates of Black, non-Hispanic and American Indian or Alaska Native infants have been consistently higher than the rates of other racial and ethnic groups.^{72,73} A higher percentage of preterm births accounts for most of the higher infant mortality for Black, non-Hispanic infants. Higher rates of sudden infant death syndrome (SIDS), birth defects, preterm births, and injuries account for much of the higher infant mortality among American Indian or Alaska Native infants.⁷⁴

Figure 27 Death rates among infants by race and Hispanic origin of mother, 1999–2013



NOTE: Infant deaths are deaths before an infant's first birthday. Race refers to mother's race. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected and reported separately. Data from states reporting multiple races were bridged to the single-race categories of the 1977 Office of Management and Budget Standards for Data on Race and Ethnicity for comparability with other states.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

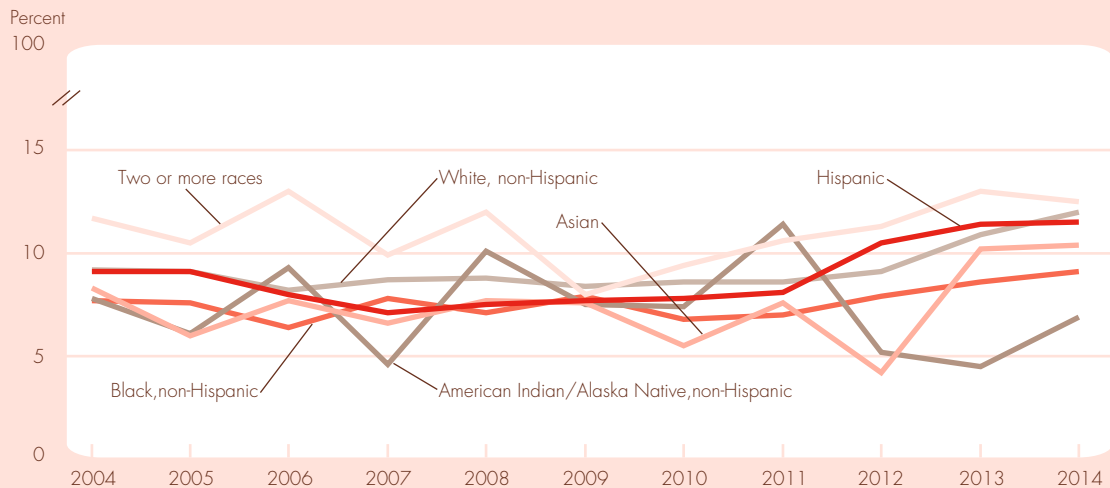
- In 2013, the infant mortality rates were 11.1 infant deaths per 1,000 live births for Black, non-Hispanics; 7.7 infant deaths per 1,000 live births for American Indian or Alaska Native, non-Hispanics; 5.1 infant deaths per 1,000 live births for White, non-Hispanics; 5.0 infant deaths per 1,000 live births for Hispanics; and 3.9 infant deaths per 1,000 live births for Asian or Pacific Islander, non-Hispanics.
- From 1999 to 2013, the total infant mortality rate declined by 1 percentage point. During the same time period, the infant mortality rate declined by 3 points for Black, non-Hispanic infants and 1 point for White, non-Hispanic; Asian or Pacific Islander, non-Hispanic; and Hispanic infants. Infant mortality for American Indian or Alaska Native, non-Hispanic infants was stable from 1999 to 2013.
- Despite the declines in infant mortality between 1999 and 2013, rates for Black, non-Hispanic and American Indian or Alaska Native, non-Hispanic infants remained higher than the rates for White, non-Hispanic; Hispanic; and Asian or Pacific Islander, non-Hispanic infants throughout the entire period.

Bullets contain references to data in table HEALTH2 on the childstats.gov website. Endnotes begin on page 46.

Adolescent Depression

Depression has a significant impact on adolescent development and well-being. Adolescent depression can adversely affect school and work performance, impair peer and family relationships, and exacerbate the severity of other health conditions such as asthma and obesity.^{75,76} Major depressive episodes (MDE) often persist, recur, or continue into adulthood.^{77,78} Youth with MDE are at greater risk for suicide and are more likely to initiate alcohol and other drug use compared with youth without MDE.^{79,80} The majority of youth with MDE do not receive depression care.^{77,78} Moreover, racial/ethnic minority youth with MDE are less likely to receive depression care compared with their White counterparts.^{77,78}

Figure 28 Percentage of youth ages 12–17 who had at least one major depressive episode (MDE) in the past year by race and Hispanic origin, 2004–2014



NOTE: MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities plus at least four additional symptoms of depression (such as problems with sleep, eating, energy, concentration, and feelings of self-worth) as described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. The 1997 Office of Management and Budget standards were used to collect race and ethnicity data. Persons could select one or more of five racial groups: White, Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or Asian. Respondents could choose more than one race. Those reporting more than one race were classified as "Two or more races." Data on Hispanic origin are collected separately. Persons of Hispanic origin may be of any race.

SOURCE: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health.

