

America's Children: Key National Indicators of Well-Being, 2025



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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 winter 2026 are as follows:

Consumer Product Safety Commission

<https://www.cpsc.gov>

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Economic Research Service

<https://www.ers.usda.gov>

Department of Commerce

U.S. Census Bureau

<https://www.census.gov>

Department of Defense

Office of the Deputy Under Secretary of Defense Military
Community and Family Policy

[https://prhome.defense.gov/M-RA/Inside-M-RA/
MCFP](https://prhome.defense.gov/M-RA/Inside-M-RA/MCFP)

Department of Education

National Center for Education Statistics

<https://nces.ed.gov>

Department of Health and Human Services

Administration for Children and Families

<https://acf.gov/>

Agency for Healthcare Research and Quality

<https://www.ahrq.gov>

Eunice Kennedy Shriver National Institute of Child Health
and Human Development

<https://www.nichd.nih.gov/>

Health Resources and Services Administration,
Maternal and Child Health Bureau

<https://www.mchb.hrsa.gov>

National Center for Health Statistics

<https://www.cdc.gov/nchs>

National Center for Immunization and
Respiratory Diseases

<https://www.cdc.gov/ncird/index.html>

National Institute of Mental Health

<https://www.nimh.nih.gov/>

National Institute on Drug Abuse

<https://nida.nih.gov/>

Office of the Assistant Secretary for Planning
and Evaluation

<https://aspe.hhs.gov>

Office of Population Affairs

<https://opa.hhs.gov/>

Substance Abuse and Mental Health Services Administration

<https://www.samhsa.gov>

Department of Housing and Urban Development

Office of Policy Development and Research

<https://www.huduser.gov/portal/home.html>

Department of Justice

Bureau of Justice Statistics

<https://bjs.ojp.gov/>

National Institute of Justice

<https://nij.ojp.gov/>

Office of Juvenile Justice and Delinquency Prevention

<https://ojjdp.ojp.gov>

Department of Labor

Bureau of Labor Statistics

<https://www.bls.gov>

Women's Bureau

<https://www.dol.gov/agencies/wb>

Department of Transportation

National Highway Traffic Safety Administration

<https://www.nhtsa.gov/>

Environmental Protection Agency

Office of Children's Health Protection

<https://www.epa.gov/children/>

Office of Management and Budget

<https://www.whitehouse.gov/omb/>

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Foreword

The Federal Interagency Forum on Child and Family Statistics (Forum) is a wonderful example of how Federal agencies can increase the effectiveness, efficiency, and accessibility of the government by working across agency boundaries to collaborate and innovate. The Forum was chartered in April 1997 through Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. It has since been successfully bringing together (from a very decentralized system) high-quality information about our Nation's children and youth that the public and policymakers can easily access and understand. Working together, Federal agencies are able to set priorities on what information to collect; develop new methods for collecting such information; improve the communication of information on the status of children to the policy community and the general public; and produce more complete data on children at the Federal, state, and local levels.

America's Children: Key National Indicators of Well-Being, 2025, is a compendium of indicators about our Nation's young people. The report, the 26th produced by the Forum, presents 30 key indicators on important aspects of children's lives. These indicators are drawn from our most reliable Federal statistics, easily understood by broad audiences, objectively based on substantial research, balanced so that no single area of children's lives dominates the report, measured often to show trends over time, and representative of large segments of the population rather than one particular group.

The report continues to present key indicators in seven domains: family and social environment; economic circumstances; health care; physical environment and safety; behavior; education; and health. To ensure that the information stays relevant, the Forum periodically revises indicators, data sources, and features.

Each volume of *America's Children* also spotlights critical data gaps identified by the Forum's Planning Committee and its Federal statistical agencies. Starting with the 2017 report, such data concerns related to understanding the condition and progress of our Nation's children were consolidated into a stand-alone Data Topics report section rather than included as Indicators Needed at the end of each report domain.

The value of the *America's Children* series and the extraordinary cooperation that these reports represent reflect the Forum's determination to work together effectively to help our Nation better understand the well-being of our children today and what may bring them a better future. The Forum agencies should be congratulated once again for developing such a comprehensive set of indicators and ensuring that they are readily accessible in both content and format. The report is an excellent reflection of the dedication of the Forum agency staff members who assess data needs, strive to present relevant statistics in an easy-to-use format, and work together to produce this substantial and important publication. Of course, suggestions of ways we can enhance this report are always welcome.

No work of this magnitude and quality would be possible without the continued cooperation of the millions of Americans who provide the data that are summarized and analyzed by Federal statistical agencies. This report is, first and foremost, for you and the entire American public. We thank you for your support and important contributions, and we hope the report will continue to be useful to you.

*Member Agencies of the Federal Interagency Forum on
Child and Family Statistics*

Acknowledgments

The success of the Forum is driven by the commitment of the members of the Federal Interagency Forum on Child and Family Statistics.

This report was written by the staff of the Forum, including Traci Cook, Forum Staff Director; Laura Hales, Economic Research Service; Calonie Gray, Administration for Children and Families; Sheila Franco and Ashley Woodall, National Center for Health Statistics; Thyria Alvarez and Barry Steffen, U.S. Department of Housing and Urban Development; Erin Tinney, Bureau of Justice Statistics; Connor Borkowski, Bureau of Labor Statistics; Mark Baldwin and Aly Lorenz, Environmental Protection Agency; Cindi Knighton, Centers for Disease Control and Prevention; Jessica Cotto, National Institute on Drug Abuse; and Jessica Minnaert, Health Resources and Services Administration.

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Other staff members of the Forum agencies provided data, developed indicators, or wrote parts of the report. They include Elaine Stedt, Administration for Children and Families; Hector Rodriguez and Shalom Williams, Bureau of Labor Statistics; Grace Robiou, Environmental Protection Agency; Mark Prell, Economic Research Service; Joseph Afful, Lara Akinbami, Yutaka Aoki, Shilpa Bengeri, Amy Branum, Debra Brody, Christopher Cairns, Anne Driscoll, Nazik Elgaddal, Cheryl Fryar, Matthew Garnett, Anne Mamish, Joyce Martin, Arialdi Miniño, Cynthia Ogden, Jeannine Schiller, Alan Simon, Anjel Vahratian, Xun Wang, Julie Weeks, and Anne Zehner, National Center for Health Statistics; Jennifer Turnham, U.S. Department of Housing and Urban Development; and Laurie Elam-Evans, Leslie Harrison, Holly Hill, Mike Underwood, and Cassandra Pingali, Centers for Disease Control and Prevention.

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About This Report

The Federal Interagency Forum on Child and Family Statistics (Forum) was chartered in 1997 by the authority of Executive Order No. 13045. The Forum fosters collaboration among 23 Federal agencies that (1) produce and/or use statistical data on children and (2) seek to improve Federal data on those children. This year's report, *America's Children: Key National Indicators of Well-Being, 2025*, provides carefully selected key national indicators of our children's well-being and monitors changes in these indicators. The purposes of this report are to improve reporting of Federal data on children and families; make the most relevant data on the well-being of children and their families available in an easy-to-use, nontechnical format; stimulate discussions among policymakers, data providers, and the public; and cultivate relationships between the statistical and policy communities.

Conceptual Framework

There are many interrelated aspects of children's well-being. This report identifies seven major domains that characterize the well-being of a child and influence the likelihood that a child will grow to be a well-educated, economically secure, productive, and healthy adult. The seven domains are family and social environment; economic circumstances; health care; physical environment and safety; behavior; education; and health. These domains are interrelated and can have synergistic effects on well-being.

Each section of the report corresponds to one of the seven domains and includes a set of key national indicators. These indicators either characterize an aspect of well-being or an influence on well-being.

- *Family and Social Environment* includes indicators that characterize children's family lives and social settings.
- *Economic Circumstances* includes indicators related to children's basic material needs.
- *Health Care* includes indicators that characterize access to and use of health services among children.
- *Physical Environment and Safety* includes indicators that characterize children's environmental conditions or are related to children's safety.
- *Behavior* includes indicators that characterize personal behaviors and their effects.
- *Education* includes indicators that characterize how children learn and progress in school.
- *Health* includes indicators that characterize the physical, mental, and social aspects of children's health.

Structure of the Report

America's Children presents a set of key national indicators that measure important aspects of children's lives and are

collected regularly, reliably, and rigorously by Federal agencies. In determining this list of key national indicators, the Forum carefully examined the available data and sought input from the Federal policymaking community, foundations, academic researchers, and state and local children's service providers. These key national indicators were chosen because they meet the following criteria:

- *Easy to understand* by broad audiences;
- *Objectively* based on reliable data with substantial research connecting them to child well-being;
- *Balanced*, so that no single area of children's lives dominates the report;
- *Measured regularly*, so that they can be updated and show trends over time; and
- *Representative* of large segments of the population rather than one particular group.

America's Children is designed as an overview of the concepts and broad findings that are presented in other, more technical or more comprehensive reports produced by various Forum agencies. This report provides not only the selected indicators of child well-being but also extensive supplementary information. Appendix A, Data Source Descriptions, describes the sources and surveys used to generate the data. In addition, detailed data tables for each indicator are available on the Forum's website (<https://www.childstats.gov>).

Changes to This Year's Report

Whenever possible, we have updated indicators with the latest available data and have included a note about when the data were last updated for each indicator.

This year's report also introduces a new indicator on School Readiness, which presents measures of school readiness for children ages 3–5, and includes a revised Any Nicotine Use indicator (formerly Regular Cigarette Smoking) that expands beyond cigarette smoking to capture any form of nicotine use among 8th, 10th, and 12th graders.

Due to operational challenges and workforce reduction, Forum representatives from several agencies were unable to participate in the development of this year's report, and their usual indicators are not included: the Census Bureau (Child Population; Children as a Percentage of the Population; Racial and Ethnic Composition; Family Structure and Children's Living Arrangements; Children of at Least One Foreign-Born Parent; Child Poverty and Income Distribution; and Supplemental Poverty Measure), the National Center for Education Statistics (Child Care; Family Reading to Young Children; Mathematics and Reading Achievement; High School Academic Coursetaking; High School Completion; and College Enrollment), the Substance Abuse and Mental Health Services

Administration (Adolescent Depression), and the Center for Nutrition Policy and Promotion (Diet Quality). However, these indicators are archived in past reports on the Forum's website (<https://www.childstats.gov>). Note that the numbering of figures and tables has therefore been updated in this year's report.

Unless otherwise noted by respective agencies, this report uses sex rather than gender in data references, per Executive Order 14168.

The data in this report may be impacted by irregular data collection and lower rates of health care access in 2020 and 2021 due to the COVID-19 pandemic.

Race and Ethnicity and Poverty Status

Most indicators in *America's Children* are tabulated by race and ethnicity. Unless otherwise noted, the data sources used in this report have implemented the standards for reporting race and ethnicity statistics issued in 1997 by the U.S. Office of Management and Budget (OMB; <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>). In March 2024, OMB issued updated standards for collecting and reporting race and ethnicity data through revisions to Statistical Policy Directive No. 15 (SPD 15). These standards replace those established in 1997 and require all Federal information collections to align with the updated guidance as soon as possible, but no later than March 28, 2029. Because agencies are still in the process of implementing these changes, indicators in this report continue to reflect the 1997 standards and will be updated as agencies revise their data collection and reporting practices.

Many indicators in this report also include data tabulated by poverty status. All poverty-status calculations in this report are based on OMB's Statistical Policy Directive 14, the official poverty measurement standard for the United States. A family is living below the poverty level if its before-tax cash income is below a defined level called the poverty threshold. Poverty thresholds are updated annually and vary based on family size and composition. Throughout the report, tabulations are shown by poverty status using categories defined as percentages of the poverty threshold (e.g., "below 100%, 100–199%, and at or above 200% of the poverty threshold"). Narrative text may describe the condition as "below the poverty level."

Statistical Significance

Most data in this report are estimates based on a sample of the population and are therefore subject to sampling error. Differences between estimates are tested for statistical significance at either the 0.05 or 0.10 cutoff level, according to agency standards; all differences discussed in the report are statistically significant according to the standards of the agency responsible for the data. Agency details about statistical

reporting standards for indicators included in the *America's Children* report and standard error tables for select indicators are available online at <https://www.childstats.gov>.

Data Topics

The Forum works with the Federal statistical agencies to identify data topics of interest. This process helps identify many important aspects of children's lives for which regular indicators have not been developed.

In some areas, Forum agencies have successfully fielded surveys incorporating new measures, but data are not yet available for monitoring purposes. In other areas, agencies are exploring ways to collect new measures and improve existing ones.

For Further Information

There are several places to obtain more information on the indicators found in this report, including the data tables, the data source descriptions, the Forum's website (<https://www.childstats.gov>). Several publications of the Federal statistical agencies provide additional details about indicators in this report and on other areas of child well-being, such as *Health, United States* (<https://www.cdc.gov/nchs/hus/index.htm>), published annually by the National Center for Health Statistics.

Detailed Tables

When available, tables show data by the following categories: sex, age, race and Hispanic origin, poverty status, parental education, region of the country, and family structure. Detailed data tables for each indicator are available on the Forum's website (<https://www.childstats.gov>).

Data Source Descriptions

Appendix A contains basic information on the data used to generate the indicators and how to contact the agency responsible for the data. These agencies can provide more detailed information about the concepts and methods used to produce their statistics.

Website

The Forum's website (<https://www.childstats.gov>) contains data tables, links to previous reports, information on statistical standards used for data reporting in the *America's Children* report, links for ordering reports, and additional information about the Forum.

Highlights

America's Children: Key National Indicators of Well-Being, 2025 continues a series of annual reports to the Nation on conditions affecting children in the United States. Highlights from each section follow.

Family and Social Environment

- In 2023, the birth rate among unmarried women ages 15–44 was 36 births for every 1,000 women, down from 37 births for every 1,000 women in 2022. From 2022 to 2023, birth rates decreased for those ages 18–19, 25–29, and 30–34, increased for those ages 20–24 and 40–44, and remained stable for those ages 15–17 and 35–39. (FAM1.A)
- In 2023, 40% of births were to unmarried women. Generally, the percentage of births to unmarried women decreased with age—mothers under age 20 were more likely to be unmarried at the time of birth, while mothers age 25 and over were less likely to be unmarried at the time of birth. (FAM1.B)
- The birth rate among female adolescents ages 15–17 declined from 9 per 1,000 in 2016 to 5 per 1,000 in 2023, a record low for the country. (FAM2)
- In 2023, the rate of substantiated child maltreatment was 7 per 1,000 children ages 0–17. The maltreatment rate for children under age 1 was 21 per 1,000, which was more than twice the rate for any other age group. (FAM3.A)
- Neglect was by far the most common form of maltreatment in 2023: nearly three-quarters (74%) of child maltreatment victims were found to have been neglected. (FAM3.B)

Economic Circumstances

- In 2023, 79% of children ages 0–17 had at least one parent who worked year round, full time. This percentage was not significantly different from the percentage in 2022. (ECON1)
- In 2023, 19% of children ages 0–17 (13.8 million children) lived in households classified as food insecure. (ECON2)

Health Care

- In 2023, the percentage of children ages 0–17 without health insurance at the time of interview was 4%. Hispanic children were more likely to be uninsured (7%) compared with Black, non-Hispanic (3%) and White, non-Hispanic (2%) children. (HC1)
- The percentage of uninsured children ages 0–17 with no usual source of health care did not significantly change from 2019 to 2023. In 2023, 24% of uninsured children had no usual source of health care compared with 4% of children with public health insurance and 1% of children with private health insurance. (HC2)

- Among children born in 2020, 68% had received the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months. The percentage who received this vaccine series was lower for those in families with incomes below the poverty threshold (58%) than for those in families with incomes at or above the poverty threshold (71%). (HC3)
- The percentage of children ages 5–17 years who had visited the dentist in the past year did not significantly change from 2019 to 2023 (90% in 2023). In 2023, children with family incomes below 100% of the poverty threshold (81%) were the least likely to have visited the dentist in the past year, followed by children with family incomes at 100%–199% of the poverty threshold (86%) and children with family incomes at or above 200% of the poverty threshold (93%). (HC4.A)
- In 2017–March 2020, the percentage of children ages 5–17 with untreated dental caries (i.e., cavities) was 12%. Children in families with incomes below 100% of the poverty threshold were more than two times as likely to have untreated dental caries (19%) compared with children in families with incomes at or above 200% of the poverty threshold (8%). (HC4.B)

Physical Environment and Safety

- In 2022, 54% of children ages 0–17 lived in counties with measured pollutant concentrations above the levels of one or more of the Environmental Protection Agency's Primary National Ambient Air Quality Standards (NAAQS) at least once during the year. (PHY1)
- Overall, the percentage of children ages 4–11 with detectable blood cotinine levels—a chemical marker of recent exposure to secondhand smoke—was 36% in 2017–March 2020. Approximately 58% of Black, non-Hispanic children ages 4–11 had detectable blood cotinine levels, compared with 39% of White, non-Hispanic children and 20% of Mexican American children. (PHY2)
- In 2023, 1% of all children ages 0–17 served by community water systems were served by systems that had violations of the disinfection byproducts standard. Exposure to disinfection byproducts may lead to cancer or developmental effects. (PHY3)
- In 2017–March 2020, the percentage of children with elevated blood lead levels (at or above 3.5 micrograms lead per deciliter of blood [$\mu\text{g}/\text{dL}$]) was 1.4%. This percentage was 18.5% in 1999–2002 and 43.0% in 1988–1994. (PHY4)

- In 2023, 39% of U.S. households with children ages 0–17 had one or more of the following housing problems: physically inadequate housing, crowded housing, or housing cost burden. This percentage is not statistically different from the percentage in 2021. (PHY5)
- In 2023, the serious violent crime victimization rate for youth ages 12–17 was 5 crimes per 1,000. (PHY6)
- In 2021–2022, the leading causes of injury-related emergency department (ED) visits for both children ages 1–4 and 5–14 were falls and being struck by or against an object or person. For children ages 1–4, the rate for falls was 45 visits per 1,000 children and the rate for being struck was 17 visits per 1,000 children. For children ages 5–14, the rate for falls was 24 visits per 1,000 children and the rate for being struck was 18 visits per 1,000 children. (PHY7.A)
- In 2023, the leading injury-related cause of death among children ages 1–4 was drowning (3 per 100,000), whereas motor-vehicle-traffic-related injuries (2 per 100,000) were the leading injury-related cause of death among children ages 5–14. (PHY7.B)
- In 2021–2022, the leading causes of injury-related ED visits among adolescents ages 15–19 were being struck by or against an object or person (20 visits per 1,000), falls (20 visits per 1,000), motor vehicle traffic crashes (17 visits per 1,000), overexertion (12 visits per 1,000), and being cut or pierced from an instrument or object (10 visits per 1,000). (PHY8.A)
- In 2023, unintentional injuries were the leading cause of injury-related death among adolescents ages 15–19 (22 per 100,000). Among males, death rates for homicide (20 per 100,000) were higher than suicide (15 per 100,000). Among females, death rates for suicide (5 per 100,000) were higher than homicide (3 per 100,000). (PHY8.B)
- In 2024, marijuana use in the past 30 days was reported by 4% of 8th-graders, 10% of 10th-graders, and 16% of 12th-graders. Rates remained stable compared with 2023. (BEH3.B)
- The percentage of high school students who reported ever having had sexual intercourse decreased from 38% in 2019 to 32% in 2023. (BEH4.A)
- Among sexually active high school students, the percentage who reported they or their partner used a condom the last time they had intercourse peaked at 63% in 2003, decreased to 52% in 2021, and remained stable through 2023. (BEH4.B)
- Among sexually active high school students, the percentage who used birth control pills to prevent pregnancy before the last time they had sexual intercourse (not counting emergency contraception such as Plan B or the “morning after” pill) was 21% in 2021 and remained stable through 2023, ranging from 10% in 9th grade to 24% in 12th grade. (BEH4.C)
- In 2023, the serious violent crime offending rate for juveniles ages 12–17 was 6 crimes per 1,000; there were 162,100 serious violent crimes involving juvenile offenders. (BEH5)