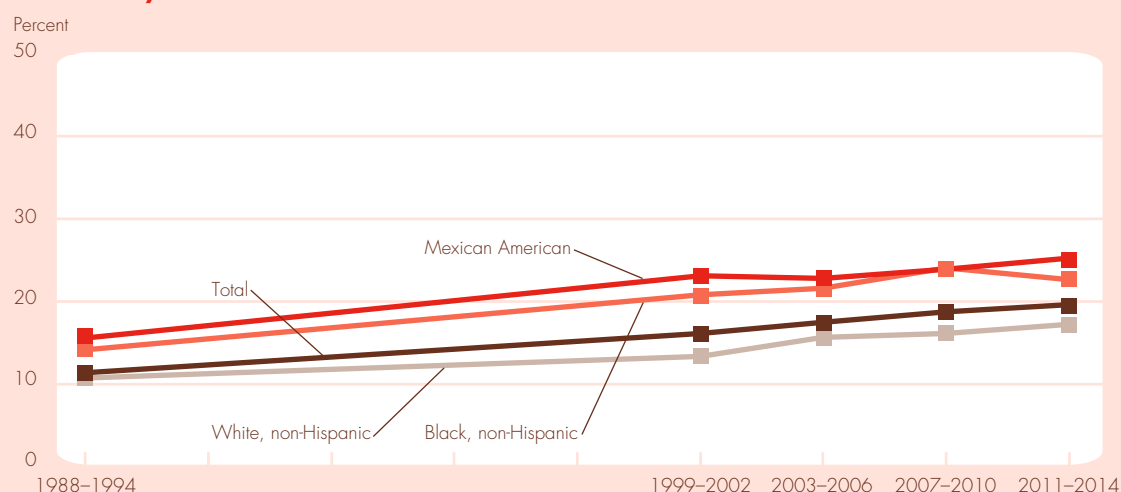
- In 2014, about 11 percent of youth ages 12–17 had a major depressive episode (MDE) during the past year, a higher prevalence than that reported in 2004 (9 percent). The prevalence of MDE in the past year among White, non-Hispanic youth in 2014 (12 percent) was higher than among Black, non-Hispanic youth (9 percent) and among American Indian or Alaska Native, non-Hispanic youth (7 percent).
- However, in 2014, the prevalence of MDE in the past year among White, non-Hispanic youth (12 percent) was similar to that among non-Hispanic youth of two or more races (13 percent), among Hispanic youth (12 percent), and among Asian, non-Hispanic youth (10 percent).
- Among White, non-Hispanic youth as well as among Hispanic youth, the prevalence of MDE in the past year increased from 9 percent in 2004 to 12 percent in 2014. However, the prevalence of MDE in the past year in 2004 did not differ from that in 2014 among the other youth by race and ethnicity.

Bullets contain references to data in table HEALTH4.A on the childstats.gov website. Endnotes begin on page 46.

Obesity

Children with obesity often become adults with obesity, with increased risks for a wide variety of poor health outcomes, including diabetes, stroke, heart disease, arthritis, and certain cancers.^{81,82} The consequences of obesity for children and adolescents are often psychosocial but also include high blood pressure, diabetes, early puberty, and asthma.^{82,83} The prevalence of obesity among U.S. children changed relatively little from the early 1960s through 1980; however, after 1980 it increased sharply.⁸⁴ In addition to individual factors such as diet and physical activity, other factors, including social, economic, and environmental forces (e.g., trends in eating out), may have contributed to the increased prevalence of obesity.⁸⁵ Previous research has found that the prevalence of obesity among children varies by race and ethnicity.^{86,87}

Figure 29 Percentage of children ages 6–17 with obesity by race and Hispanic origin, selected years 1988–2014

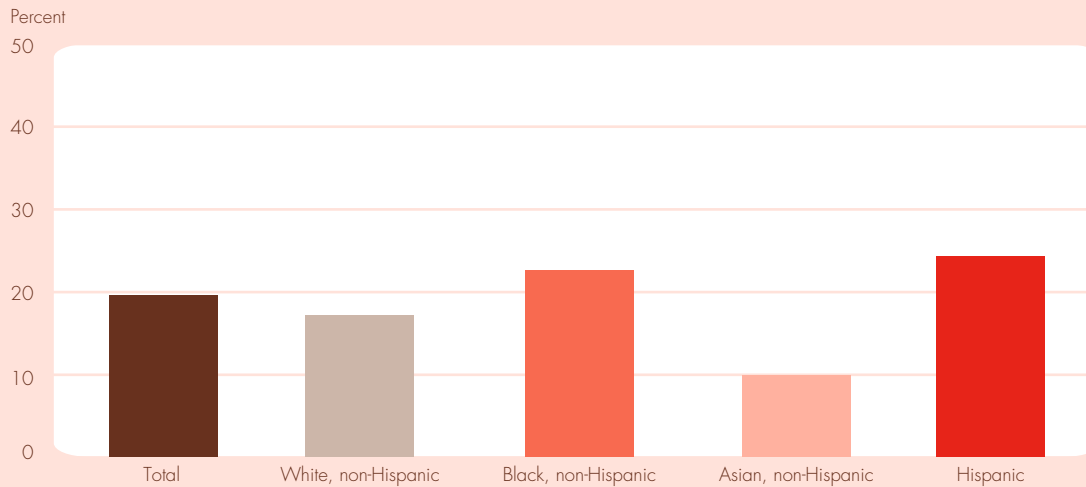


NOTE: Previously a body mass index (BMI) at or above the 95th percentile of the sex-specific BMI growth charts was termed overweight (<http://www.cdc.gov/growthcharts>); it is now termed obesity.⁸⁸ Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity for comparability with other states. Beginning in 2007, the National Health and Nutrition Examination Survey allows for reporting of both total Hispanics and Mexican Americans; however, estimates reported here are for Mexican Americans to be consistent with earlier years.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- From 1988–1994 to 2011–2014, the percentage of children ages 6–17 with obesity increased by 8 percentage points from 11 to 19 percent. During the same time period, the percentage of children with obesity increased by 7 percentage points for White, non-Hispanic; 9 percentage points for Black, non-Hispanic; and 10 percentage points for Mexican American children.
- From 1988–1994 to 2011–2014, White, non-Hispanic children were less likely to have obesity than Black, non-Hispanic and Mexican American children. During the same period, the percentages of Black, non-Hispanic and Mexican American children with obesity were similar.
- Between 2007–2010 and 2011–2014, the percentage of children ages 6–17 with obesity was not measurably different for each racial and ethnic group.

Figure 30 Percentage of children ages 6–17 with obesity by race and Hispanic origin, 2011–2014



NOTE: Previously a body mass index (BMI) at or above the 95th percentile of the sex-specific BMI growth charts was termed overweight (<http://www.cdc.gov/growthcharts>); it is now termed obesity.⁸⁸ Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected separately and combined for reporting according to the 1997 Office of Management and Budget Standards for Data on Race and Ethnicity for comparability with other states. Beginning in 2007, National Health and Nutrition Examination Survey (NHANES) allows for reporting of both total Hispanics and Mexican Americans. Beginning in 2011, the NHANES sample was designed to provide estimates for Asians. Estimates reported in the trend chart do not include Asian, non-Hispanics or Hispanics to be consistent with earlier years.

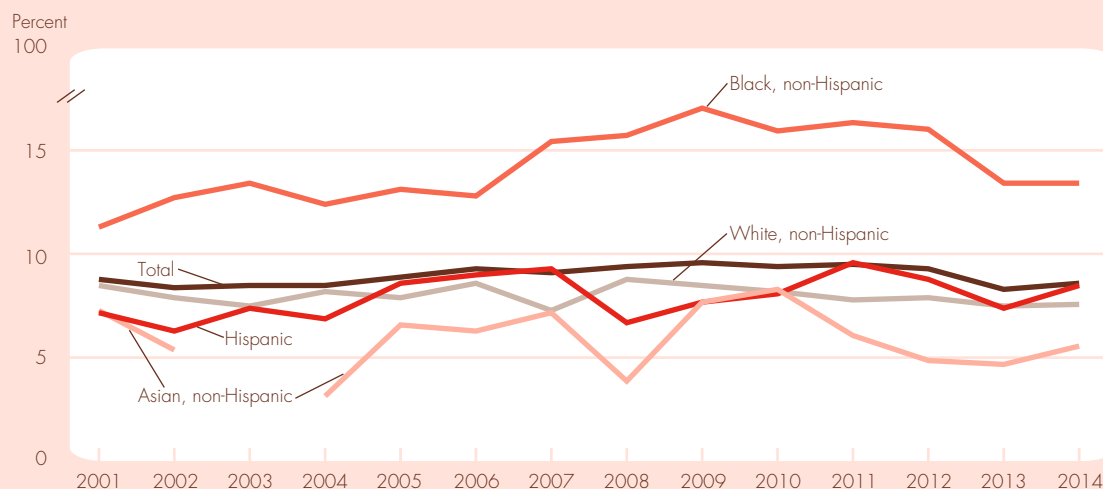
SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- In 2011–2014, 19 percent of children ages 6–17 had obesity.
- Asian, non-Hispanic children ages 6–17 (10 percent) were least likely to have obesity, followed by White, non-Hispanic children (17 percent). The prevalence of obesity was highest among Black, non-Hispanic (23 percent) children and Hispanic (24 percent) children.

Asthma

Asthma is one of the most common childhood chronic diseases. It causes wheezing, difficulty in breathing, and chest tightness. Some children diagnosed with asthma may not experience any serious respiratory effects. Others may have mild symptoms or may respond well to management of their asthma, typically through the use of medication. However, some children with asthma may suffer serious attacks that limit their activities, result in visits to emergency rooms or hospitals, or, in rare cases, cause death. Air pollution and secondhand tobacco smoke, along with infections, exercise, and allergens, can trigger asthma attacks in children with asthma.^{89–94} The prevalence of asthma among children doubled from 1980 to 1995 and then increased more slowly during the 2000s. Racial disparities in childhood asthma prevalence have emerged since 1996. Higher asthma prevalence among children has been observed by poverty level and geographic region of residence.⁹⁵

Figure 31 Percentage of children ages 0–17 who currently have asthma by race and Hispanic origin, 2001–2014



NOTE: Children are identified as ever having been diagnosed with asthma by asking parents, “Has a doctor or other health professional ever told you that your child has asthma?” If the parent answers yes to this question, they are then asked, (1) “Does your child still have asthma?” and (2) “During the past 12 months, has your child had an episode of asthma or an asthma attack?” The question “Does your child still have asthma?” was introduced in 2001 and identifies children who currently have asthma. Persons of Hispanic origin may be of any race. Data on race and Hispanic origin are collected and combined for reporting according to 1997 Office of Management and Budget Standards for Data on Race and Ethnicity. The 2003 estimate for Asian, non-Hispanic children was unreliable and therefore not presented.

SOURCE: National Center for Health Statistics, National Health Interview Survey.

- In 2014, 13 percent of Black, non-Hispanic children were reported to currently have asthma, compared with 8 percent of White, non-Hispanic; 8 percent of Hispanic; and 6 percent of Asian, non-Hispanic children.
- From 2001 to 2014, the percentage of Hispanic; White, non-Hispanic; and Asian, non-Hispanic⁹⁶ (trend from 2004 to 2014) children with current asthma was stable. The percentage of Black, non-Hispanic children with current asthma increased from 2001 to 2010 and then declined from 2011 to 2014.
- Throughout this period, the percentage of Black, non-Hispanic children with current asthma was higher than the corresponding percentages for Hispanic; White, non-Hispanic; and Asian, non-Hispanic children with current asthma.

Bullets contain references to data in table HEALTH8.B on the childstats.gov website. Endnotes begin on page 46.



Notes to Indicators

-
- ¹ Hernandez, D. J., Denton, N. A., & Macartney, S. E. (2008). Children in immigrant families: Looking to America's future. *Social Policy Report*, 22(3), 3–23. Retrieved from http://www.srcd.org/sites/default/files/documents/22_3_hernandez_final.pdf
- ² Grieco, E. M. (2010). *Race and Hispanic origin of the foreign-born population in the United States: 2007* (American Community Survey Report No. ACS-11). Retrieved from <http://www.census.gov/prod/2010pubs/acs-11.pdf>
- ³ Ventura, S. J., & Bachrach, C. A. (2000). Nonmarital childbearing in the United States, 1940–1999. *National Vital Statistics Reports*, 48(16), 1–40. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr48/nvs48_16.pdf
- ⁴ Mathews, T. J., & MacDorman, M. F. (2013). Infant mortality statistics from the 2010 period linked birth/infant death data set. *National Vital Statistics Reports*, 62(8), 1–26. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf
- ⁵ Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2013. *National Vital Statistics Reports*, 64(1), 1–65. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf
- ⁶ Kiely, J. L., Brett, K. M., Yu, S., & Rowley, D. L. (1994). Low birthweight and intrauterine growth retardation. In L. S. Wilcox & J. S. Marks (Eds.), *From data to action: CDC's public health surveillance for women, infants, and children* (pp. 185–202). Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- ⁷ Maynard, R. A. (Ed.). (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.
- ⁸ Ventura, S. J., Mathews, T. J., & Hamilton, B. E. (2001). Births to teenagers in the United States, 1940–2000. *National Vital Statistics Reports*, 49(10), 1–24. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_10.pdf
- ⁹ Hamilton, B. E., & Ventura, S. J. (2012). *Births rates for U.S. teenagers reach historic lows for all age and ethnic groups* (NCHS Data Brief No. 39). Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db89.pdf>
- ¹⁰ U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect. (2003). *A coordinated response to child abuse and neglect: The foundation for practice*. Retrieved from <https://www.childwelfare.gov/pubPDFs/foundation.pdf>
- ¹¹ U.S. Department of Health and Human Services, Administration for Children and Families, Administration of Children, Youth and Families, Children's Bureau. (2014). National child abuse and neglect data system (FFY2014 OLAP cube) [Data file]. Retrieved July 29, 2015.
- ¹² Strohschein, L. (2005, December). Household income histories and child mental health trajectories. *Journal of Health and Social Behavior*, 46(4), 357–359. doi:10.1177/002214650504600404
- ¹³ Duncan, G., & Brooks-Gunn, J. (Eds.). (1997). *Consequences of growing up poor*. New York, NY: Russell Sage Press.
- ¹⁴ Wagmiller, R.L. Jr., Lennon, M. C., Kuang, L., Alberti, P. M., & Aber, J. L. (2006, October). The dynamics of economic disadvantage and children's life changes. *American Sociological Review*, 71(5), 847–866. doi:10.1177/000312240607100507
- ¹⁵ Dahl, G., & Lochner, L. (2008). *The impact of family income on child achievement: Evidence from the earned income tax credit* (NBER Working Paper No. 14599). Retrieved from <http://www.nber.org/papers/w14599>
- ¹⁶ Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Black may be defined as those who reported Black and no other race (the race-alone or single-race concept) or as those who reported Black regardless of whether they also reported another race (the race-alone-or-in-combination concept). This indicator shows data using the first approach (race alone). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Data on race and Hispanic origin are collected separately. People of Hispanic origin may be of any race.
- ¹⁷ Interagency Technical Working Group. (2010, March). *Observations from the Interagency Technical Working Group on developing a Supplemental Poverty Measure*. Retrieved from www.census.gov/hhes/www/poverty/SPM_TWGObservations.pdf
-