Education

- In 2024, 9% of youth ages 16–19 were neither enrolled in school nor working. This rate has remained between 8% and 9% since 2000, with the exception of 2020 (when the rate was 10%). (ED1)
- In 2023, nearly two-thirds (66%) of children ages 3–5 were developmentally on track and ready for school. Percentages varied by developmental domain—from 68% for motor development to 89% for health—and by race/ethnicity, ranging from 60% for Black, non-Hispanic and Hispanic children to 70% for White, non-Hispanic children. These measures show no significant difference from the prior year. (ED2)

Health

- The percentage of infants born preterm varied year-to-year from 2013 to 2023 but was about 10% throughout the period. In 2023, infants of Black, non-Hispanic women (15%) were the most likely to be born preterm, followed by infants of Native Hawaiian or Other Pacific Islander, non-Hispanic (13%) and American Indian or Alaska Native, non-Hispanic (12%) women. Infants of Hispanic (10%); White, non-Hispanic (9%); and Asian, non-Hispanic (9%) women were the least likely to be born preterm. (HEALTH1.A)

Behavior

- In 2024, 5% of 8th-graders used any nicotine products and 6% vaped nicotine; 11% of 10th-graders used any nicotine products and 10% vaped nicotine; and 16% of 12th-graders used any nicotine products and 15% vaped nicotine. (BEH1)
- Youth binge drinking rates remained steady among 8th-, 10th-, and 12th-graders from 2023 to 2024. (BEH2)
- In 2024, illicit drug use in the past 30 days was reported by 5% of 8th-graders, 10% of 10th-graders, and 17% of 12th-graders. These estimates were not significantly different from those in 2023 for 8th- and 10th-graders. For 12th-graders, the estimate reflects a significant decrease compared with 2023 (20%). (BEH3.A)

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- In 2023, 9% of infants were born with low birthweight. Infants of Black, non-Hispanic women were the most likely to have low birthweight (15%), compared with infants of Asian, non-Hispanic (9%); American Indian or Alaska Native, non-Hispanic (9%); Native Hawaiian or Other Pacific Islander, non-Hispanic (9%); Hispanic (8%); and White, non-Hispanic (7%) women. (HEALTH1.B)
 - After a long-term downward trend since 1995, the infant mortality rate was stable from 2020 to 2021 (5 deaths per 1,000 live births) and then increased in 2022 to 6 per 1,000. In 2022, infant mortality rates continued to be the highest for infants of Black, non-Hispanic women (11 per 1,000) and lowest for infants of Asian, non-Hispanic women (4 per 1,000). (HEALTH2)
 - In 2022, 7% of children ages 4–17 were reported by parents to have serious emotional or behavioral difficulties. This percentage was higher for male children (8%) than for female children (6%). (HEALTH3)
 - In 2022–2023, 14% of children ages 5–17 had disability. The likelihood of disability increased with decreasing poverty status—children with family incomes below 100% of the poverty threshold were the most likely to have disability (20%), followed by children with family incomes at 100%–199% of the poverty threshold (15%) and children with family incomes at or above 200% of the poverty threshold (11%). (HEALTH4)
 - In August 2021–August 2023, 22% of children ages 6–11 and 23% of adolescents ages 12–17 had obesity. (HEALTH5)
 - In 2024, among children ages 0–17, 7% currently had asthma, and 4% had one or more asthma attacks in the past year. (HEALTH6.A)
 - The prevalence of current asthma in 2024 was highest among Black, non-Hispanic children ages 0–17 (10%), followed by children who were Hispanic (7%); White, non-Hispanic (6%); and Asian, non-Hispanic (4%). (HEALTH6.B)

America's Children at a Glance

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Family and Social Environment			
Births to unmarried women			
Births to unmarried females ages 15–44	37 per 1,000 (2022)	36 per 1,000 (2023)	↓
Births to unmarried females among all births	39.8% (2022)	40.0% (2023)	↑
Adolescent births			
Births to females ages 15–17	6 per 1,000 (2022)	5 per 1,000 (2023)	↓
Child maltreatment^a			
Substantiated reports of maltreatment of children ages 0–17	8 per 1,000 (2022)	7 per 1,000 (2023)	NC
Economic Circumstances			
Secure parental employment			
Children ages 0–17 living with at least one parent employed year round, full time	79% (2022)	79% (2023)	NS
Food insecurity			
Children ages 0–17 in households classified by the USDA as “food insecure”	19% (2022)	19% (2023)	NS
Health Care			
Health insurance coverage			
Children ages 0–17 who were uninsured at the time of interview	4% (2022)	4% (2023)	NS
Usual source of health care			
Children ages 0–17 with no usual source of health care	3% (2022)	3% (2023)	NS
Immunization			
Children who completed the combined 7-vaccine series by age 24 months	70% (2019)	68% (2020)	NS
Oral health			
Children ages 5–17 with a dental visit in the past year	89% (2022)	90% (2023)	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	59% (2021)	54% (2022)	NS
Secondhand smoke			
Children ages 4–11 with any detectable blood cotinine level, a measure for recent exposure to secondhand smoke	37% (2015–2016)	36% (2017–March 2020)	NS
Drinking water quality			
Children ages 0–17 served by community water systems that did not meet all applicable health-based drinking water standards	8% (2022)	7% (2023)	NC
Lead in the blood of children			
Children ages 1–5 with blood lead levels greater than or equal to 3.5 µg/dL	2% (2013–2016)	1% (2017–March 2020)	NS

See notes at end of table.

Legend: NC = Not calculated NS = No statistically significant change ↑ = Statistically significant increase ↓ = Statistically significant decrease

	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Physical Environment and Safety—cont.			
Housing problems			
Households with children ages 0–17 reporting physically inadequate housing, crowding, and/or housing cost burden	39% (2021)	39% (2023)	NS
Youth victims of serious violent crimes			
Serious violent crime victimizations of youth ages 12–17	6 per 1,000 (2022)	5 per 1,000 (2023)	NS
Child injury and mortality			
Injury-related deaths of children ages 1–4	12 per 100,000 (2022)	11 per 100,000 (2023)	NS
Injury-related deaths of children ages 5–14	7 per 100,000 (2022)	7 per 100,000 (2023)	NS
Adolescent injury and mortality			
Injury-related deaths of adolescents ages 15–19	46 per 100,000 (2022)	45 per 100,000 (2023)	NS
Behavior			
Any nicotine use			
Students who reported any nicotine use in the past 30 days			
8th grade	9% (2023)	5% (2024)	↓
10th grade	13% (2023)	11% (2024)	NS
12th grade	20% (2023)	16% (2024)	NS
Alcohol use			
Students who reported having five or more alcoholic beverages in a row in the past 2 weeks			
8th grade	2% (2023)	2% (2024)	NS
10th grade	5% (2023)	5% (2024)	NS
12th grade	10% (2023)	9% (2024)	NS
Illicit drug use			
Students who reported using illicit drugs in the past 30 days			
8th grade	7% (2023)	5% (2024)	NS
10th grade	11% (2023)	10% (2024)	NS
12th grade	20% (2023)	17% (2024)	↓
Sexual activity			
High school students who reported ever having had sexual intercourse	30% (2021)	32% (2023)	NS
Youth perpetrators of serious violent crimes			
Youth offenders ages 12–17 involved in serious violent crimes	6 per 1,000 (2022)	6 per 1,000 (2023)	NS
Education			
Youth neither enrolled in school^b nor working			
Youth ages 16–19 who are neither enrolled in school nor working	8% (2023)	9% (2024)	NS

See notes at end of table.

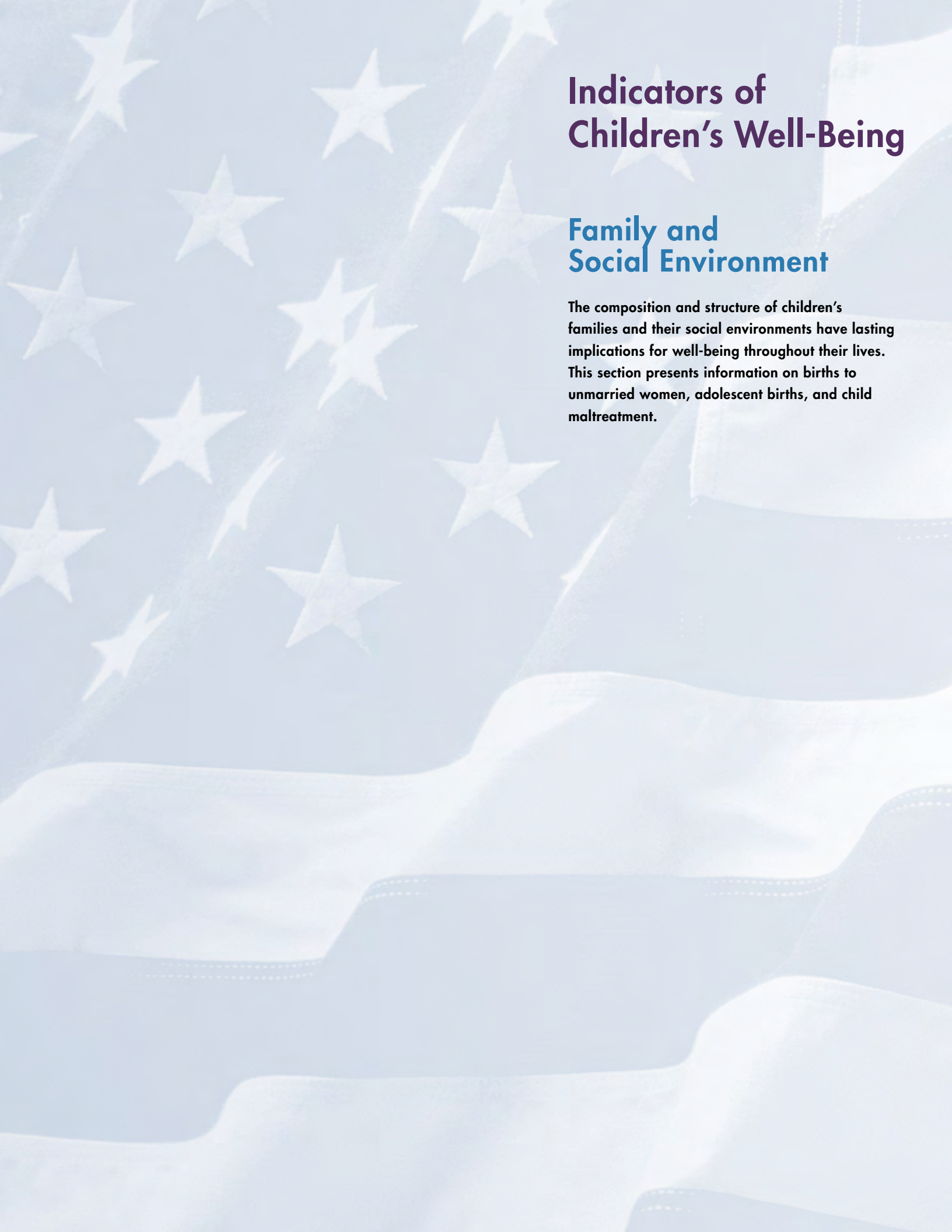
Legend:	NC = Not calculated	NS = No statistically significant change	↑ = Statistically significant increase	↓ = Statistically significant decrease
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	Previous Value (Year)	Most Recent Value (Year)	Change Between Years
Education — cont.			
School readiness			
Percentage of children ages 3–5 who were developmentally on track and ready for school	64% (2022)	66% (2023)	NS
Health			
Preterm birth and low birthweight			
Infants less than 37 completed weeks of gestation at birth	10% (2022)	10% (2023)	NS
Infants weighing less than 5 lb 8 oz at birth	9% (2022)	9% (2023)	NS
Infant mortality			
Deaths before first birthday	5 per 1,000 (2021)	6 per 1,000 (2022)	↑
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	6% (2019)	7% (2022)	↑
Disability			
Children ages 5–17 with disability	13% (2020–2021)	14% (2022–2023)	NS
Obesity			
Children ages 6–17 who had obesity	21% (2017– Mar. 2020)	23% (Aug. 2021– Aug. 2023)	NS
Asthma			
Children ages 0–17 who currently have asthma	7% (2023)	7% (2024)	NS

^a Population estimates are not sample derived and thus not subject to statistical testing. Change between years identifies differences in the proportionate size of these estimates.

^b School refers to high school and college.

Legend:	NC = Not calculated	NS = No statistically significant change	↑ = Statistically significant increase	↓ = Statistically significant decrease
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Indicators of Children's Well-Being

Family and Social Environment

The composition and structure of children's families and their social environments have lasting implications for well-being throughout their lives. This section presents information on births to unmarried women, adolescent births, and child maltreatment.

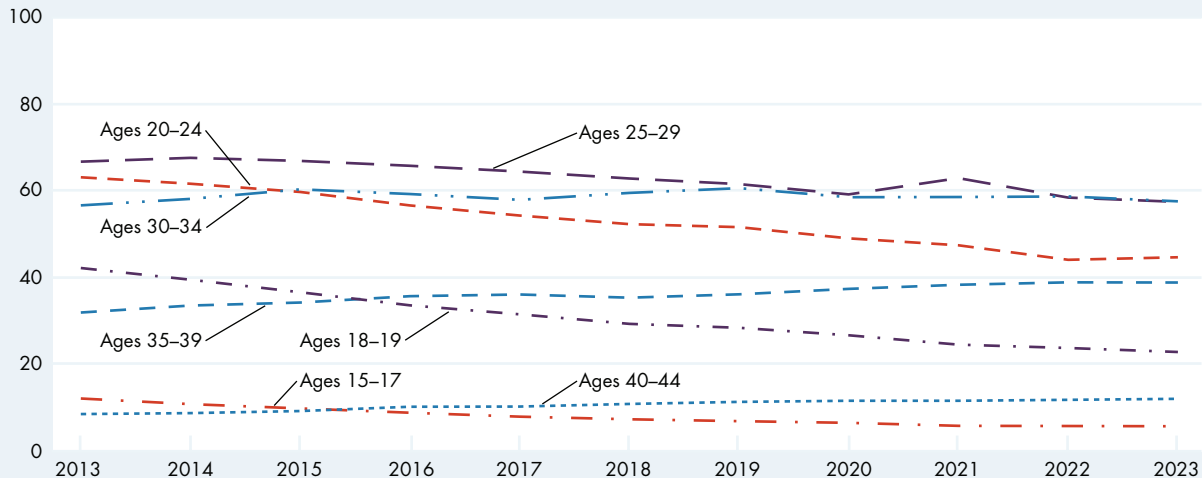
Births to Unmarried Women

The birth rate among married women has increased overall since 1980. Recent increases are primarily due to increased births to mothers living with a partner rather than to single, unpartnered mothers.¹ Moreover, the demography of unmarried births has changed over the past 40 years. Unmarried births to younger mothers, particularly teens, have declined, whereas births to older mothers, including first births, have increased.² However, it is important to continue to track outcomes of unmarried births as differences persist in racial and ethnic, economic, and other key demographic factors between births to unmarried women and those to married women. Historically, children of unmarried mothers are at a higher risk of adverse birth outcomes, such as low birthweight, preterm birth, and infant mortality, compared with children of married mothers.^{1,3}

Indicator FAM1.A

Birth rates for unmarried women by age of mother, 2013–2023

Live births per 1,000 unmarried women in specified age group

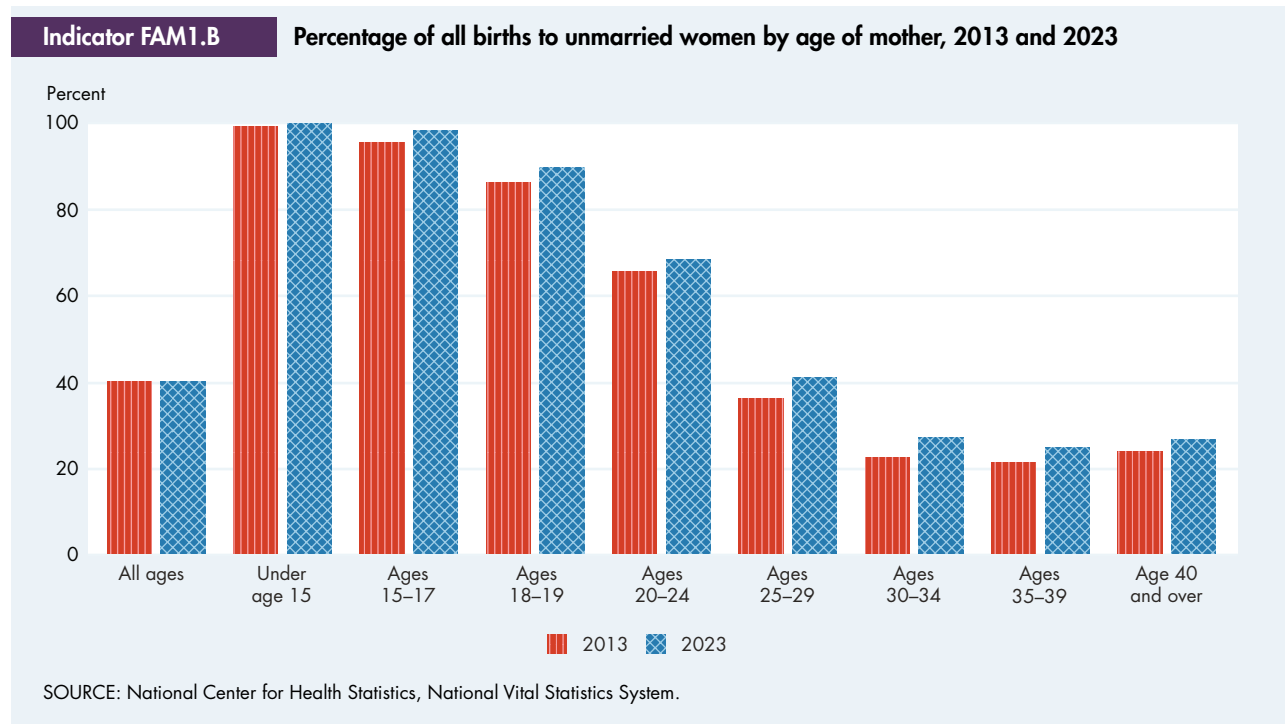


NOTE: Rates for women ages 40–44 are calculated by dividing the number of births to unmarried women age 40 and over by the population of unmarried women ages 40–44.

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

- In 2023, the birth rate for unmarried females ages 15–44 was 36 births for every 1,000 unmarried females.
- The birth rate was highest for unmarried women ages 30–34 (58 per 1,000) and 25–29 (57 per 1,000), followed by women ages 20–24 (45 per 1,000), 35–39 (39 per 1,000), 18–19 (23 per 1,000), 40–44 (12 per 1,000), and 15–17 (5 per 1,000).
- From 2013 to 2023, birth rates decreased for unmarried women under age 30, whereas birth rates varied for unmarried women age 30 and over. Birth rates did not significantly change for unmarried women ages 30–34 and increased for unmarried women ages 35–39. For unmarried women ages 40–44, birth rates increased from 2013 to 2019 and then remained stable year to year through 2023.