-
- ¹⁸ For the latest report, see Short, K. (2015, September). *The Supplemental Poverty Measure: 2014* (Current Population Report P60-254). Retrieved from <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-254.pdf>
- ¹⁹ Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Black may be defined as those who reported Black and no other race (the race-alone or single-race concept) or as those who reported Black regardless of whether they also reported another race (the race-alone-or-in-combination concept). This indicator shows data using the first approach (race alone). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Data on race and Hispanic origin are collected separately. People of Hispanic origin may be of any race.
- ²⁰ Child Trends. (2011). *Secure parental employment*. Retrieved from <http://www.childtrends.org/?indicators=secure-parental-employment>
- ²¹ Cauthen, N. (2002). *Improving children's economic security: Research findings about increasing family income through employment: Policies that improve family income matter for children* (Policy Brief No. 1). Retrieved from http://www.nccp.org/publications/pdf/text_480.pdf
- ²² Anderson, S. A. (Ed.). (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition*, 120(11S), 1557–1600. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/2243305>
- ²³ Coleman-Jensen, A., McFall, W., & Nord, M. (2013). *Food insecurity in households with children: Prevalence, severity, and household characteristics, 2010–11* (Economic Information Bulletin No. 113). Retrieved from <http://www.ers.usda.gov/publications/eib-economic-information-bulletin/eib113>
- ²⁴ In reports prior to 2006, households with “very low food security among children” were described as “food insecure with hunger among children.” The methods used to assess children's food security remained unchanged, so the statistics for 2005 and later years are directly comparable with those for 2004 and earlier years. For further information, see <http://ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx>.
- ²⁵ The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2012). *The uninsured and the difference health insurance makes*. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/1420-14.pdf>
- ²⁶ See Usual Source of Health Care (http://www.childstats.gov/pdf/ac2015/ac_15.pdf) HC2 in *America's Children: Key National Indicators of Well-Being, 2015*.
- ²⁷ Howell, E. M., & Kenney, G. M. (2012). The impact of the Medicaid/CHIP expansions on children: A synthesis of the evidence. *Medical Care Research and Review*, 69(4), 372–396. doi:10.1177/1077558712437245
- ²⁸ Selden, T., & Hudson, J. L. (2006). Access to care and utilization among children: Estimating the effects of public and private coverage. *Medical Care*, 44(5 Suppl.), I19–I26. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16625060>
- ²⁹ The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2013). *Health coverage by race and ethnicity: The potential impact of the Affordable Care Act*. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8423-health-coverage-by-race-and-ethnicity.pdf>
- ³⁰ See figure for Health Insurance Coverage (http://www.childstats.gov/americaschildren/care_fig.asp#hc1) HC1 on childstats.gov.
- ³¹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (1999). Ten great public health achievements—United States, 1900–1999. *Morbidity and Mortality Weekly Report*, 48(12), 241–243. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm>
- ³² Hill, H. A., Elam-Evans, L. D., Yankey, D., Singleton, J. A., & Kolasa, M. (2015). National, state, and selected local area vaccination coverage among children aged 19–35 months—United States, 2014. *Morbidity and Mortality Weekly Report*, 64(33), 889–896. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6433a1.htm?s_cid=mm6433a1_w
- ³³ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Oral Health. (2014). *Children's oral health*. Retrieved from http://www.cdc.gov/OralHealth/children_adults/child.htm
- ³⁴ Flores, G., & Tomany-Korman, S. C. (2008). Racial and ethnic disparities in medical and dental health, access to care, and use of services in U.S. children. *Pediatrics* 121(2): e286–e298. doi:10.1542/peds.2007-1243
-