The proportion of births to unmarried women is useful for understanding the extent to which children born in a given year may be affected by any disadvantage—social, financial, or health—associated with being born outside of marriage. The change in the percentage of births to unmarried women reflects both changes in the birth rate for unmarried women relative to the birth rate for married women and changes in the percentage of women of childbearing age who are unmarried.⁴



- The percentage of births to unmarried females of all ages did not significantly change from 2013 to 2023. In 2023, 40% of births were to unmarried females.
- Among females under age 20, the percentage of births to unmarried females increased from 2013 to 2023. For females ages 15–17, the percentage of births to unmarried females increased from 95% in 2013 to 98% in 2021 and then remained stable through 2023. For women ages 18–19, the percentage of births to unmarried women increased from 86% in 2013 to 90% in 2023.
- Among women in their 20s, the percentage of births to unmarried women generally increased during this time period. For women ages 20–24, the percentage of births to unmarried women increased from 65% in 2013 to 68% in 2023. For women ages 25–29, the percentage of births to unmarried women increased from 36% in 2013 to 41% in 2020 and then remained stable through 2023.
- Among women in their 30s, the percentage of births to unmarried women increased during this time period. For women ages 30–34, the percentage of births to unmarried women increased from 22% in 2013 to 27% in 2023. For women ages 35–39, the percentage of births to unmarried women increased from 21% in 2013 to 25% in 2023.
- Among women age 40 and over, the percentage of births to unmarried women increased from 24% in 2013 to 28% in 2021 and then remained stable through 2023 (27% in 2023).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

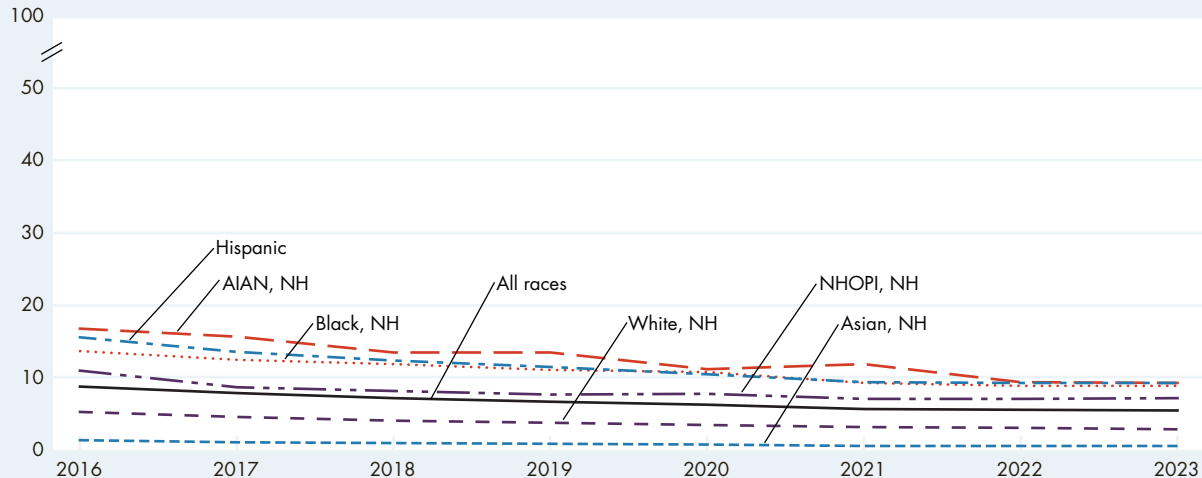
Adolescent Births

Childbirth during adolescence often is associated with long-term difficulties for both mother and child. Babies born to adolescent mothers—especially younger adolescent mothers—are at higher risk for low birthweight and infant mortality than are babies born to older mothers.^{2,5,6} These babies are also more likely to grow up in homes that offer lower than average levels of emotional support and cognitive stimulation, and they are less likely to earn high school diplomas.^{7,8} For the mothers, giving birth during adolescence is associated with limited educational attainment, which in turn can reduce employment prospects and earning potential.^{7,8} Although adolescent birth rates for all racial and ethnic groups have been on a long-term decline since the late 1950s, birth rates historically have been higher for Hispanic and Black, non-Hispanic adolescents than for White, non-Hispanic adolescents.^{2,9}

Indicator FAM2

Birth rates for females ages 15–17 by race and Hispanic origin, 2016–2023

Live births per 1,000 females ages 15–17



NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander. Race and Hispanic origin refer to the mother's race and Hispanic origin. The 1997 U.S. Office of Management and Budget standards for data on race and ethnicity were used to classify people into one of the following five racial groups: White, Black or African American, Asian, American Indian or Alaska Native, or Native Hawaiian or Other Pacific Islander. All categories are single race. Data on race and Hispanic origin are collected and reported separately. People of Hispanic origin may be of any race.

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

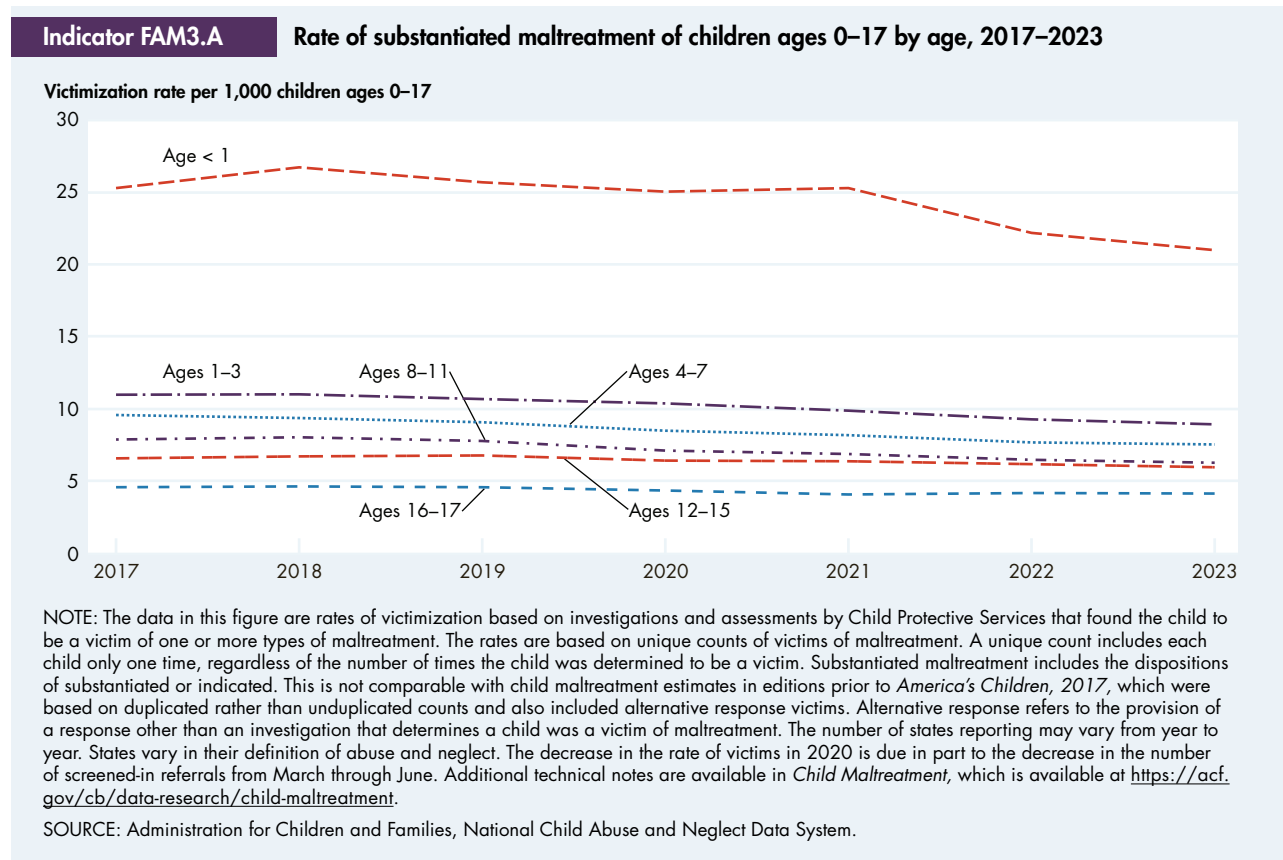
- The birth rate for female adolescents (i.e., those ages 15–17) declined from 9 per 1,000 in 2016 to 6 per 1,000 in 2021 and then remained stable through 2023. In 2023, the birth rate for adolescents was 5 per 1,000, a record low for the United States.
- From 2016 to 2023, birth rates decreased throughout the period for adolescents who were White, non-Hispanic (from 5 per 1,000 to 3 per 1,000); Black, non-Hispanic (from 14 per 1,000 to 9 per 1,000); American Indian or Alaska Native, non-Hispanic (from 17 per 1,000 to 9 per 1,000); and Asian, non-Hispanic (from 1.4 per 1,000 to 0.6 per 1,000).
- For Native Hawaiian or Other Pacific Islander, non-Hispanic adolescents, the birth rate decreased from 11 per 1,000 in 2016 to 8 per 1,000 in 2018 and then remained stable through 2023 (7 per 1,000).
- For Hispanic adolescents, the birth rate decreased from 16 per 1,000 in 2016 to 9 per 1,000 in 2021 and then remained stable through 2023.
- Despite the declines for each race and Hispanic origin group, substantial racial and ethnic disparities persisted. In 2023, adolescents who were American Indian or Alaska Native, non-Hispanic; Black, non-Hispanic; and Hispanic had the highest birth rates (9 per 1,000 each), followed by those who were Native Hawaiian or Other Pacific Islander, non-Hispanic (7 per 1,000); White, non-Hispanic (3 per 1,000); and Asian, non-Hispanic (0.6 per 1,000).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

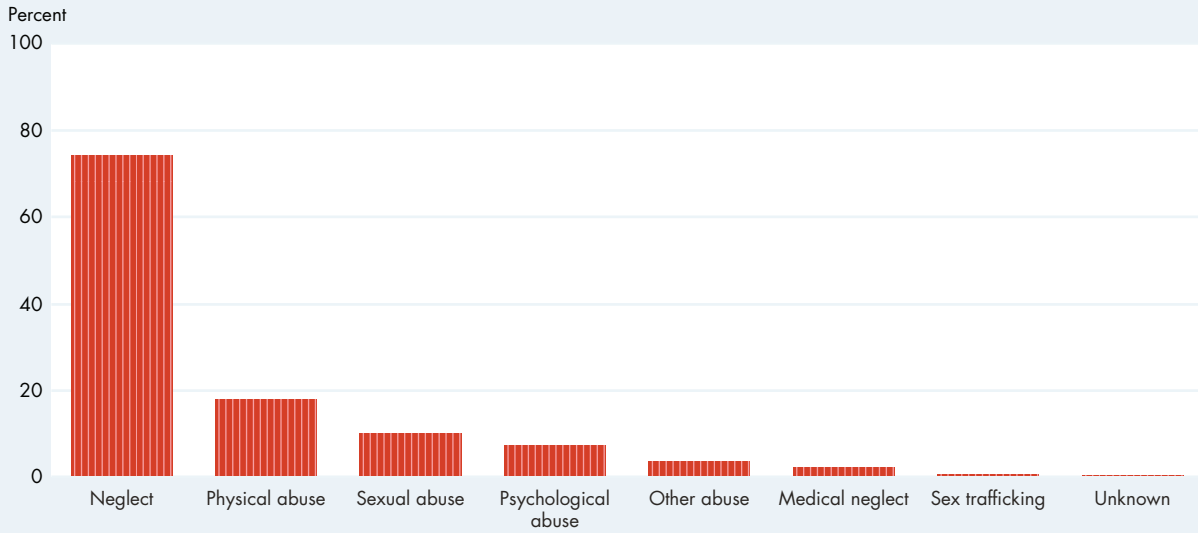
Child Maltreatment

Child maltreatment includes physical, sexual, and psychological abuse, as well as neglect (including medical neglect). Maltreatment is associated with several negative outcomes for children, including developmental delays, lower school achievement, juvenile delinquency, substance abuse, and mental health problems. Many of these problems can follow maltreated children into adulthood.¹⁰ Certain types of maltreatment can result in long-term physical, social, and emotional problems—even death. For example, abusive head trauma can result in visual, neurological, cognitive, behavioral, and sleep impairments, which can result in special education needs.^{10,11}

Note that the calculation of child maltreatment recently changed and is not comparable with data in editions prior to *America's Children, 2017*. Specifically, rates are now based on unduplicated counts, and alternative response victims are no longer included.



- The national maltreatment rate of children ages 0–17 decreased from 9 to 7 per 1,000 children between 2017 and 2023.
- The risk of maltreatment is higher for younger children, particularly those under age 1. In 2023, the maltreatment rate for children under age 1 was 21 per 1,000, which was more than twice the rate for any other age group.
- Between 2017 and 2023, the maltreatment rate among children under age 1 decreased from 25 to 21 per 1,000 children.
- In 2023, maltreatment rates for children ages 0–17 varied substantially among race and Hispanic origin groups. Rates per 1,000 children were, in ascending order, as follows: 1 for Asian, non-Hispanic; 6 for White, non-Hispanic; 7 for Hispanic; 8 for Native Hawaiian or Other Pacific Islander, non-Hispanic; 9 for children of Two or more races, non-Hispanic; 12 for Black, non-Hispanic; and 14 for American Indian or Alaska Native, non-Hispanic.

Indicator FAM3.B**Percentage of substantiated maltreatment of children ages 0–17 by maltreatment type, 2023**

NOTE: Percentages for neglect do not include medical neglect. Medical neglect is reported separately. Bars total to more than 100% because a single child may be the victim of multiple kinds of maltreatment. Substantiated maltreatment includes the dispositions of substantiated or indicated. This is a change from estimates in editions prior to *America's Children, 2017*, when substantiated maltreatment included dispositions of substantiated, indicated, and alternative response victim. Alternative response refers to the provision of a response other than an investigation that determines a child was a victim of maltreatment. Additional technical notes are available in *Child Maltreatment*, which is available at <https://acf.gov/cb/data-research/child-maltreatment>.

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

- Neglect is by far the most common form of maltreatment: nearly three-quarters (74%) of all maltreated children were found to have been neglected in 2023.
- In 2023, 18% of maltreated children were found to have been physically abused, 10% were sexually abused, and 7% were psychologically abused.
- Differences by age are particularly pronounced for sexual abuse, increasing from 1% for children ages 0–3 to 22% for those ages 12–15 and 23% for those ages 16–17 in 2023.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

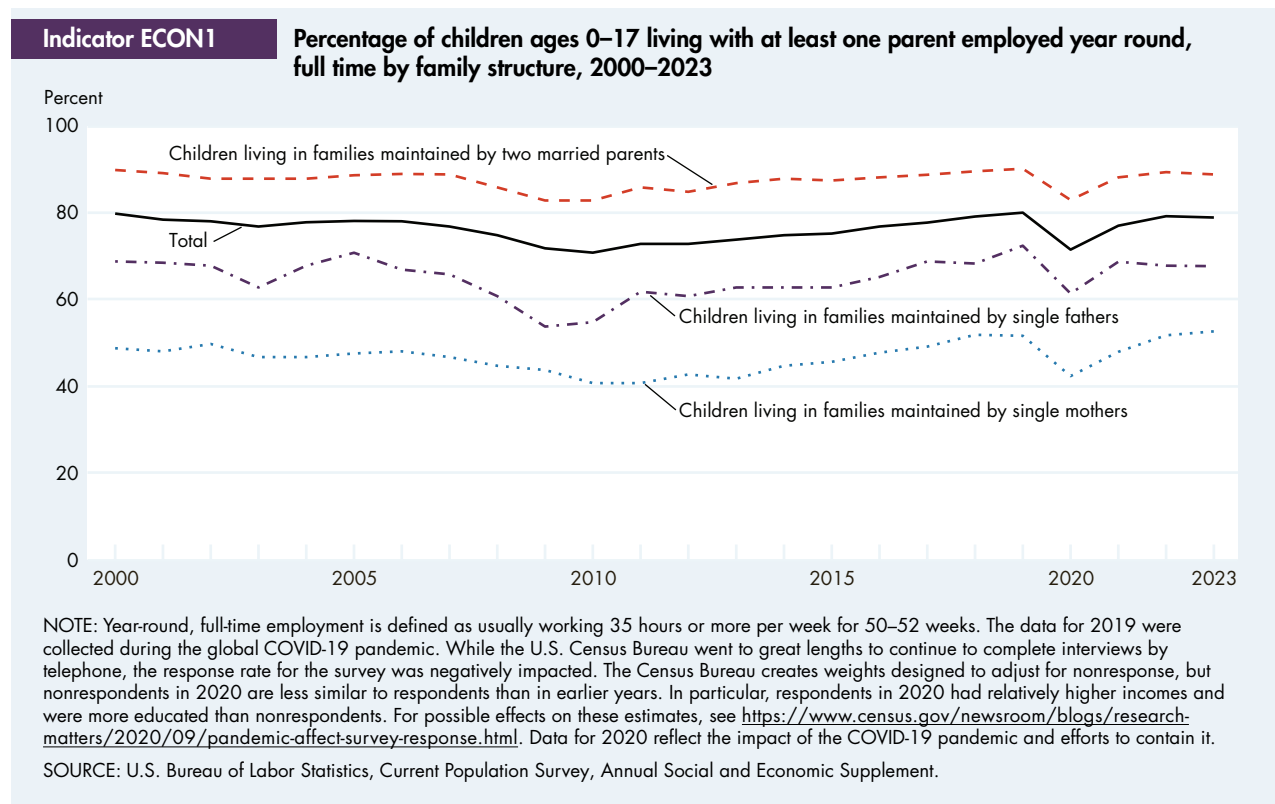


Economic Circumstances

The well-being of children depends greatly on the economic circumstances and material well-being of their families. This section presents information on secure parental employment and food insecurity (i.e., the difficulty of obtaining adequate food).

Secure Parental Employment

Secure parental employment is a major factor in the financial well-being of families.¹² It is associated with higher family income and has been linked to a number of positive outcomes for children, including better health, education, and social and emotional development.¹³ One measure of secure parental employment is the percentage of children whose resident parent or parents were employed full time throughout a given year.

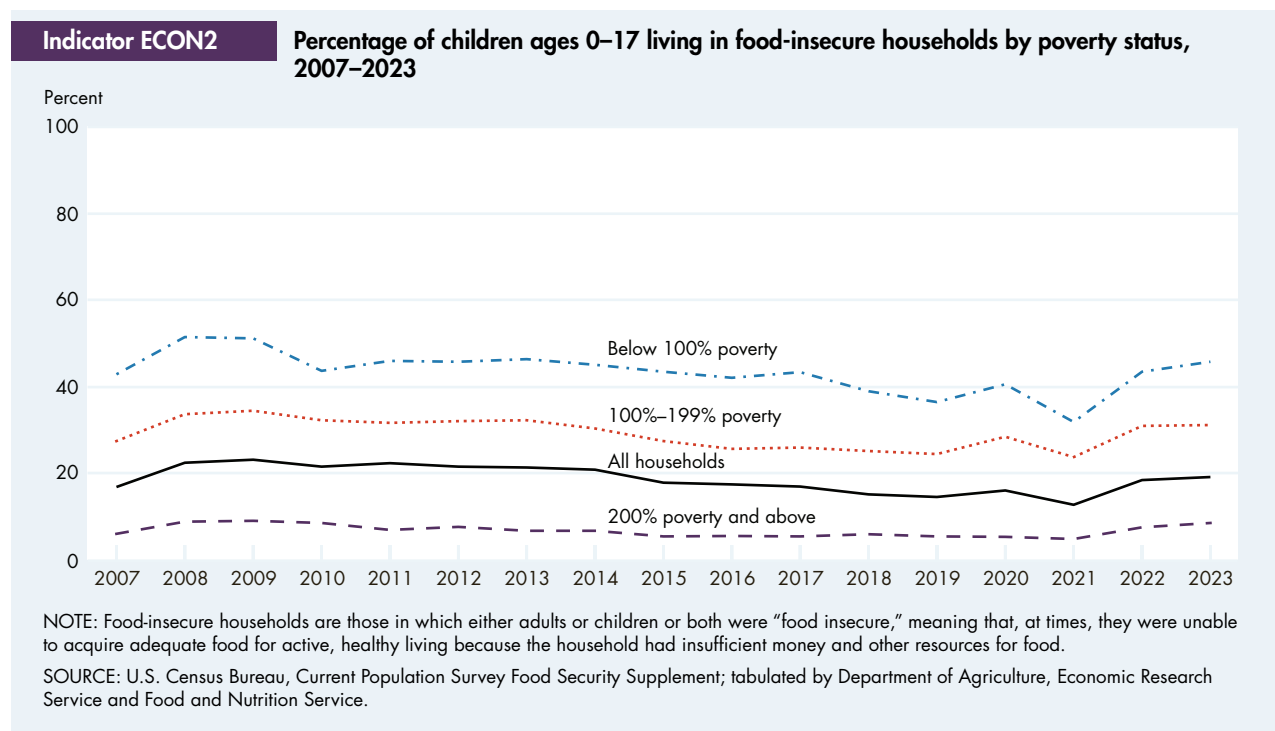


- In 2023, 79% of children ages 0–17 had at least one parent employed year round, full time. This percentage was not significantly different from the percentage in 2022.
 - In 2023, 89% of children living in families maintained by two married parents had at least one parent employed year round, full time. In contrast, 68% of children living in families maintained by a single father and 53% of children living in families maintained by a single mother had a parent employed year round, full time.
 - Since 2010, approximately 80% to 90% of children living in families maintained by two married parents have had at least one parent employed year round, full time. In contrast, approximately 60% to 70% of children living in families maintained by a single father and approximately 40% to 50% of children living in families maintained by a single mother had a least one parent employed year round, full time. All family structures experienced increases in 2021 as labor market conditions improved from the prior year.
 - In 2023, 76% of children ages 0–5 and 81% of children ages 6–17 had at least one parent employed year round, full time.
 - In 2023, 50% of children in families maintained by two married parents who were living below the poverty threshold had at least one parent employed year round, full time. In contrast, 92% of children in families maintained by two married parents who were living at or above the poverty threshold had at least one parent employed year round, full time.
 - Black, non-Hispanic children and Hispanic children were less likely than White, non-Hispanic children to have a parent employed year round, full time. In 2023, 72% of Hispanic children and 70% of Black, non-Hispanic children had a parent employed year round, full time, compared with 86% of White, non-Hispanic children.
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

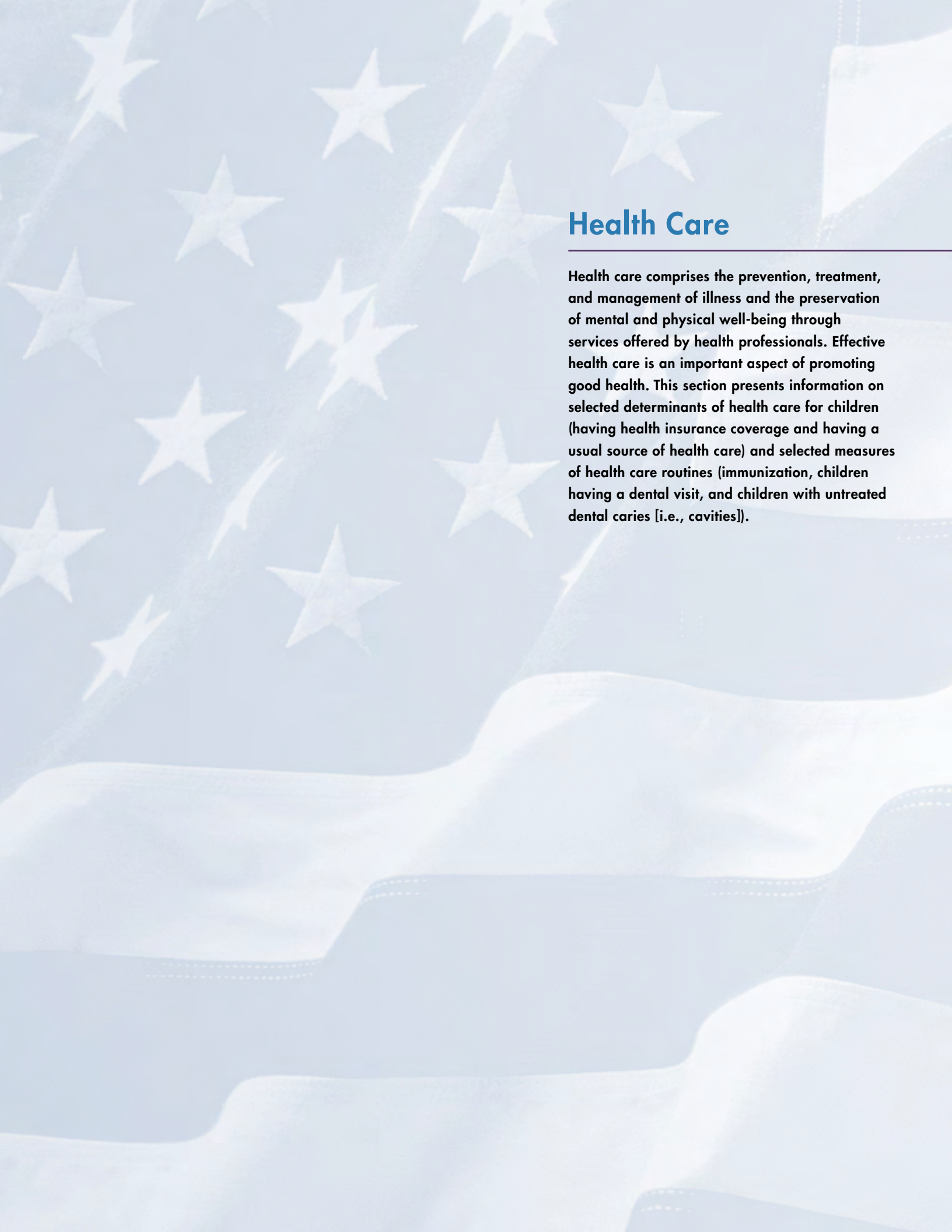
Food Insecurity

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.¹⁴ The food security status of households is based on self-reported 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.¹⁵ In households classified as having very low food security among children—a subset of food-insecure households—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.^{16,17}



- In 2023, 19% of children ages 0–17 (13.8 million children) lived in households classified as food insecure. The prevalence of food insecurity among households with children was not significantly different from the prevalence in 2022.
 - The prevalence of food insecurity among households with children has consistently been highest for households with annual incomes below the official poverty threshold, followed by households with incomes at 100%–199% of the poverty threshold and households with incomes at or above 200% of the poverty threshold. In 2023, 46% of children in households with incomes below 100% of the poverty threshold lived in food-insecure households (well above the national average of 19%). Meanwhile, 9% of children in households with incomes at or above 200% of the poverty threshold lived in food-insecure households (well below the national average).
 - In 2023, the percentages of children living in food-insecure households were above the national average of 19% for those whose parents or guardians were Black, non-Hispanic (27%); those whose parents or guardians were Hispanic (27%); those whose parents or guardians did not have a high school diploma or GED certificate (35%); those whose parents' or guardians' highest level of education was high school diploma or a GED certificate (33%); those whose parents' or guardians' highest level of education was some college (25%); those who lived with a single mother (38%); those who lived with a single father (25%); and those who lived in the South (22%).
 - In 2023, the percentages of children living in food-insecure households were below the national average of 19% for those whose parents or guardians were White, non-Hispanic (14%); those whose parents' or guardians' highest level of education was a bachelor's degree or higher (9%); those whose parents or guardians were married (12%); and those who lived in the Midwest (17%).
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

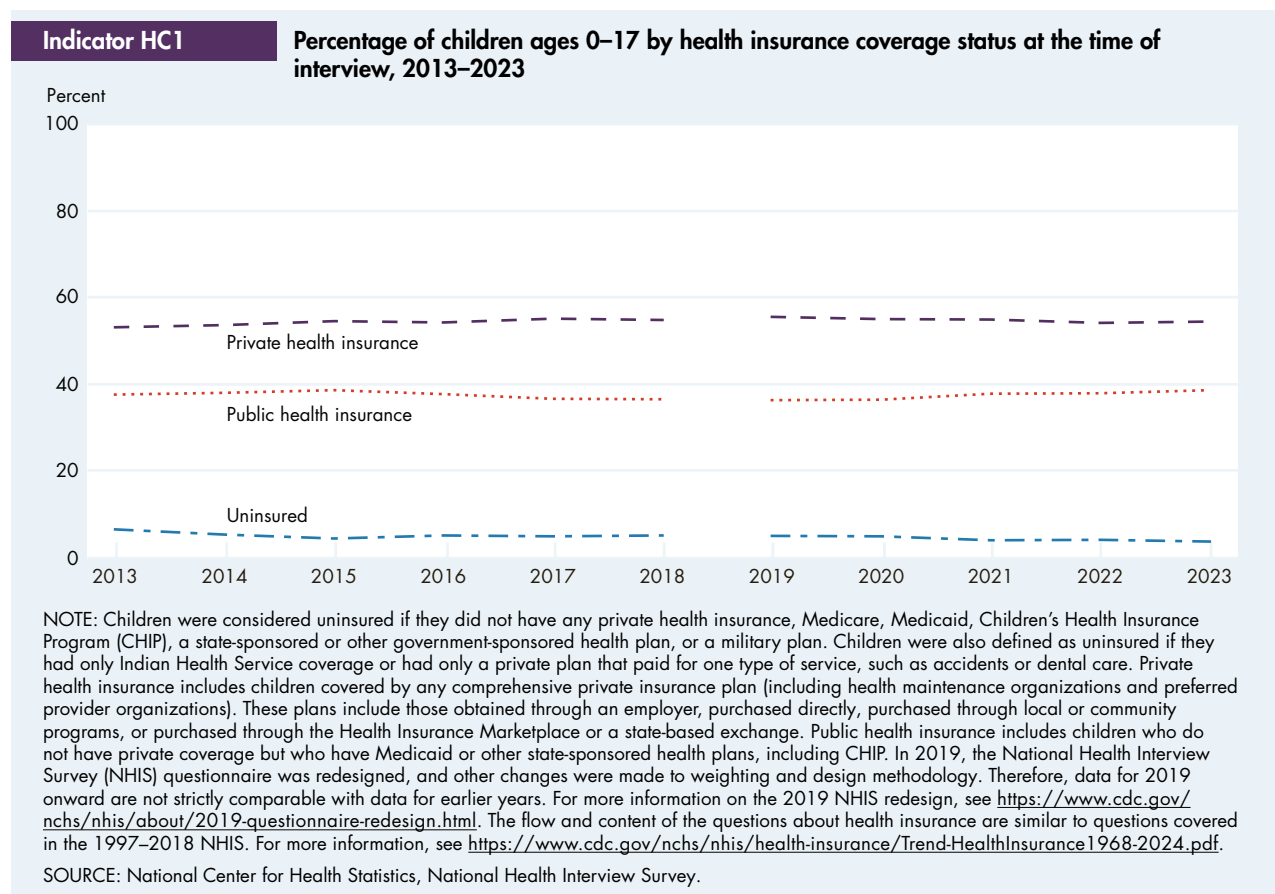
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Health Care

Health care comprises the prevention, treatment, and management of illness and the preservation of mental and physical well-being through services offered by health professionals. Effective health care is an important aspect of promoting good health. This section presents information on selected determinants of health care for children (having health insurance coverage and having a usual source of health care) and selected measures of health care routines (immunization, children having a dental visit, and children with untreated dental caries [i.e., cavities]).

Health Insurance Coverage

Health insurance is a major determinant of access to health care.¹⁸ Children and adolescents need regular and ongoing health care to treat acute and chronic conditions and provide injury care and routine preventive care, including vaccinations.¹⁹ Children may be eligible for health insurance through private coverage or public programs such as Medicaid, enacted in 1966, and the Children's Health Insurance Program (CHIP), started in 1997.^{20,21} Children with health insurance, whether public or private, are more likely than children without insurance to have a regular and accessible source of health care (see HC2). 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.²²

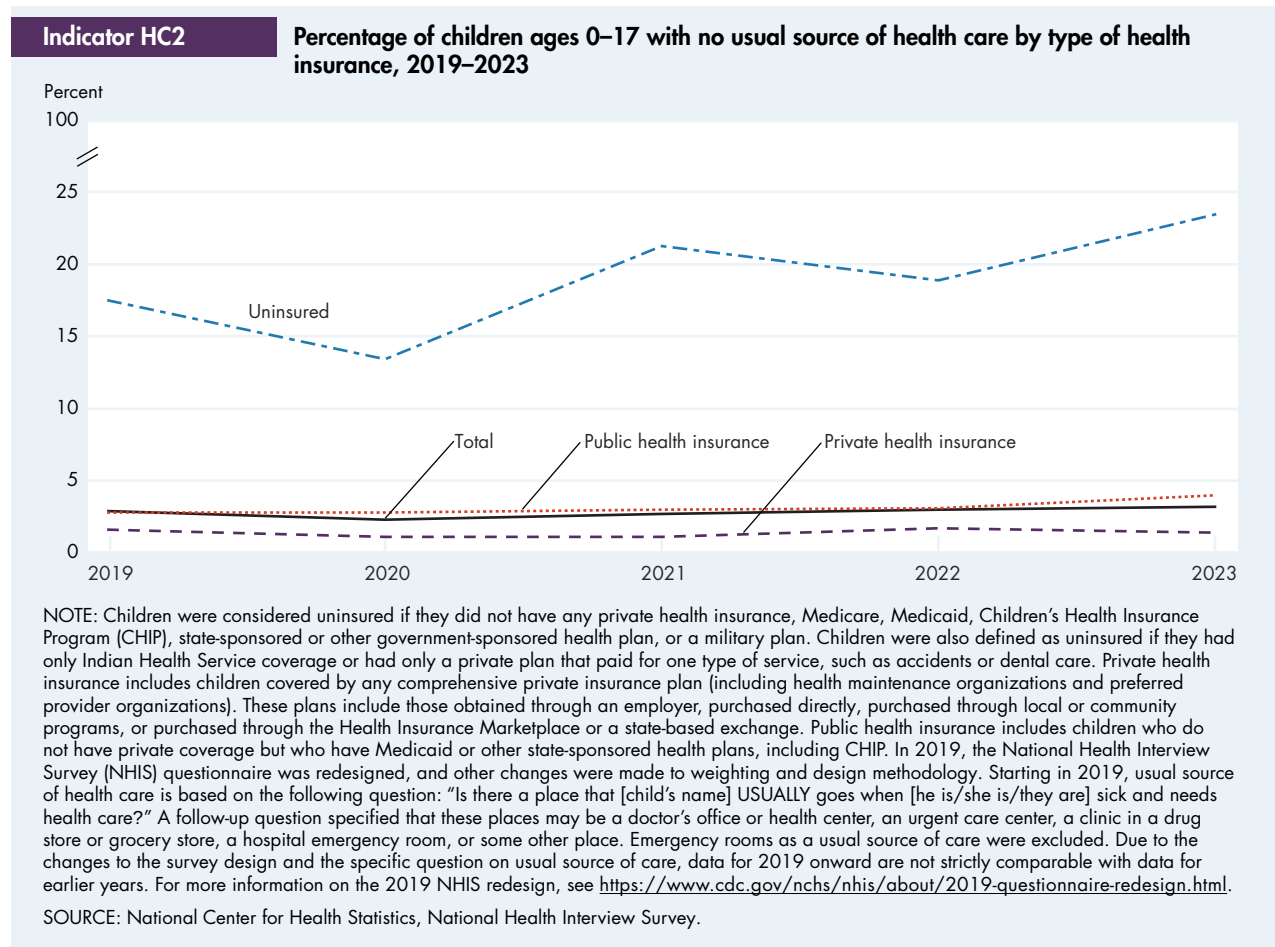


- The percentage of children ages 0–17 without health insurance at the time of interview decreased from 7% in 2013 to 4% in 2023.
- The percentage of children with private health insurance increased from 53% in 2013 to 56% in 2019 and then remained stable through 2023. In 2023, 54% of children had private health insurance.
- The percentage of children with public health insurance did not significantly change from 2013 to 2023. In 2023, 39% of children had public health insurance.
- In 2023, Hispanic children were more likely to be uninsured (7%) than were Black, non-Hispanic (3%) and White, non-Hispanic (2%) children. White, non-Hispanic children were more likely to have private health insurance (69%) than were Black, non-Hispanic (38%) and Hispanic (33%) children. Black, non-Hispanic and Hispanic children (57% each) were more likely to have public health insurance than were White, non-Hispanic children (26%).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Usual Source of Health Care

Children's health depends at least partially on their access to health services, including physical examinations, preventive care, health education, observations, screening, immunizations, and sick care.²³ Having a usual source of health care—a particular person or place a child goes to for preventive and sick care—facilitates the timely and appropriate use of pediatric services.²⁴ Emergency rooms are excluded here as a usual source of care because their focus on emergency care generally excludes the continuity and types of health services previously mentioned.²⁵



- The percentage of children ages 0–17 who had no usual source of health care was stable from 2019 to 2023. While estimates varied from 2% to 3% during this period, differences were not significant.
- From 2019 to 2023, the percentage of children who had no usual source of health care did not significantly change for children in any insurance category.
- Uninsured children are more likely than insured children to lack a usual source of health care. In 2023, 1% of children with private health insurance and 4% of children with public health insurance lacked a usual source of health care. In contrast, 24% of uninsured children lacked a usual source of care—roughly 22 percentage points higher than the rate for privately insured children and 20 percentage points higher than for publicly insured children.²⁶
- In 2023, children in families with incomes below the poverty threshold (6%) were more likely than children in families with incomes at or above 200% of the poverty threshold (2%) to lack a usual source of health care. There was no significant difference between children in families with incomes below the poverty threshold and at 100%–199% of the poverty threshold or between children in families with incomes at 100%–199% of the poverty threshold and at or above 200% of the poverty threshold.

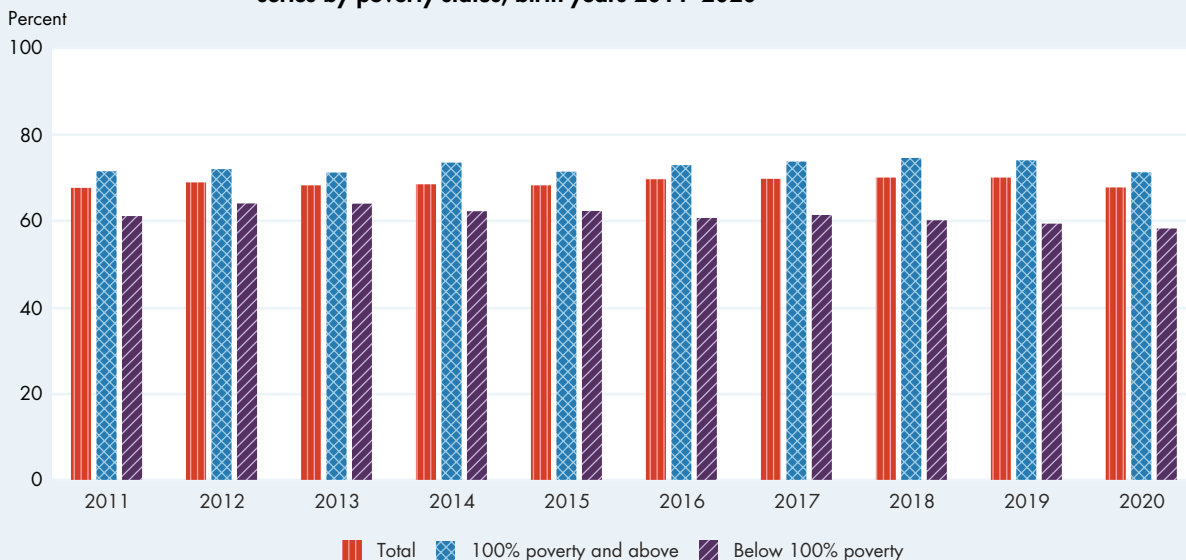
Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Immunization

Childhood immunization, achieved through vaccinations, is essential to protect children from severe illness, disability, and death from vaccine-preventable diseases. Data on vaccination coverage are used to identify groups at risk of vaccine-preventable diseases, monitor trends in vaccination over time, and evaluate the effectiveness of interventions designed to increase coverage.