- ³⁵ General Accountability Office. (2000). *Oral health: Dental disease is a chronic problem among low-income populations* (Report No. GAO/HEHS-00-72). Retrieved from <http://www.gao.gov/new.items/he00072.pdf>
- ³⁶ This measure does not differentiate between counties in which the Primary National Ambient Air Quality Standards are exceeded frequently or by a large margin and counties in which the standards are exceeded only rarely or by a small margin. It must also be noted that this analysis differs from the analysis utilized by the U.S. Environmental Protection Agency for the designation of “nonattainment areas” for regulatory compliance purposes.
- ³⁷ U.S. Environmental Protection Agency. (2013). *Integrated science assessment of ozone and related photochemical oxidants* (EPA Report No. 600/R-10/076F). Washington, DC: Author. Retrieved from <http://cfpub.epa.gov/ncea/isa/recordisplay.cfm?deid=247492>
- ³⁸ U.S. Environmental Protection Agency. (2009). *2009 Final report: Integrated science assessment for particulate matter* (EPA/600/R-08/139F). Washington, DC: Author. Retrieved from <http://cfpub.epa.gov/ncea/risk/recordisplay.cfm?deid=216546>
- ³⁹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. (2006). *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General*. Retrieved from <http://www.surgeongeneral.gov/library/reports/secondhandsmoke/fullreport.pdf>
- ⁴⁰ Marano, C., Schober, S. E., Brody, D. J., & Zhang, C. (2009). Secondhand tobacco smoke exposure among children and adolescents: United States, 2003–2006. *Pediatrics*, 124(5), 1299–1305. doi:10.1542/peds.2009-0880
- ⁴¹ U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Environmental Health Sciences, Division of the National Toxicology Program, Office of Health Assessment and Translation. (2012). *NTP monograph on health effects of low-level lead*. Retrieved from <http://ntp.niehs.nih.gov/go/36443>
- ⁴² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Childhood Lead Poisoning Prevention. (2012). *Low level lead exposure harms children: A renewed call for primary prevention*. Retrieved from http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf
- ⁴³ Wheeler, W., & Brown, M. J. (2013). Blood lead levels in children aged 1–5 years—United States, 1999–2010. *Morbidity and Mortality Weekly Report*, 62(13), 245–248. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a3.htm>
- ⁴⁴ U.S. Environmental Protection Agency. (2013). *2013 Final report: Integrated science assessment for lead* (EPA/600/R-10/075F), Washington, DC: Author. Retrieve from <http://cfpub.epa.gov/ncea/risk/recordisplay.cfm?deid=255721>
- ⁴⁵ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Environmental Health. (2012). *CDC response to advisory committee on childhood lead poisoning prevention recommendations in “Low level lead exposure harms children: A renewed call for primary prevention.”* Retrieved from http://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf
- ⁴⁶ U.S. Department of Housing and Urban Development, Office of Healthy Homes and Lead Hazard Control. (2011). *American Healthy Homes Survey: Lead and arsenic findings*. Retrieved from http://portal.hud.gov/hudportal/documents/huddoc?id=AHHS_REPORT.pdf
- ⁴⁷ U.S. Environmental Protection Agency. (2013). *America’s children and the environment, third edition* (EPA Report No. 240-R-13-001). Retrieved from www.epa.gov/ace
- ⁴⁸ Turner, H. A., Finkelhor, D., & Ormrod, R. (2006). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science and Medicine*, 62(1), 13–27. doi:10.1016/j.socscimed.2005.05.030
- ⁴⁹ Schreck, C. J., Stewart, E. A., & Osgood, D. W. (2008). A reappraisal of the overlap of violent offenders and victims. *Criminology*, 46(4), 871–905. doi:10.1111/j.1745-9125.2008.00127.x
- ⁵⁰ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (n.d.). National Vital Statistics System. Retrieved from <http://www.cdc.gov/nchs/nvss.htm>
- ⁵¹ Gilchrist, J., & Ballesteros, M. F. (2012). Vital signs: Unintentional injury deaths among persons aged 0–19 year—United States, 2000–2009. *Morbidity and Mortality Weekly Report*, 61(15), 270–276. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6115a5.htm>

- ⁵² Bergen, G., Chen, L. H., Warner, M., & Fingerhut, L. A. (2008). *Injury in the United States: 2007 chartbook*. Retrieved from U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics website: <http://www.cdc.gov/nchs/data/misc/injury2007.pdf>
- ⁵³ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (in press). *Health, United States, 2015*. Retrieved from <http://www.cdc.gov/nchs/hs.htm>
- ⁵⁴ Anderson, R. N., Copeland, G., & Hayes J. M. (2014). Linkages to improve mortality data for American Indians and Alaska Natives: A new model for death reporting? *American Journal of Public Health, 104*(S3), S258–S262. doi:10.2105/AJPH.2013.301647
- ⁵⁵ Pollack, K.M., Frattaroli, S., Young, J.L., Dana-Sacco, G., & Gielen, A.C. Motor Vehicle Deaths Among American Indian and Alaska Native Populations. *Epidemiological Reviews, 2012*; 34: 73–88.
- ⁵⁶ Meier, M. H., Caspi, A., Ambler, A., Harrington, H. L., Houts, R., Keefe, R. S. E., . . . Moffitt, T. E. (2012). Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proceedings of the National Academy of Sciences of the United States of America, 109*(40), E2657–E2664. doi:10.1073/pnas.1206820109
- ⁵⁷ Meier, A. M. (2007). Adolescent first sex and subsequent mental health. *American Journal of Sociology, 112*(6), 1811–1847. doi:10.1086/512708
- ⁵⁸ Chandra, A., Martinez, G. M., Mosher, W. D., Abma, J. C., & Jones, J. (2005). Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. *Vital and Health Statistics, 23*(25), 1–160. Retrieved from http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf
- ⁵⁹ Dunne, E. F., Unger, E. R., Sternberg, M., McQuillan, G., Swan, D. C., Patel, S. S., & Markowitz, L. E. (2007). Prevalence of HPV infection among females in the United States. *Journal of the American Medical Association, 297*(8), 813–819. doi:10.1001/jama.297.8.813
- ⁶⁰ Gottlieb, S. L., Pope, V., Sternberg, M. R., McQuillan, G. M., Beltrami, J. F., Berman, S. M., & Markowitz, L. E. (2008). Prevalence of syphilis seroreactivity in the United States: Data from the National Health and Nutrition Examination Surveys (NHANES) 2001–2004. *Sexually Transmitted Diseases, 35*(5), 507–511. doi:10.1097/OLQ.0b013e3181644bae
- ⁶¹ Beginning in 2011, t-tests were used for this report to test for significant differences between groups. Comparison of confidence intervals was used to test for significant differences prior to 2011.
- ⁶² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. (2014). *The health consequences of smoking: 50 years of progress. A report of the Surgeon General*. Retrieved from <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf>
- ⁶³ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2015). *Results from the 2014 National Survey on Drug Use and Health: Detailed tables*. Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf>
- ⁶⁴ National Institute on Alcohol Abuse and Alcoholism. A Developmental Perspective on Underage Alcohol Use. *Alcohol Alert*. July 2009: No. 78. Retrieved from <http://pubs.niaaa.nih.gov/publications/AA78/AA78.pdf>
- ⁶⁵ For more information on NAEP mathematics proficiency levels, see <https://nces.ed.gov/nationsreportcard/mathematics/achieveall.aspx>.
- ⁶⁶ Kena, G., Hussar, W., deBrey, C., Musu-Gillette, L., Wang, X., Zhang, J., . . . & Dunlop Velez, E. (2015). *The Condition of Education 2016* (NCES Publication No. 2016-144). Retrieved from U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics website.
- ⁶⁷ “High school completer” refers to those who completed 12 years of school for survey years 1980–1991 and to those who earned a high school diploma or equivalent (e.g., a GED certificate) for all years since 1992.
- ⁶⁸ Radford, A. W., Berkner, L., Wheelless, S. C., & Shepherd, B. (2010). *Persistence and attainment of 2003–04 beginning postsecondary students: After 6 years* (NCES Publication No. 2011-151). Retrieved from <http://nces.ed.gov/pubspubs2011/2011151.pdf>
- ⁶⁹ Due to some short-term data fluctuations associated with small sample sizes, estimates for the racial/ ethnic groups were calculated based on 3-year moving averages, except in 2014, when estimates were calculated based on 2-year moving averages.

- ⁷⁰ Fernandes, A., and Gabe, T. (2009). *Disconnected youth: A look at 16- to 24-year-olds who are not working or in school*. (CRS Report No. R40535). Retrieved from <http://www.fas.org/sgp/crs/misc/R40535.pdf>
- ⁷¹ Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2015). Births: Final data for 2013. *National Vital Statistics Reports*, 64(1), 1–65. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf
- ⁷² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2013). CDC health disparities and inequalities report—United States, 2013. *Morbidity and Mortality Weekly Report*, 62(3 Suppl.), 1–186. Retrieved from <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>
- ⁷³ Krieger, N., Rehkopf, D. H., Chen, J. T., Waterman, P. D., Marcelli, E., & Kennedy, M. (2008). The fall and rise of U.S. inequalities in premature mortality: 1960–2002. *PLOS Medicine*, 5(2), e46. doi:10.1371/journal.pmed.0050046
- ⁷⁴ 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>
- ⁷⁵ Van Lieshout, R.J., & MacQueen, G. (2008). Psychological factors in asthma. *Allergy, Asthma and Clinical Immunology*, 4(1), 12–28.
- ⁷⁶ Goodman, E., & Whitaker, R.C. (2007). A prospective study of the role of depression in the development and persistence of adolescent obesity. *Pediatrics*, 110(3), 497–504.
- ⁷⁷ Cummings, J.R., & Druss, B.G. (2011). Racial/ethnic differences in mental health service use among adolescents with major depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(2), 160–170.
- ⁷⁸ Cummings, J.R., Case, B.G., Ji, X., Chae, D.H., & Druss, B.G. (2014). Racial/ethnic differences in perceived reasons for mental health treatment in U.S. adolescents with major depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 53(9), 980–990.
- ⁷⁹ Nock, M.K., Green, J.G., Hwang, I., McLaughlin, K.A., Sampson, N.A., Zaslavsky, A.M., & Kessler, R.C. (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents. *JAMA Psychiatry*, 70(3), 300–310.
- ⁸⁰ Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD
- ⁸¹ Singh, A. S., Mulder, C., Twisk, J. W., Van, M. W., & Chinapaw, M. J. (2008). Tracking of childhood overweight into adulthood: A systematic review of the literature. *Obesity Review*, 9(5), 474–488. doi:10.1111/j.1467-789X.2008.00475.x
- ⁸² Whitlock, E. P., Williams, S. B., Gold, R., Smith, P. R., & Shipman, S. A. (2005). Screening and interventions for childhood overweight: A summary of evidence for the U.S. Preventive Services Task Force. *Pediatrics*, 116(1), e125–e144. doi:10.1542/peds.2005-0242
- ⁸³ Lakshman, R., Elks, C. E., & Ong, K. K. (2012). Childhood obesity. *Circulation*, 126(14), 1770–1779. doi: 10.1161/CIRCULATIONAHA.111.047738
- ⁸⁴ Ogden, C. L., Flegal, K. M., Carroll, M. D., & Johnson, C. L. (2002). Prevalence and trends in overweight among U.S. children and adolescents, 1999–2000. *Journal of the American Medical Association*, 288(14), 1728–1732. doi:10.1001/jama.288.14.1728.
- ⁸⁵ Barlow, S. E. (2007). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. *Pediatrics*, 120(Suppl. 4), S164–S192. doi:10.1542/peds.2007-2329C
- ⁸⁶ Ogden, C. L., & Flegal, K. M. (2010). Changes in terminology for childhood overweight and obesity. *National Health Statistics Reports*, 25, 1–8. Retrieved from <http://www.cdc.gov/nchs/data/nhsr/nhsr025.pdf>
- ⁸⁷ Ogden C. L., Carroll M. D., Kit B. K., & Flegal K. M. (2014). Prevalence of childhood and adult obesity in the United States, 2011–2012. *Journal of the American Medical Association*, 311(8), 806–814. doi: 10.1001/jama.2014.732
- ⁸⁸ Ogden C. L., Carroll M. D., Kit B. K., & Flegal K. M. (2012). Prevalence of obesity and trends in body mass index among U.S. children and adolescents, 1999–2010. *Journal of the American Medical Association*, 307(5), 483–490. doi:10.1001/jama.2012.40