Indicator HC3.A

Percentage of children who, by age 24 months, have completed the combined 7-vaccine series by poverty status, birth years 2011–2020

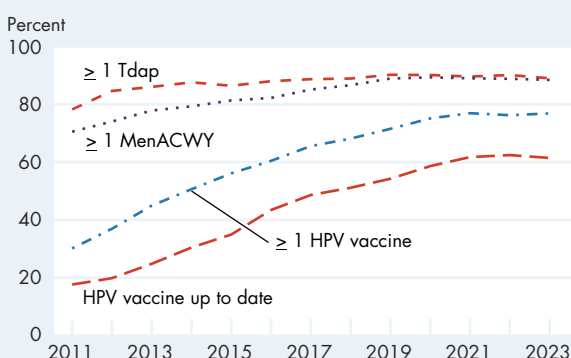


NOTE: The combined 7-vaccine series includes 4 doses or more of diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), 3 doses or more of poliovirus vaccine, 1 dose or more of measles-containing vaccine, the full series of Haemophilus influenzae type b conjugate vaccine (Hib), 3 doses or more of hepatitis B vaccine (HepB), 1 dose or more of varicella vaccine (VAR), and 4 doses or more of pneumococcal conjugate vaccine (PCV). The recommended immunization schedule for children is available at <https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html>. Poverty status is based on family income and household size using U.S. Census Bureau poverty thresholds for the year of data collection. National Immunization Survey—Child data for the 2020 birth year are from survey years 2021, 2022, and 2023.

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

Indicator HC3.B

Percentage of adolescents ages 13–17 years with routinely recommended-for-age vaccinations, survey years 2011–2023



NOTE: The routine vaccination recommendation for adolescents beginning at ages 11–12 includes tetanus-diphtheria-acellular pertussis vaccine (Tdap), meningococcal conjugate vaccine (MenACWY), and human papillomavirus (HPV) vaccine (2 or 3 doses, depending on when first dose is received). The recommended immunization schedule for adolescents is available at <https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html>.

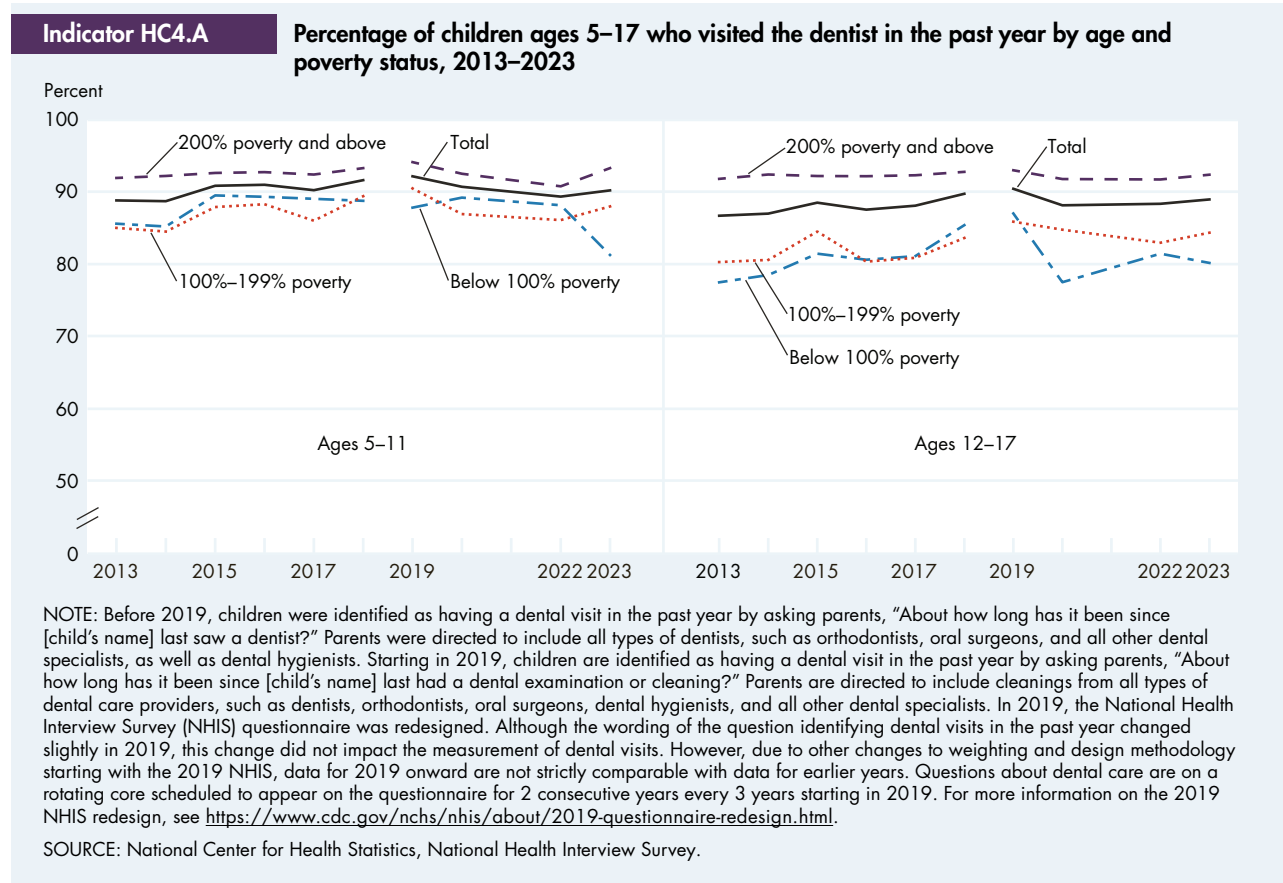
SOURCE: Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, National Immunization Survey—Teen.

- Among children born in 2020, 68% had received the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months. The percentage who received this vaccine series was lower for those in families with incomes below the poverty threshold (58%) than for those in families with incomes at or above the poverty threshold (71%).
- Among children born since 2011, the total percentage who received the combined 7-vaccine series by age 24 months has remained steady (approximately 68%). Disparity in coverage by poverty status has persisted.
- In 2023, 77% of adolescents ages 13–17 years received one dose or more of the human papillomavirus (HPV) vaccine, and 61% were up to date on the HPV vaccine series.²⁷
- In 2023, the proportion of adolescents ages 13–17 years who received one dose or more of the HPV vaccine (77%) was lower than the percentages who received one dose or more of the other two routinely recommended adolescent vaccinations: tetanus, diphtheria, and acellular pertussis (Tdap) (89%) and meningococcal conjugate (MenACWY) (88%).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Oral Health

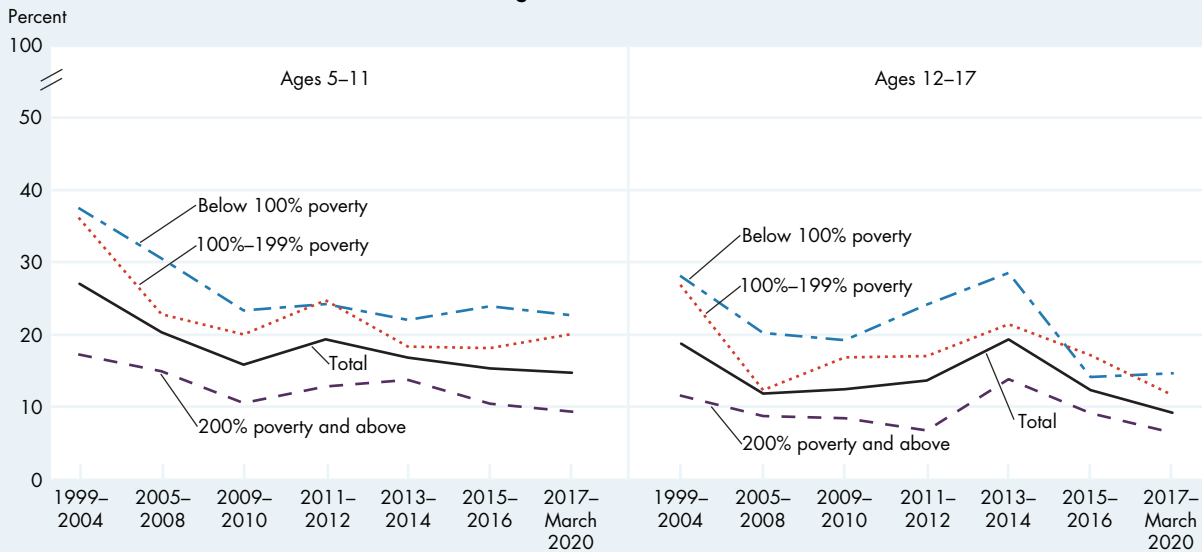
Oral health is an essential component of overall health.²⁸ Good oral health requires both self-care and professional care. Routine dental visits are recommended beginning at 1 year of age.²⁹ Dental caries (i.e., cavities) continue to be one of the most common childhood diseases and are a significant problem among children in some racial and ethnic groups and among children in poverty.^{30,31} Untreated dental caries are associated with tooth loss and can cause pain and infections that may lead to problems with eating, speaking, playing, and learning.^{32,33}



- In 2023, 90% of children ages 5–17 had visited the dentist in the past year.
- Among children ages 5–11, the percentage who had visited the dentist in the past year did not significantly change from 2013 to 2023 for children at any family income level.
- Among children ages 12–17, the percentage who had visited the dentist in the past year did not significantly change from 2013 to 2023 for those with family incomes at 100%–199% of the poverty threshold or those with family incomes at or above 200% of the poverty threshold. For those with family incomes below the poverty threshold, the percentage who had visited the dentist in the past year increased from 77% in 2013 to 87% in 2019 and then did not significantly change from 2019 to 2023 (80%).
- In 2023, children ages 5–11 with family incomes at or above 200% of the poverty threshold were the most likely to have visited the dentist in the past year (93%), followed by those with family incomes at 100%–199% of the poverty threshold (88%) and those with family incomes below the poverty threshold (81%).
- In 2023, children ages 12–17 with family incomes at or above 200% of the poverty threshold were more likely to have visited the dentist in the past year (92%) than were those with family incomes at 100%–199% of the poverty threshold (84%) and those with family incomes below the poverty threshold (80%). There was no significant difference between those with family incomes below the poverty threshold and those with family incomes at 100%–199% of the poverty threshold.

Indicator HC4.B

Percentage of children ages 5–17 with untreated dental caries (cavities) by age and poverty status, 1999–2004 through 2017–March 2020

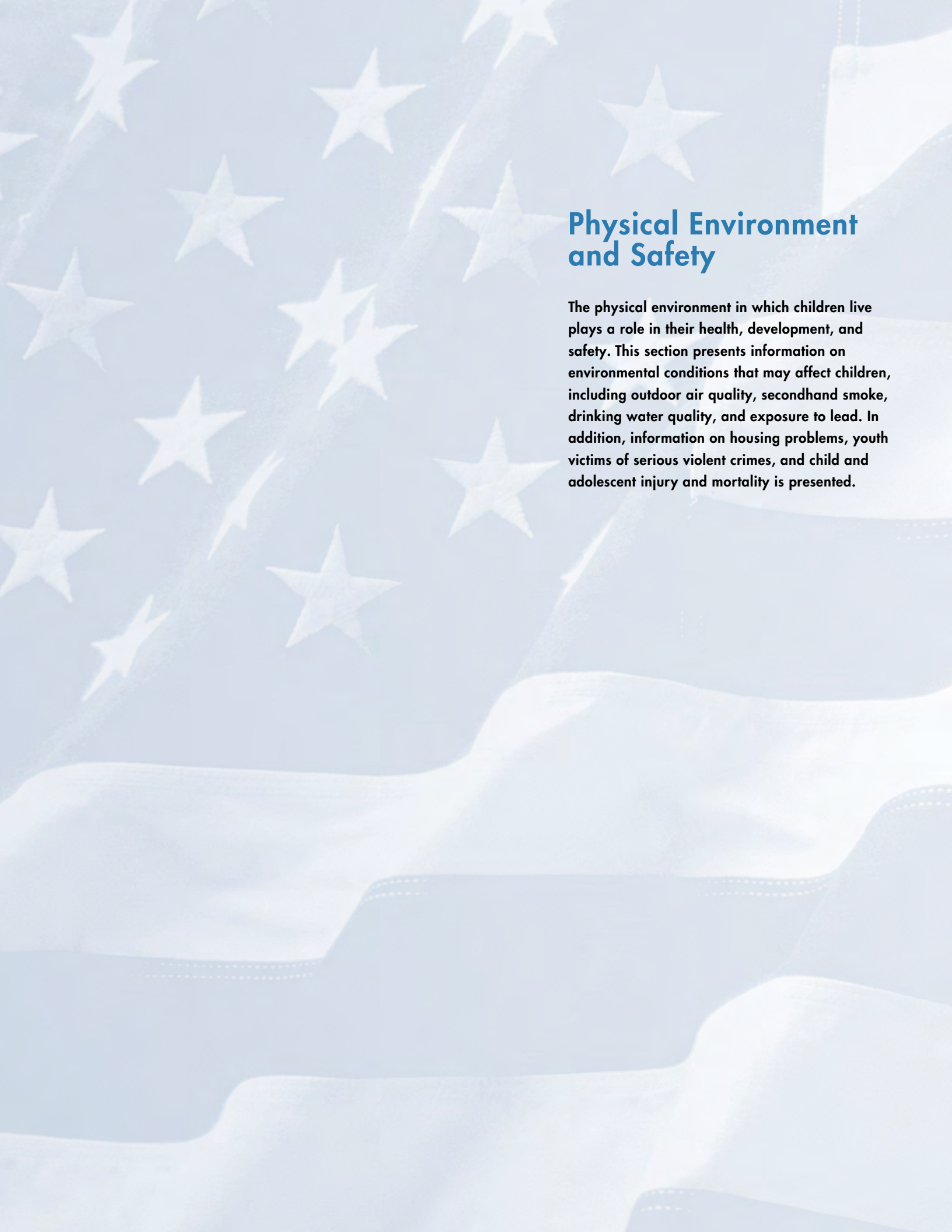


NOTE: The National Health and Nutrition Examination Survey program suspended field operations in March 2020 due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed. Therefore, data collected from 2019 to March 2020 were combined with data from the 2017–2018 cycle to create a 2017–March 2020 pre-pandemic file. This file covers 3.2 years of data collection. For more information, see <https://wwwn.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>. Dental caries data are not available for August 2021–August 2023.

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

- The percentage of children ages 5–11 who had untreated dental caries (i.e., cavities) decreased from 27% in 1999–2004 to 16% in 2009–2010 and then did not significantly change through 2017–March 2020. In 2017–March 2020, 15% of children ages 5–11 had untreated dental caries.
- The percentage of children ages 12–17 who had untreated dental caries fluctuated from 1999–2004 to 2017–March 2020 but did not significantly change. In 2017–March 2020, 9% of children ages 12–17 had untreated dental caries.
- In 2017–March 2020, 23% of children ages 5–11 who were in families with incomes below the poverty threshold had untreated dental caries—more than two times the percentage for those in families with incomes at or above 200% of the poverty threshold (9%).
- In 2017–March 2020, 15% of children ages 12–17 who were in families with incomes below the poverty threshold had untreated dental caries—more than two times the percentage for those with family incomes at or above 200% of the poverty threshold (6%).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

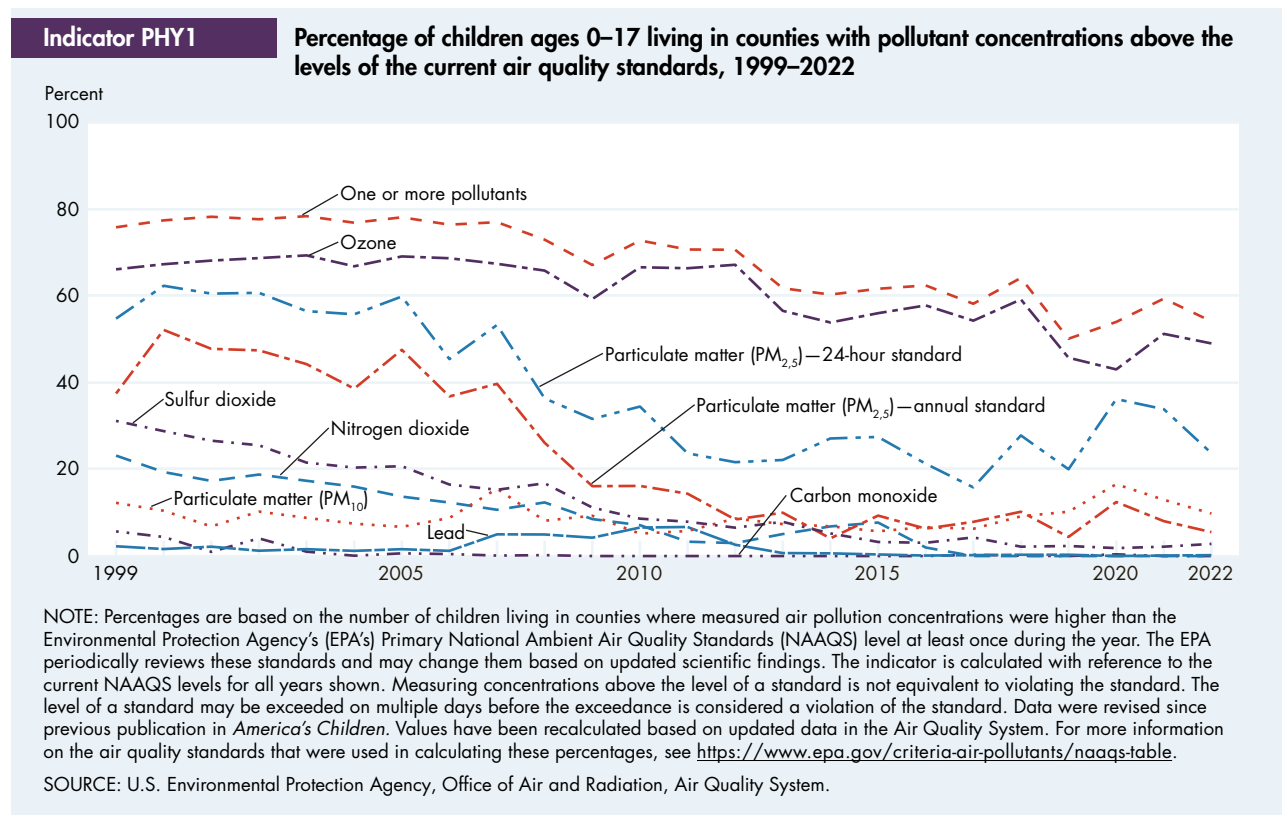


Physical Environment and Safety

The physical environment in which children live plays a role in their health, development, and safety. This section presents information on environmental conditions that may affect children, including outdoor air quality, secondhand smoke, drinking water quality, and exposure to lead. In addition, information on housing problems, youth victims of serious violent crimes, and child and adolescent injury and mortality is presented.

Outdoor Air Quality

The environment in which children live plays an important role in their health and development. Children may be more vulnerable than adults to the adverse effects of environmental contaminants in air, food, drinking water, and other sources because their bodies are still developing. In addition, children have increased potential for exposure to pollutants because they eat, drink, and breathe more, in proportion to the size of their bodies, than adults. One important measure of children's environmental health 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 (referred to as NAAQS in this indicator).³⁴ These standards, established by the U.S. Environmental Protection Agency under the Clean Air Act, are designed to protect public health, including the health of susceptible populations such as children. Ozone, particulate matter, sulfur dioxide, and nitrogen dioxide are air pollutants associated with increased asthma episodes and other respiratory illnesses in children. These problems can lead to increased emergency room visits and hospitalizations.^{35,36,37,38} Lead can affect the development of the central nervous system in young children,³⁹ and exposure to carbon monoxide can reduce the capacity of blood to carry oxygen.⁴⁰



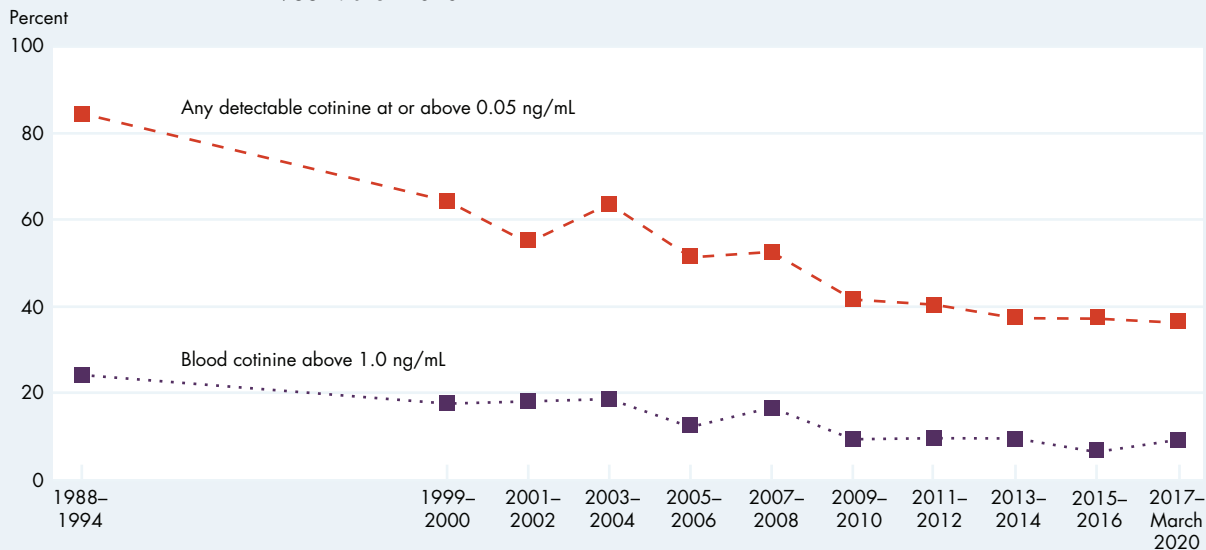
- From 1999 to 2022, the percentage of children ages 0–17 living in counties with measured pollutant concentrations above the allowable levels of one or more NAAQS at least once during the year decreased from 76% to 54%.
 - From 1999 to 2022, the percentage of children living in counties with measured ozone concentrations above the level of the NAAQS at least 1 day per year decreased from 66% to 49%.
 - In 2022, 24% of children lived in counties with measured concentrations of fine particulate matter (PM_{2.5}) above the level of the 24-hour NAAQS at least once during the year. This percentage was 55% in 1999.
 - From 1999 to 2022, the percentage of children living in counties with measured sulfur dioxide concentrations above the level of the NAAQS at least 1 day per year decreased from 31% to 3%. During this timeframe, the percentage of children living in counties with measured nitrogen dioxide concentrations above the level of the NAAQS at least 1 day per year decreased from 23% to nearly 0%.
 - In 2022, the percentage of children living in counties with measured pollutant concentrations above the levels of one or more NAAQS at least once during the year was 42% for those who were American Indian or Alaska Native, non-Hispanic; 45% for those who were White, non-Hispanic; 55% for those who were of Two or more races, non-Hispanic; 55% for those who were Black, non-Hispanic; 57% for those who were Native Hawaiian or Other Pacific Islander, non-Hispanic; 67% for those who were Asian, non-Hispanic; and 69% for those who were Hispanic.
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

Secondhand Smoke

Children who are exposed to secondhand smoke have an increased probability of experiencing adverse health effects such as infections of the lower respiratory tract, bronchitis, pneumonia, middle ear disease, sudden infant death syndrome (SIDS), and respiratory symptoms.⁴¹ Secondhand smoke also can play a role in the development and exacerbation of asthma.⁴¹ The U.S. Surgeon General has determined that there is no risk-free level of exposure to secondhand smoke.⁴¹ Cotinine, a breakdown product of nicotine, is a marker for recent (previous 1–2 days) exposure to secondhand smoke in nonsmokers.

Indicator PHY2.A

Percentage of children ages 4–11 with specified blood cotinine levels, selected years 1988–March 2020

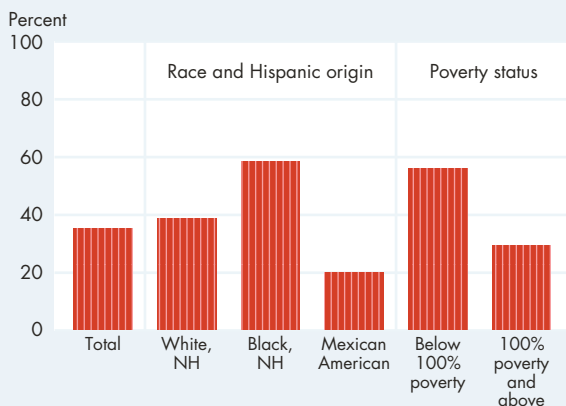


NOTE: Cotinine levels are reported for nonsmoking children only. “Any detectable cotinine” indicates blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL), the level of cotinine that could be detected in blood in 1988–1994. The average (geometric mean) blood cotinine level in children living in homes in which someone smoked was 1.0 ng/mL in 1988–1994.⁴² The National Health and Nutrition Examination Survey (NHANES) program suspended field operations in March 2020 due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed. Therefore, data collected from 2019 to March 2020 were combined with data from the 2017–2018 cycle to create a 2017–March 2020 pre-pandemic file. This file covers 3.2 years of data collection. For more information, see <https://wwwn.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>.

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

Indicator PHY2.B

Percentage of children ages 4–11 with any detectable blood cotinine level by race and Hispanic origin and poverty status, 2017–March 2020



NOTE: NH = non-Hispanic origin. Cotinine levels are reported for nonsmoking children only. “Any detectable blood cotinine” indicates blood cotinine levels at or above 0.05 nanograms per milliliter (ng/mL), the detectable level of cotinine in the blood in 1988–1994. Beginning in 2007, NHANES allows the reporting of both total Hispanics and Mexican Americans; however, estimates reported here are for Mexican Americans to be consistent with earlier years. Persons of Mexican American origin may be of any race.

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

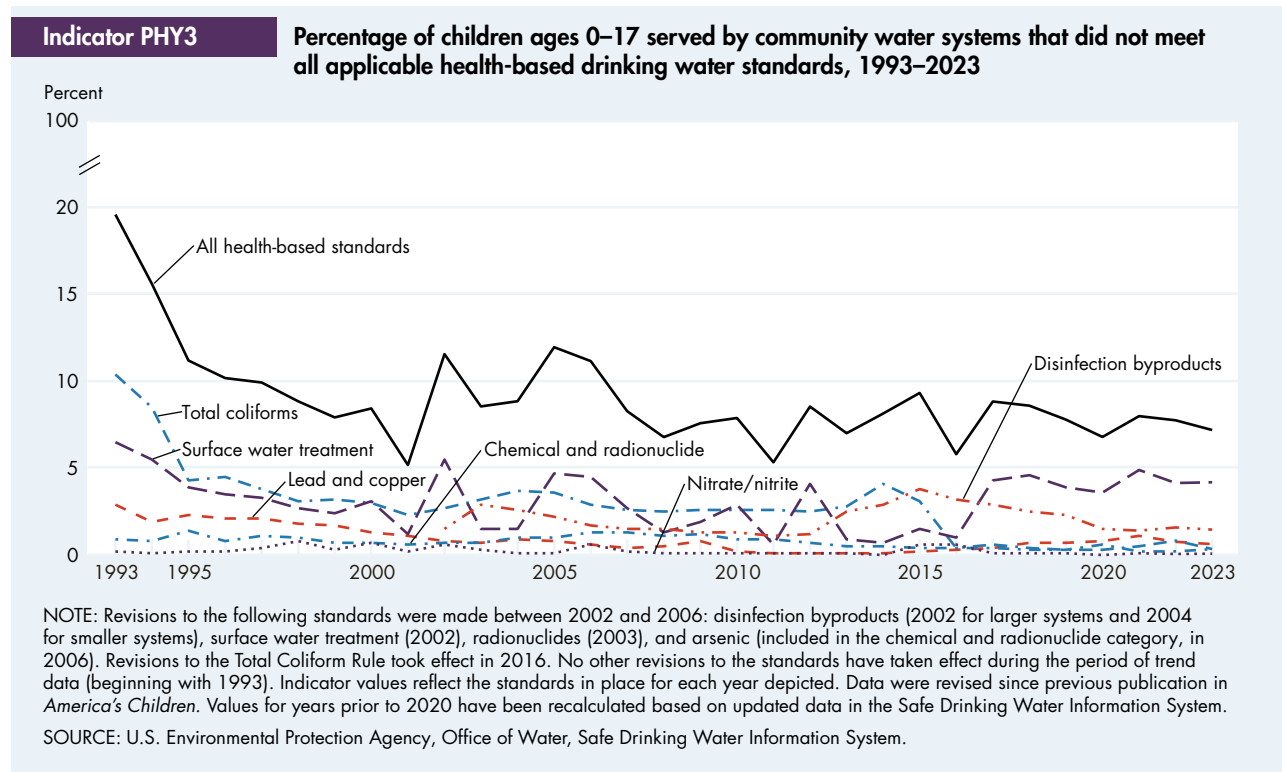
- The percentage of children ages 4–11 with detectable blood cotinine levels (at or above 0.05 nanograms per milliliter [ng/mL]) was 85% in 1988–1994 and 36% in 2017–March 2020.
- In 2017–March 2020, 58% of Black, non-Hispanic children ages 4–11 had detectable blood cotinine levels, compared with 39% of White, non-Hispanic children and 20% of Mexican American children.
- About 56% of children ages 4–11 living in poverty had detectable blood cotinine levels in 2017–March 2020, compared with 29% of children living above the poverty level.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Drinking Water Quality

Contaminants in surface and ground waters that serve as sources of drinking water may be quite varied and may cause a range of health effects in children, including acute diseases such as gastrointestinal illness, developmental effects such as learning disorders, and serious long-term illnesses such as cancer.⁴³ The U.S. Environmental Protection Agency (EPA) sets drinking water standards designed to protect people against adverse health effects. These standards currently include Maximum Contaminant Levels and treatment technique requirements for more than 90 chemical, radiological, and microbiological contaminants.⁴⁴

One way to gain insight into children's potential exposure to drinking water contaminants is to look at community water system compliance with these standards. The EPA's drinking water regulations require public water systems, including community water systems, to monitor for compliance with Federal health-based standards and treat their water if needed to meet standards. About 13% of the population receives drinking water from private water systems that are not required to monitor and report the quality of drinking water.⁴⁵

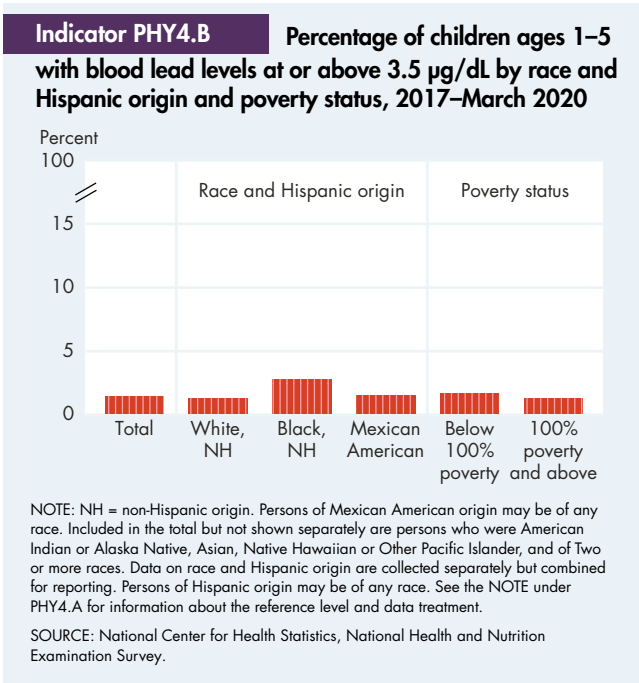
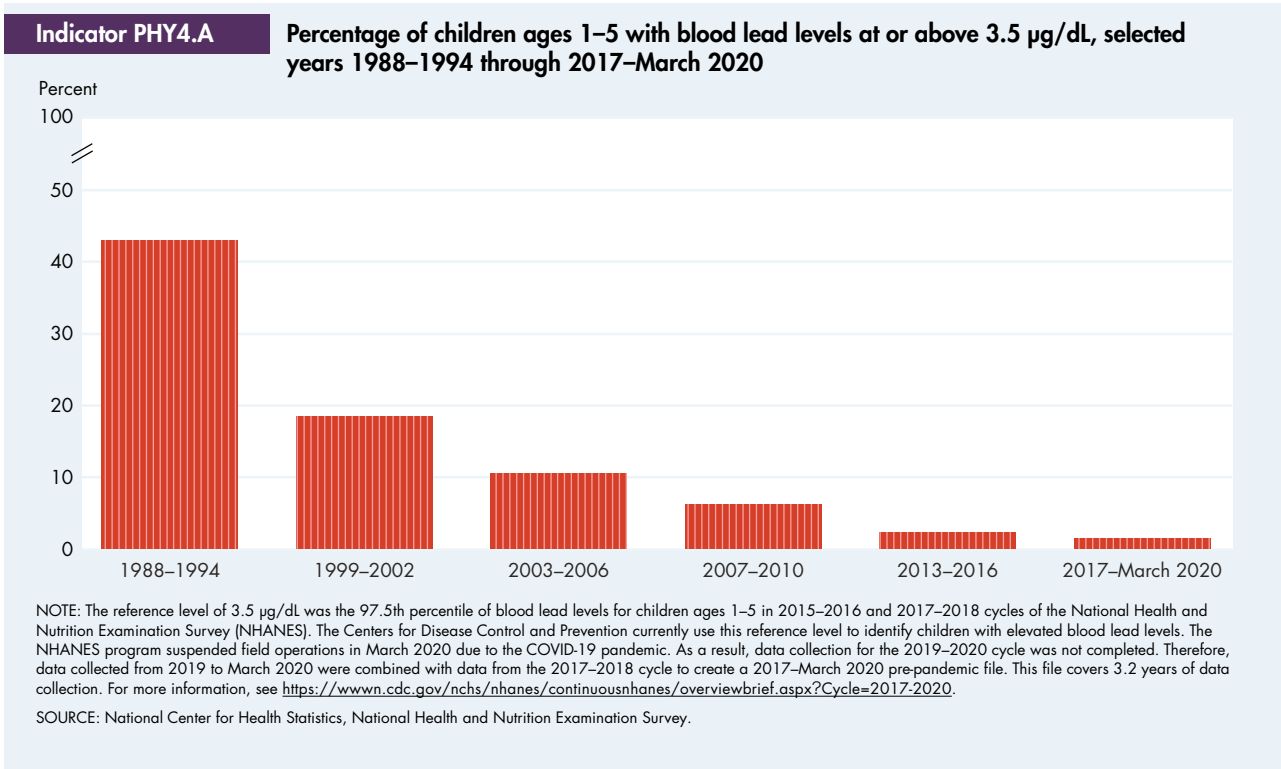


- The percentage of children ages 0–17 served by community drinking water systems that did not meet all applicable health-based standards declined from 20% in 1993 to 7% in 2023.
- Drinking water can be a source of lead and copper exposure for children. The percentage of children served by community drinking water systems that did not meet the health-based standard for lead and copper was 3% in 1993 and less than 1% in 2023.
- Coliforms indicate the potential presence of harmful bacteria associated with infectious illnesses. The percentage of children served by community drinking water systems that did not meet the health-based standard for total coliforms was 10% in 1993 and less than 1% in 2023.
- Disinfection byproducts are formed when drinking water disinfectants react with naturally occurring organic matter in water. In 2023, 1% of all children served by community water systems were served by systems that had violations of the disinfection byproducts standard. Exposure to disinfection byproducts may lead to cancer or developmental effects.⁴⁶

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Lead in the Blood of Children

Lead is a major environmental health hazard for young children. Childhood exposure to lead contributes to learning problems, including reduced intelligence quotient (IQ) and reduced academic achievement, as well as behavioral problems.⁴⁷ The Centers for Disease Control and Prevention (CDC) lowered the blood lead reference level from 5 micrograms lead per deciliter of blood (µg/dL) to 3.5 µg/dL in 2021 to identify children with elevated blood lead levels.⁴⁸ A blood lead level above CDC’s reference value is defined as “elevated” for purposes of identifying children for follow-up activities, such as environmental investigations and ongoing monitoring,⁴⁹ but no level of childhood lead exposure can be considered safe,⁵⁰ and adverse health effects can occur at much lower concentrations.⁴⁷ Lead exposure has declined since the 1970s, due largely to the removal of lead from gasoline and paint. Children ages 1–5—the focus of this indicator—are particularly vulnerable because they frequently engage in hand-to-mouth behavior.