-
- ⁸⁹ U.S. Environmental Protection Agency, Office of Research and Development, National Center for Environmental Assessment. (2013). *Integrated science assessment of ozone and related photochemical oxidants* (EPA Report No. 600/R-10/076F). Retrieved from <http://cfpub.epa.gov/ncea/isa/recordisplay.cfm?deid=247492>
- ⁹⁰ U.S. Environmental Protection Agency, Office of Research and Development, National Center for Environmental Assessment. (2009). *Integrated science assessment for particulate matter* (EPA Report No. 600/R-08/139F). Retrieved from <http://cfpub.epa.gov/ncea/CFM/recordisplay.cfm?deid=216546>
- ⁹¹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. (2006). *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General*. Retrieved from <http://www.surgeongeneral.gov/library/reports/secondhandsmoke/fullreport.pdf>
- ⁹² Institute of Medicine, Division of Health Promotion and Disease Prevention, Committee on the Assessment of Asthma and Indoor Air. (2000). *Clearing the air: Asthma and indoor air exposures* [National Academies Press OpenBook version]. Retrieved from <http://books.nap.edu/catalog/9610.html>
- ⁹³ Gern, J. E. (2004). Viral respiratory infection and the link to asthma. *Pediatric Infectious Disease Journal*, 23(1 Suppl.), S78–S86. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/14730274>
- ⁹⁴ Lemanske, R. F., Jr., & Busse, W. W. (2003). Asthma. *Journal of Allergy and Clinical Immunology*, 111(2 Suppl.), S502–S519. doi:10.1067/mai.2003.94
- ⁹⁵ Akinbami, L. J., Simon, A. E., & Rossen, L. M. (2016). Changing trends in asthma prevalence among children. *Pediatrics*, 137(1), 1–7. doi:10.1542/peds.2015-2354.
- ⁹⁶ Reliable data for Asian, non-Hispanic children are only available for 2001 to 2002 and 2004 to 2014.

America's Children at a Glance

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Demographic Background			
Child population*			
Children ages 0–17 in the United States	73.6 million (2014)	73.6 million (2015)	NS
Children as a percentage of the population*			
Children ages 0–17 in the United States	23.1% (2014)	22.9% (2015)	↓
Racial and ethnic composition*			
Children ages 0–17 by race and Hispanic origin**			
White, non-Hispanic	51.9% (2014)	51.5% (2015)	↓
Black, non-Hispanic	13.8% (2014)	13.8% (2015)	NS
American Indian or Alaska Native, non-Hispanic	0.9% (2014)	0.9% (2015)	NS
Asian, non-Hispanic	4.8% (2014)	4.9% (2015)	↑
Native Hawaiian or Other Pacific Islander, non-Hispanic	0.2% (2014)	0.2% (2015)	NS
Two or more races, non-Hispanic	4.0% (2014)	4.1% (2015)	↑
Hispanic	24.4% (2014)	24.6% (2015)	↑
Family and Social Environment			
Family structure and children's living arrangements			
Children ages 0–17 living with two married parents	64% (2014)	65% (2015)	NS
Births to unmarried women			
Births to unmarried women ages 15–44	44.3 per 1,000 (2013)	43.9 per 1,000 (2014)	↓
Births to unmarried women among all births	40.6% (2013)	40.2% (2014)	↓
Child care			
Children ages 0–4, with employed mothers, whose primary child care arrangement is with a relative	48% (2010)	49% (2011)	NS
Children, ages 3–6, not yet in kindergarten, who were in center-based care arrangements	55% (2007)	61% (2012)	↑
Children of at least one foreign-born parent			
Children ages 0–17 living with at least one foreign-born parent	24% (2014)	25% (2015)	NS
Language spoken at home and difficulty speaking English			
Children ages 5–17 who speak a language other than English at home	22% (2013)	22% (2014)	NS
Children ages 5–17 who speak a language other than English at home and who have difficulty speaking English	5% (2013)	5% (2014)	NS
Adolescent births			
Births to females ages 15–17	12 per 1,000 (2013)	11 per 1,000 (2014)	↓
Child maltreatment*			
Substantiated reports of maltreatment of children ages 0–17	10 per 1,000 (2013)	10 per 1,000 (2014)	NS

* Population estimates are not sample derived and are not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates as rounded.

** Percentages may not sum to 100 due to rounding.

Legend

NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Economic Circumstances			
Child poverty and family income			
Children ages 0–17 in poverty	22% (2013)	21% (2014)	NS
Secure parental employment			
Children ages 0–17 living with at least one parent employed year round, full time	74% (2013)	75% (2014)	↑
Food insecurity			
Children ages 0–17 in households classified by USDA as “food insecure”	21% (2013)	21% (2014)	NS
Health Care			
Health insurance coverage			
Children ages 0–17 who were uninsured at time of interview	7% (2013)	5% (2014)	↓
Usual source of health care			
Children ages 0–17 with no usual source of health care	4% (2013)	4% (2014)	NS
Immunization			
Children ages 19–35 months with the 4:3:1:3*:3:1:4 combined series	70% (2013)	72% (2014)	NS
Oral health			
Children ages 5–17 with a dental visit in the past year	88% (2013)	88% (2014)	NS
Physical Environment and Safety			
Outdoor air quality			
Children ages 0–17 living in counties with pollutant concentrations above the levels of the current air quality standards	62% (2013)	60% (2014)	NS
Secondhand smoke			
Children ages 4–11 with any detectable blood cotinine level, a measure for recent exposure to secondhand smoke	42% (2009–10)	40% (2011–12)	NS
Drinking water quality			
Children served by community water systems that did not meet all applicable health-based drinking water standards	7% (2013)	6% (2014)	NS
Lead in the blood of children			
Children ages 1–5 with blood lead greater than or equal to 5 µg/dL	3% (2007–2010)	1%** (2011–2014)	NS
Housing problems			
Households with children ages 0–17 reporting shelter cost burden, crowding, and/or physically inadequate housing	46% (2011)	40% (2013)	↓
Youth victims of serious violent crimes			
Serious violent crime victimization of youth ages 12–17	9 per 1,000 (2013)	7 per 1,000 (2014)	NS
Child injury and mortality			
Injury deaths of children ages 1–4	11 per 100,000 (2013)	10 per 100,000 (2014)	NS
Injury deaths of children ages 5–14	5 per 100,000 (2013)	5 per 100,000 (2014)	NS

* Coverage with the full Hib vaccine series increased in 2010, suggesting that children received a booster as supplies became adequate starting in July 2009.