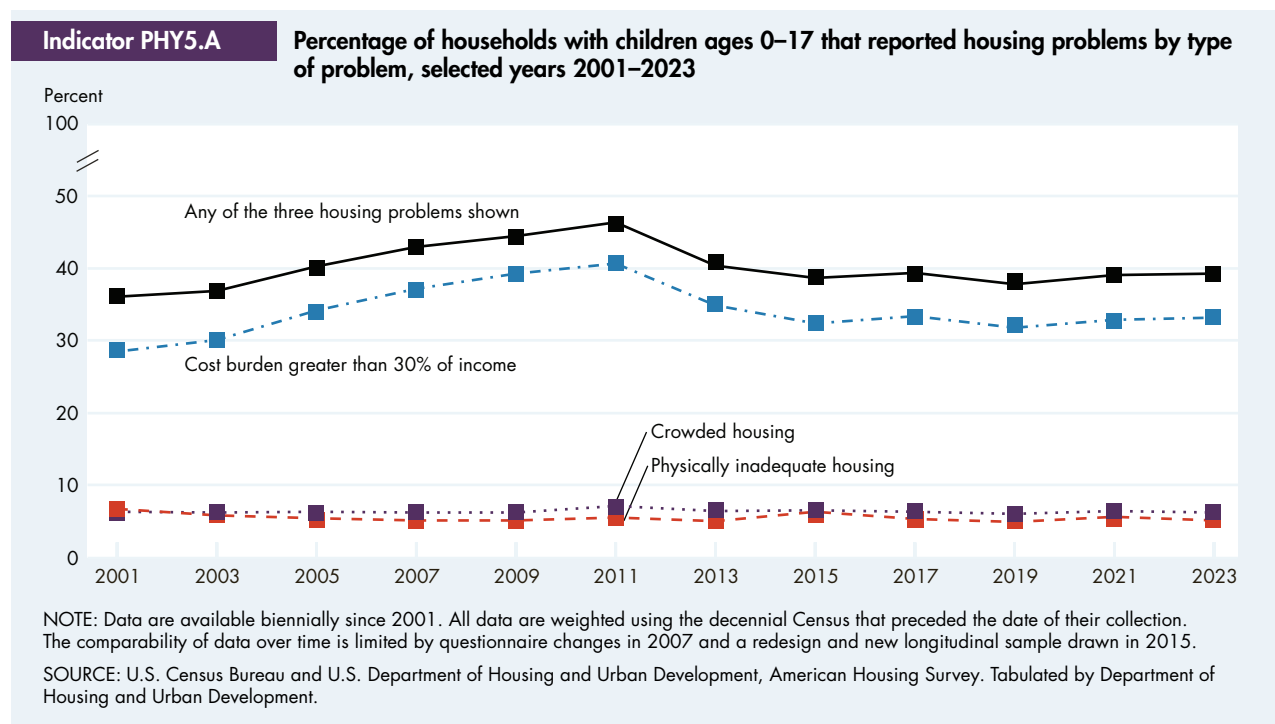
- In 2017–March 2020, the percentage of children ages 1–5 with elevated blood lead levels (at or above 3.5 µg/dL) was 1.4%. This percentage was 18.5% in 1999–2002 and 43.0% in 1988–1994.
- In 2017–March 2020, 2.8% of Black, non-Hispanic children, 1.5% of Mexican American children, and 1.3% of White, non-Hispanic children had blood lead levels at or above 3.5 µg/dL. These differences were not statistically significant.
- In 2017–March 2020, 1.7% of children living in poverty had blood lead levels at or above 3.5 µg/dL. This percentage was 29.6% in 1999–2004.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Housing Problems

Housing that is inadequate, crowded, or too costly can pose serious problems to children's physical, psychological, and material well-being.^{51,52,53} Housing cost burdens, especially at high levels, are a risk factor for negative outcomes for children and their caregivers, including eviction and homelessness, overcrowded housing, frequent moving, degraded physical and mental health, poor nutrition, lack of supervision while parents are at work, and low cognitive achievement.⁵³⁻⁵⁸

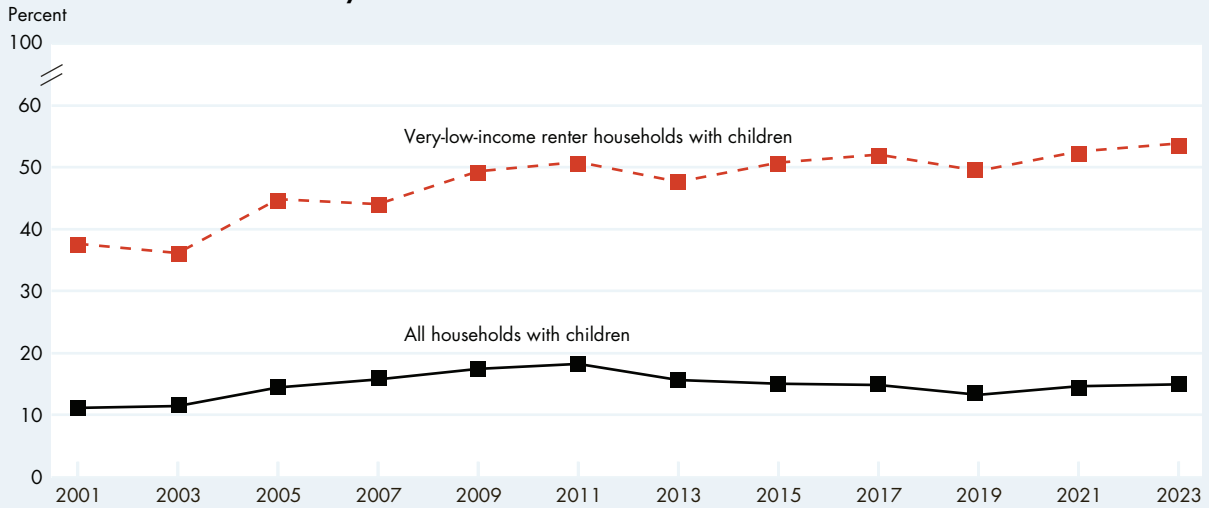
In 2024, a record 148,200 children were estimated to be homeless at a single point in time, and 7% of these children were unsheltered.⁵⁹ The percentage of households with children that report that they are living in physically inadequate,⁶⁰ crowded, or costly housing provides insight into the impact of economic factors on housing choices and children's well-being.



- In 2023, 39% of U.S. households with children ages 0–17 had one or more of the following housing problems: physically inadequate housing, crowded housing, or housing cost burden (i.e., expenditures on housing and utilities that were greater than 30% of household income). This percentage increased from 36% in 2001 but is not statistically different from the percentage in 2021.⁶¹
- In 2023, 5% of households with children had physically inadequate housing (i.e., housing with severe or moderate physical problems). This percentage is not statistically different from the percentage in 2021 (6%).
- In 2023, 33% of households with children experienced housing cost burden. This percentage is greater than the percentage in 2001 (29%) but not statistically different from the percentage in 2021.

Indicator PHY5.B

Percentage of households with children ages 0–17 that reported severe housing cost burden, selected years 2001–2023



SOURCE: U.S. Census Bureau and U.S. Department of Housing and Urban Development, American Housing Survey. Tabulated by Department of Housing and Urban Development.

■ In 2023, 15% of households with children experienced severe housing cost burden (i.e., expenditures on housing and utilities that were greater than 50% of household income). This percentage is not statistically different from the percentage in 2021.

■ Among very-low-income renter households⁶² with children, 54% experienced severe housing cost burden in 2023. This percentage increased substantially from 38% in 2001 but is not statistically different from the percentage in 2021 (53%).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

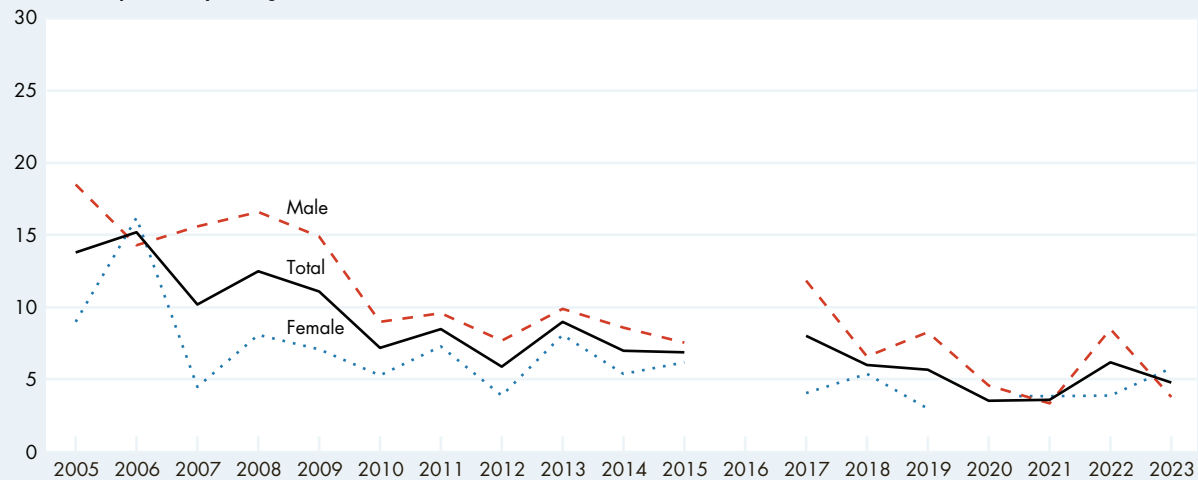
Youth Victims of Serious Violent Crimes

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.^{63,64}

Indicator PHY6

Rate of serious violent crime victimization of youth ages 12–17 by sex, 2005–2023

Victimizations per 1,000 youth ages 12–17



NOTE: Serious violent crimes include aggravated assault, rape, robbery (stealing by force or threat of violence), and homicide. In 2023, homicides represented 1.09% of serious violent crimes, and the total number of homicides of juveniles has been relatively stable over the last decade. Beginning in 2021, the number of homicides was estimated using the Federal Bureau of Investigation's (FBI's) National Incident-Based Reporting System. From 1993–2020, the number of homicides was estimated using the FBI's Supplementary Homicide Reports. Due to methodological changes in the 2006 National Crime Victimization Survey (NCVS), use caution when comparing 2006 criminal victimization estimates with other years. See *Criminal Victimization, 2007*, <https://bjs.ojp.gov/content/pub/pdf/cv07.pdf>, for more information. In 2016, the NCVS sample was redesigned, so 2016 estimates among youth are not comparable with estimates for other years. The 2020 NCVS weights include an additional adjustment to address the impact of modified field operations due to the COVID-19 pandemic. The 2020 estimate for female youth did not meet reporting standards due to insufficient unweighted sample cases and is excluded from the graphic. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 NCVS in the *NCVS 2020 Codebook* (<https://www.icpsr.umich.edu/web/NACJD/studies/38090/summary>) and *Criminal Victimization, 2020* (<https://bjs.ojp.gov/sites/g/files/xyckuh2336/files/media/document/cv20.pdf>).

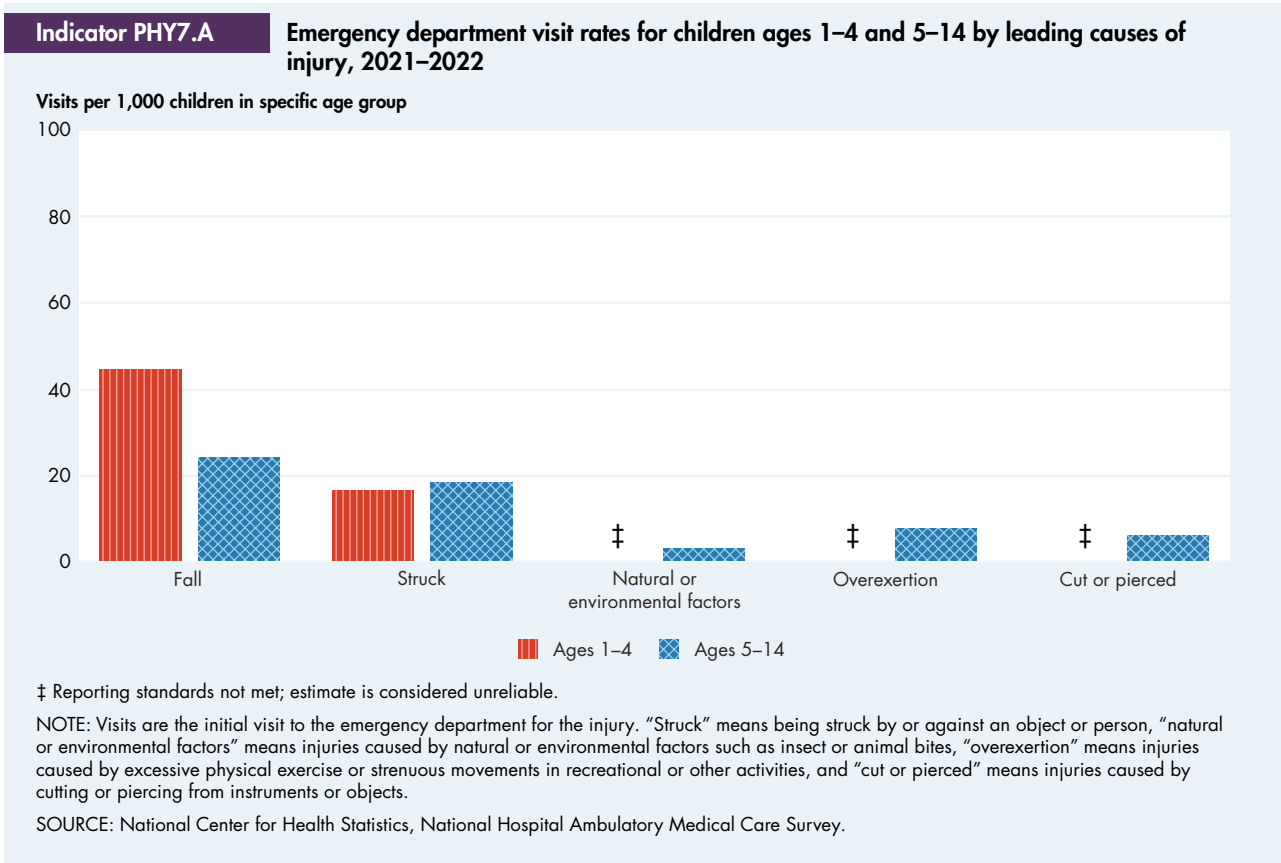
SOURCE: Bureau of Justice Statistics, National Crime Victimization Survey and Federal Bureau of Investigation, Uniform Crime Reporting Program, National Incident-Based Reporting System.

- In 2023, the serious violent crime victimization rate for youth ages 12–17 was 5 crimes per 1,000. There were a total of 122,500 such crimes involving youth victims.
- The rate of serious violent crimes involving youth victims ages 12–17 was lower in 2023 (5 crimes per 1,000) than a decade prior in 2013 (9 crimes per 1,000). The rate in 2023 was also lower than the rate in 2005 (14 crimes per 1,000).
- In 2023, older youth (ages 15–17) were just as likely as younger youth (ages 12–14) to be victims of a serious violent crime.
- Among youth ages 12–17 in 2023, male youth were just as likely as female youth to be victims of a serious violent crime.
- Among youth ages 12–17, the rate at which male youth were victims of serious violent crime decreased from 18 crimes per 1,000 in 2005 to 4 crimes per 1,000 in 2023. For female youth, there was no statistically significant difference between the rate in 2005 and the rate in 2023 (6 crimes per 1,000).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Child Injury and Mortality

Although injury death rates have declined in the past two decades for children ages 1–14, unintentional injuries remain the leading cause of death for children ages 1–4 and ages 5–14. In addition, nonfatal injuries continue to be important causes of child morbidity, disability, and reduced quality of life.⁶⁵ Among children ages 1–14 in 2023, there were 4,388 fatal injuries and more than 4 million emergency department (ED) visits for nonfatal injuries.⁶⁶ The leading causes of injury differ for children and adolescents (see PHY8.A).

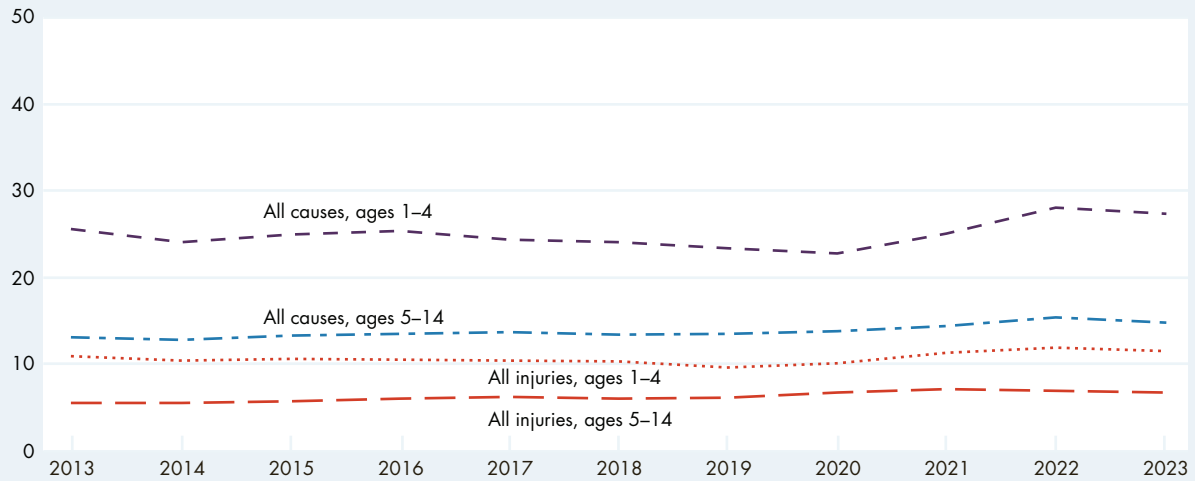


- In 2021–2022, the leading cause of injury-related ED visits for children ages 1–4 was falls. For children ages 5–14 over the same time period, the leading causes were falls and being struck by or against an object or person.
- In 2021–2022, the rate of ED visits for falls was 45 visits per 1,000 children ages 1–4 and 24 visits per 1,000 children ages 5–14. Falls accounted for 33% of initial injury-related ED visits for children ages 1–4 and 26% of initial injury-related ED visits for children ages 5–14.
- The rate of injury-related ED visits resulting from being struck by or against an object or person was 17 visits per 1,000 children ages 1–4 and 18 visits per 1,000 children ages 5–14.

Indicator PHY7.B

Death rates among children ages 1–14 by all causes, all injury causes, and age group, 2013–2023

Deaths per 100,000 children in specific age group

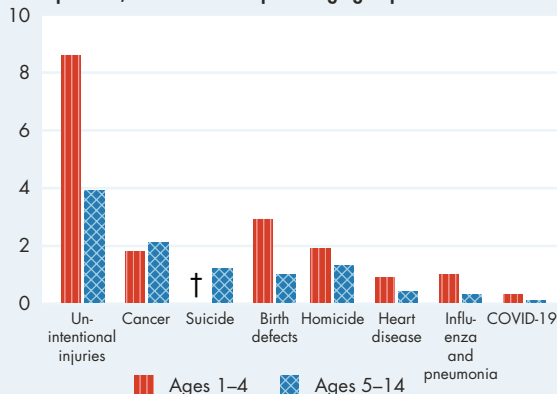


SOURCE: National Center for Health Statistics, National Vital Statistics System.

Indicator PHY7.C

Death rates among children ages 1–14 by cause of death and age group, 2023

Deaths per 100,000 children in specific age group



† Not applicable (not a cause of death for children ages 1–4).

NOTE: Most suicides in the 5–14 age group are among those ages 10–14.