** Estimate is considered unstable (relative standard error is greater than 30 percent but less than 40 percent).

Legend

NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

America's Children at a Glance

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Physical Environment and Safety—continued			
Adolescent injury and mortality			
Injury deaths of adolescents ages 15–19	33 per 100,000 (2013)	34 per 100,000 (2014)	↑
Behavior			
Regular cigarette smoking			
Students who reported smoking daily in the past 30 days			
8th grade	1% (2014)	1% (2015)	NS
10th grade	3% (2014)	3% (2015)	NS
12th grade	7% (2014)	6% (2015)	↓
Alcohol use			
Students who reported having five or more alcoholic beverages in a row in the past two weeks			
8th grade	4% (2014)	5% (2015)	NS
10th grade	13% (2014)	11% (2015)	↓
12th grade	19% (2014)	17% (2015)	↓
Illicit drug use			
Students who reported using illicit drugs in the past 30 days			
8th grade	8% (2014)	8% (2015)	NS
10th grade	19% (2014)	17% (2015)	↓
12th grade	24% (2014)	24% (2015)	NS
Sexual activity			
High school students who reported ever having had sexual intercourse	47% (2011)	47% (2013)	NS
Youth perpetrators of serious violent crimes			
Youth offenders ages 12–17 involved in serious violent crimes	9 per 1,000 (2013)	7 per 1,000 (2014)	NS
Education			
Family reading to young children			
Children ages 3–5 who were read to three or more times in the last week	83% (2007)	83% (2012)	NS
Mathematics and reading achievement			
Average mathematics scale score of			
4th-graders (0–500 scale)	242 (2013)	240 (2015)	↓
8th-graders (0–500 scale)	285 (2013)	282 (2015)	↓
12th-graders (0–300 scale)	153 (2009)	153 (2013)	NS
Average reading scale score of			
4th-graders (0–500 scale)	222 (2013)	223 (2015)	NS
8th-graders (0–500 scale)	268 (2013)	265 (2015)	↓
12th-graders (0–500 scale)	288 (2009)	288 (2013)	NS

Legend

NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Education — continued			
High school academic coursetaking			
High school graduates who completed selected mathematics and science courses			
Algebra II	70% (2005)	76% (2009)	↑
Analysis/precalculus	29% (2005)	35% (2009)	↑
Biology and chemistry	64% (2005)	68% (2009)	↑
Biology, chemistry, and physics	27% (2005)	30% (2009)	↑
High school completion			
Young adults ages 18–24 who have completed high school	92% (2013)	92% (2014)	NS
Youth neither enrolled in school* nor working			
Youth ages 16–19 who are neither enrolled in school nor working	9% (2014)	9% (2015)	NS
College enrollment			
Recent high school completers enrolled in college the October immediately after completing high school	66% (2013)	68% (2014)	NS
Health			
Preterm birth and low birthweight			
Infants less than 37 completed weeks of gestation at birth	10% (2013)	10% (2014)	NS
Infants weighing less than 5 lb. 8 oz. at birth	8% (2013)	8% (2014)	NS
Infant mortality			
Deaths before first birthday	6 per 1,000 (2012)	6 per 1,000 (2013)	NS
Emotional and behavioral difficulties			
Children ages 4–17 reported by a parent to have serious difficulties with emotions, concentration, behavior, or getting along with other people	5% (2013)	5% (2014)	NS
Adolescent depression			
Youth ages 12–17 with major depressive episode in the past year	11% (2013)	11% (2014)	NS
Activity limitation			
Children ages 5–17 with activity limitation resulting from one or more chronic health conditions	9% (2013)	9% (2014)	NS
Diet quality			
Average diet quality for children ages 2–17, using the Healthy Eating Index–2010 total scores (maximum score = 100)	53 (2009–2010)	55** (2011–2012)	NC
Obesity			
Children ages 6–17 who had obesity	19% (2007–2010)	19% (2011–2014)	NS
Asthma			
Children ages 0–17 who currently have asthma	8% (2013)	9% (2014)	NS

* School refers to high school and college.

** Statistical significance tests not calculated due to methodological changes.

Legend

NC = Not calculated

NS = No statistically significant change

↑ = Statistically significant increase

↓ = Statistically significant decrease





Recommended citation:

Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2016*. Washington, DC: U.S. Government Printing Office.

This report was printed by the U.S. Government Printing Office in cooperation with the National Center for Health Statistics, July 2016.

Single copies are available through the Health Resources and Services Administration Information Center while supplies last: P.O. Box 2910 Merrifield, VA 22116

Toll-Free Lines:
1-888-Ask-HRSA
TTY: 1-877-4TY-HRSA

Fax: 703-821-2098
E-mail: ask@hrsa.gov

This report is also available on the Web:
<http://childstats.gov>

Federal Interagency Forum on Child and Family Statistics

The Federal Interagency Forum on Child and Family Statistics was founded in 1994. Executive Order No. 13045 formally established the Forum in April 1997 to foster coordination and collaboration in the collection and reporting of Federal data on children and families. Agencies that are members of the Forum as of Spring 2016 are listed below.

Department of Agriculture

Economic Research Service
<http://www.ers.usda.gov>

Department of Commerce

U.S. Census Bureau
<http://www.census.gov>

Department of Defense

Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy
<http://prhome.defense.gov/RFM/MCFP/>

Department of Education

National Center for Education Statistics
<http://nces.ed.gov>

Department of Health and Human Services

Administration for Children and Families
<http://www.acf.hhs.gov>

Agency for Healthcare Research and Quality
<http://www.ahrq.gov>

Eunice Kennedy Shriver National Institute of Child Health and Human Development
<http://www.nichd.nih.gov>

Maternal and Child Health Bureau
<http://www.mchb.hrsa.gov>

National Center for Health Statistics
<http://www.cdc.gov/nchs>

National Institute of Mental Health
<http://www.nimh.nih.gov>

Office of Adolescent Health
<http://www.hhs.gov/ash/oah>

Office of the Assistant Secretary for Planning and Evaluation
<http://aspe.hhs.gov>

Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov>

Department of Housing and Urban Development

Office of Policy Development and Research
<http://www.huduser.org>

Department of Justice

Bureau of Justice Statistics
<http://bjs.ojp.usdoj.gov>

National Institute of Justice
<http://www.nij.gov>

Office of Juvenile Justice and Delinquency Prevention
<http://www.ojjdp.gov>

Department of Labor

Bureau of Labor Statistics
<http://www.bls.gov>

Women's Bureau
<http://www.dol.gov/wb>

Department of Transportation

National Highway Traffic Safety Administration
<http://www.nhtsa.dot.gov>

Environmental Protection Agency

Office of Children's Health Protection
<http://www.epa.gov/children/>

Office of Management and Budget

Statistical and Science Policy Office
http://www.whitehouse.gov/omb/inforeg_statpolicy

U.S. Consumer Product Safety Commission

<http://www.cpsc.gov>