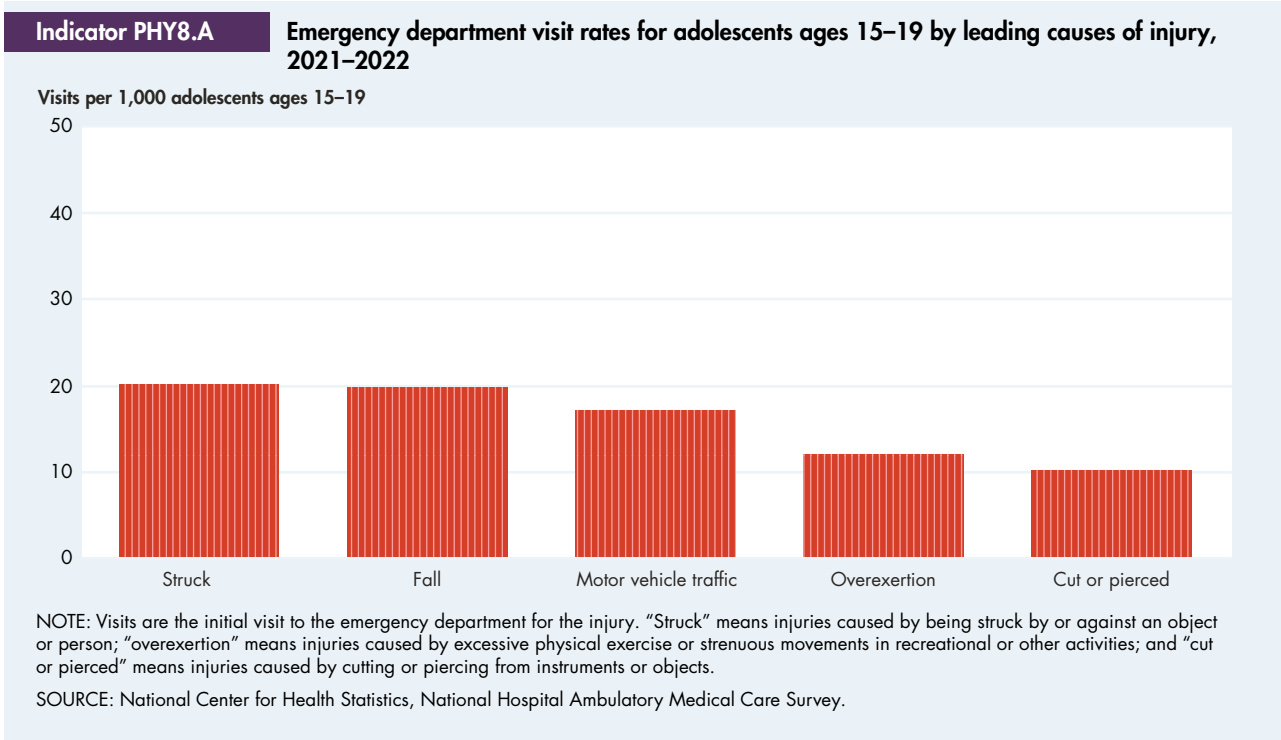
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- Among children ages 1–4, the all-cause death rate did not significantly change from 2013 to 2020 and then increased from 23 deaths per 100,000 in 2020 to 27 deaths per 100,000 in 2023. The injury-related death rate did not significantly change from 2013 to 2019 and then increased from 9 deaths per 100,000 in 2019 to 11 deaths per 100,000 in 2023.
- Among children ages 5–14, the all-cause death rate increased from 13 deaths per 100,000 in 2013 to 15 deaths per 100,000 in 2023. The injury-related death rate increased from 5 deaths per 100,000 in 2013 to 7 deaths per 100,000 in 2023.
- In 2023, unintentional injuries (accidents) were the leading cause of death for children ages 1–4 (9 deaths per 100,000) and ages 5–14 (4 deaths per 100,000). The second leading cause of death was birth defects for children ages 1–4 (3 deaths per 100,000) and cancer for children ages 5–14 (2 deaths per 100,000).
- Among both children ages 1–4 and 5–14, males had higher death rates than females. In 2023, males ages 1–4 had a death rate of 31 deaths per 100,000, compared with 24 deaths per 100,000 for females. Among children ages 5–14, males had a death rate of 17 deaths per 100,000, compared with 12 deaths per 100,000 for females.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Adolescent Injury and Mortality

Injury accounts for 78% of adolescent deaths. Compared with younger children (ages 1–14), adolescents ages 15–19 have much higher death rates overall and from injuries. Adolescents are much more likely than younger children to die from injuries sustained from motor vehicle traffic crashes and firearms.^{67,66} The leading causes of nonfatal injury resulting in an emergency department (ED) visit also differ between adolescents and younger children. For example, the leading cause of adolescent nonfatal injury ED visits is being struck by or against an object or person, whereas for younger children, the leading cause is falls (see PHY7.A). Compared with younger children, adolescents were more likely to visit the ED for nonfatal injuries resulting from violence, sports-related activities, or motor vehicle traffic crashes. Among adolescents in 2023, there were 9,943 fatal injuries and 1.9 million ED visits for nonfatal injuries.⁶⁶

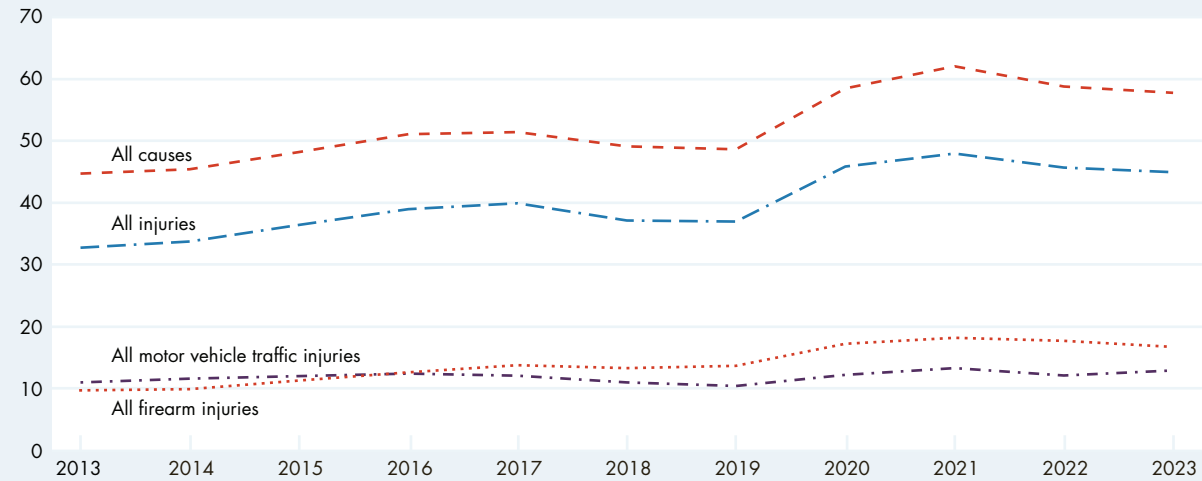


- In 2021–2022, the leading causes of injury-related ED visits for adolescents ages 15–19 were being struck by or against an object or person (20 visits per 1,000), falls (20 visits per 1,000), motor vehicle traffic crashes (17 visits per 1,000), overexertion (12 visits per 1,000), and being cut or pierced from an instrument or object (10 visits per 1,000).
- These five leading causes accounted for 62% of initial injury-related ED visits for adolescents in 2021–2022.

Indicator PHY8.B

Death rates among adolescents ages 15–19 by all causes and all injury causes and selected mechanisms of injury, 2013–2023

Deaths per 100,000 adolescents ages 15–19

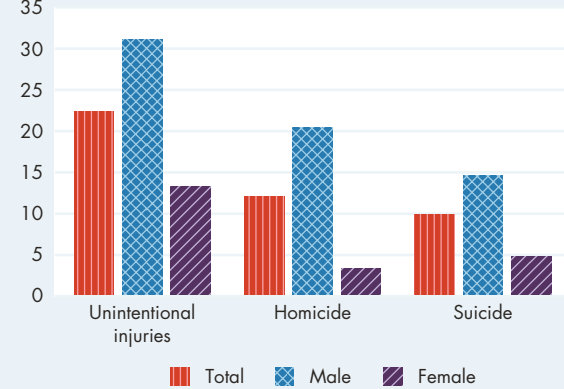


SOURCE: National Center for Health Statistics, National Vital Statistics System.

Indicator PHY8.C

Injury mortality rates among adolescents ages 15–19 by manner of intent and sex, 2023

Deaths per 100,000 adolescents ages 15–19



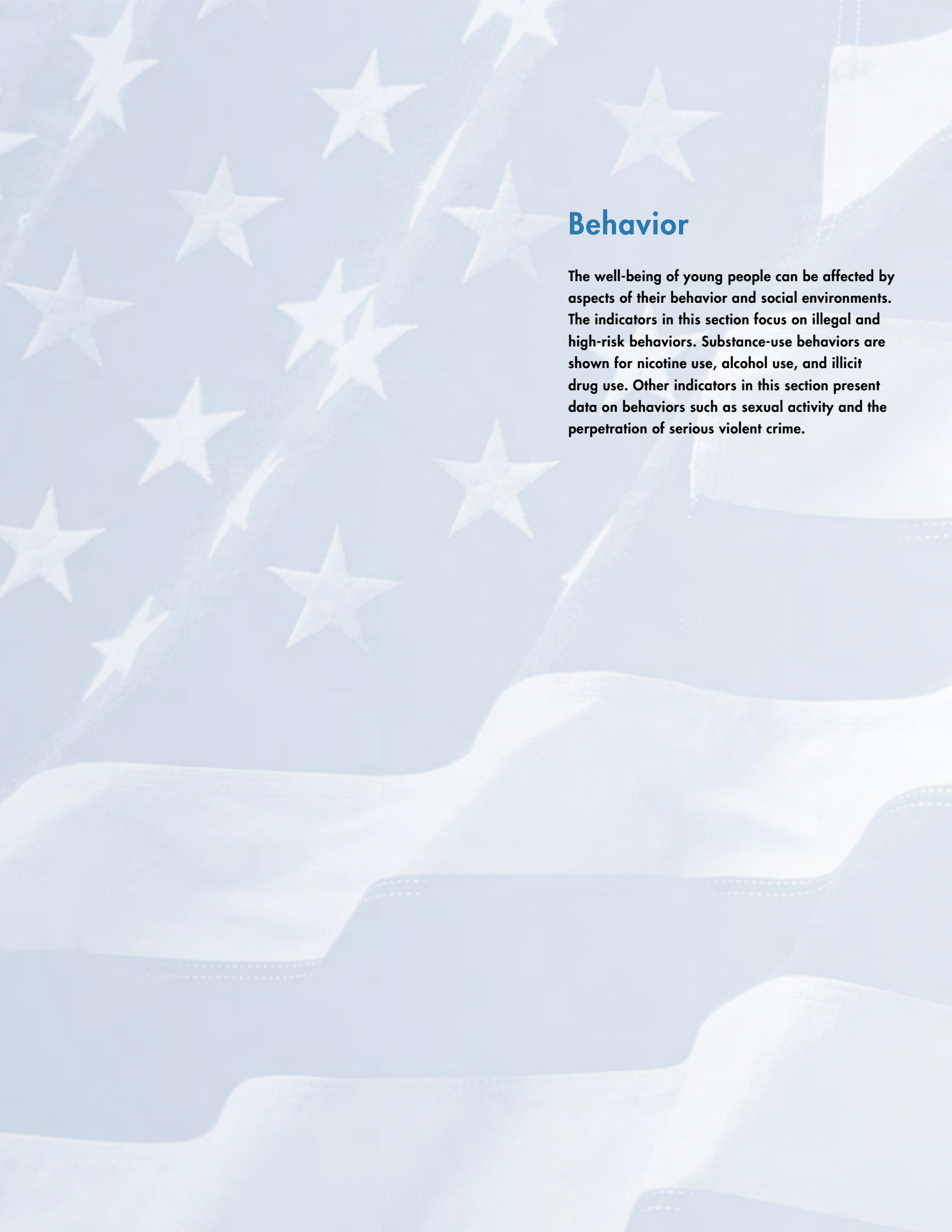
NOTE: The manner of intent involves whether the injury was purposefully inflicted (if it can be determined) or unintentional. If the injury is deemed intentional, it is further classified as self-inflicted (suicide) or inflicted on another person (homicide).

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

- In 2023, the death rate for adolescents ages 15–19 was 58 deaths per 100,000—13 points higher than the death rate in 2013 (45 deaths per 100,000).
- From 2013 to 2023, injuries were the leading cause of death for adolescents. In 2023, injuries accounted for more than three quarters of adolescent deaths.

- Before 2016, motor vehicle traffic injuries were the leading mechanism of injury-caused deaths among adolescents. In 2016, there was no significant difference in the rate of deaths occurring because of motor vehicle traffic injuries and firearm injuries. However, beginning in 2017, firearm injury deaths became more common than motor vehicle traffic injury deaths. In 2023, firearm injury deaths occurred at a rate of 17 deaths per 100,000, while motor vehicle traffic deaths occurred at a rate of 13 deaths per 100,000.
- For firearm injuries, the death rate increased from 10 deaths per 100,000 in 2013 to 18 deaths per 100,000 in 2021 and then remained stable through 2023 (17 deaths per 100,000).
- For motor vehicle traffic injuries, the death rate fluctuated from 2013 to 2023 but did not significantly change.
- In 2023, the unintentional injury (accident) death rate was higher among male adolescents (31 deaths per 100,000) than among female adolescents (13 deaths per 100,000). This pattern was also observed for homicide (20 deaths per 100,000 for males and 3 deaths per 100,000 for females) and suicide (15 deaths per 100,000 for males and 5 deaths per 100,000 for females).
- Among males, death rates for homicide (20 per 100,000) were higher than for suicide (15 per 100,000). Among females, death rates for suicide (5 per 100,000) were higher than for homicide (3 per 100,000).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

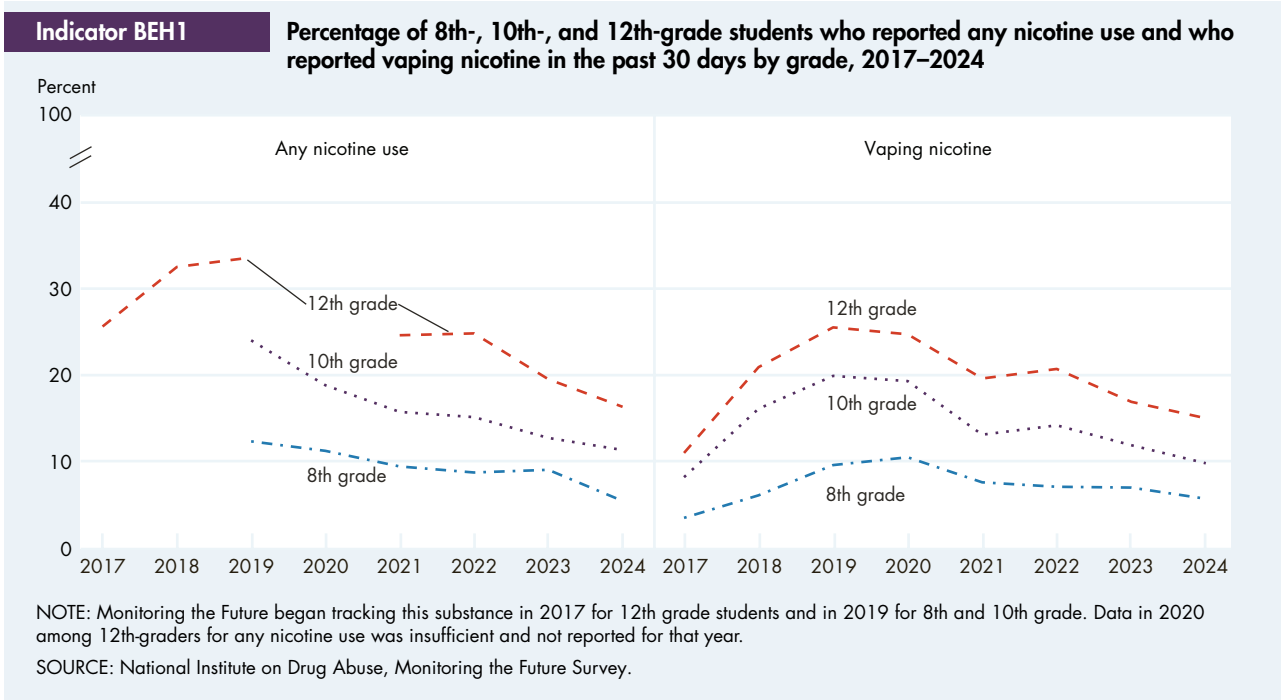


Behavior

The well-being of young people can be affected by aspects of their behavior and social environments. The indicators in this section focus on illegal and high-risk behaviors. Substance-use behaviors are shown for nicotine use, alcohol use, and illicit drug use. Other indicators in this section present data on behaviors such as sexual activity and the perpetration of serious violent crime.

Any Nicotine Use

Over the last decade, the tobacco product landscape has evolved dramatically, with new delivery devices and nontobacco nicotine products being developed and marketed to both adults and youth. Nicotine is the drug or substance in tobacco products that can lead to addiction. While cigarette smoking among teens has trended downward since 1997, overall nicotine use remains high, largely driven by nicotine vaping.⁶⁸ Vaping devices are battery-operated devices that people use to inhale an aerosol, which typically contains nicotine or marijuana (though not always), flavorings, and other chemicals. By the time they reach 12th grade, one in three adolescents will have vaped nicotine at least once,⁶⁸ and each day, nearly 4,020 youth ages 12–17 vape nicotine for the first time.⁶⁹ The high rate of adolescent nicotine use underscores the importance of studying and understanding patterns of use among this population. Nicotine use is defined in this indicator as use of any of the following products in the past 30 days: cigarettes, large cigars, flavored small cigars, regular small cigars, tobacco using a hookah, smokeless tobacco, or vapes with nicotine.

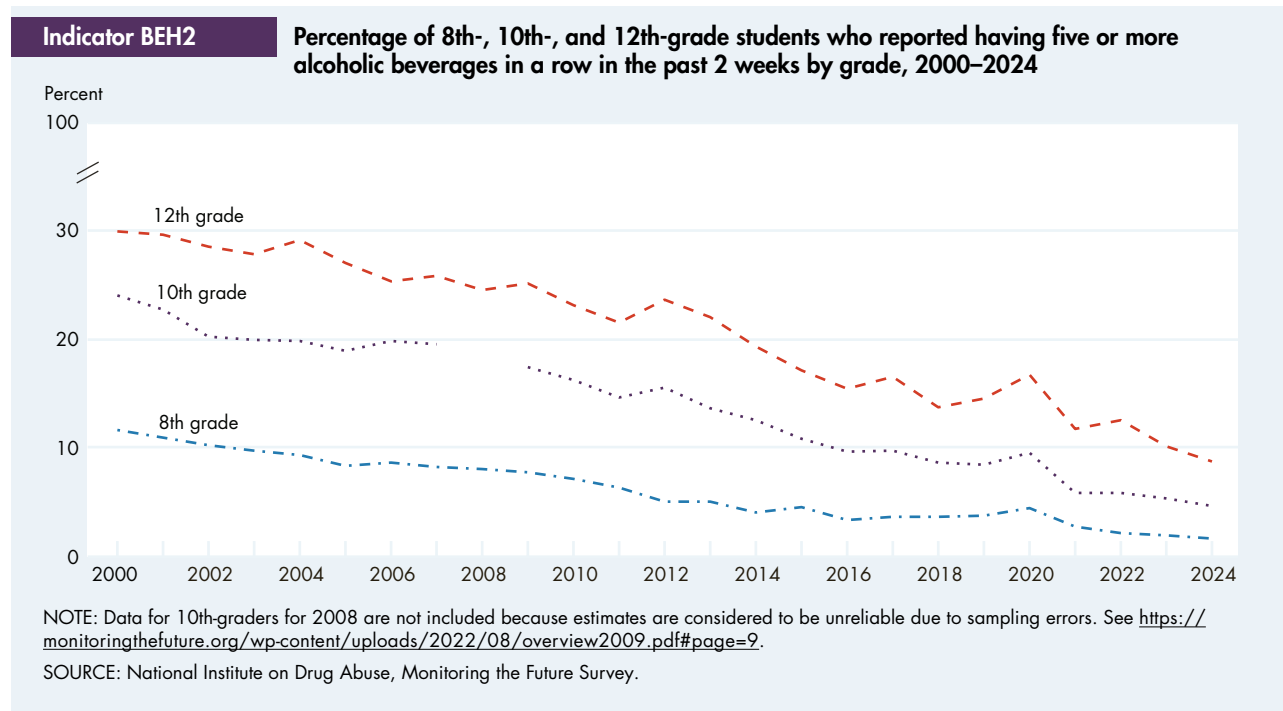


- Use of any nicotine products in the past 30 days declined for 8th-graders from 9% in 2023 to 5% in 2024. The percentage of 10th- and 12th-graders who reported any nicotine use in 2024 was 11% and 16%, respectively, unchanged from 2023.
- Vaping nicotine is the main driver of nicotine use among youth. In 2024, use of any nicotine was reported by 6% of 8th-graders, 11% of 10th-graders, and 16% of 12th-graders. Vaping nicotine was reported by 5%, 10%, and 15% of 8th-, 10th-, and 12th-graders, respectively.
- The percentage of youth vaping nicotine increased faster among girls than boys. In 2017, the percentage of youth who reported vaping nicotine was similar for boys and girls among 8th- and 10th-graders but higher for boys than girls among 12th-graders. By 2024, the percentage of girls who reported vaping nicotine was higher than the percentage of boys in all three grades.
- Among 8th graders, vaping nicotine was reported by 4% of boys and 3% of girls in 2017; by 2024, these percentages were 4% for boys and 7% for girls. Among 10th-grade girls, the percentage reporting vaping nicotine increased from 8% in 2017 to 11% in 2024, while among 12th grade girls it rose from 8% to 16% over the same period. In contrast, the prevalence among boys remained steady. In 2024, 8% of 10th grade boys and 13% of 12th-grade boys reported vaping nicotine, similar to the levels observed in 2017 (8% and 14%, respectively).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Alcohol Use

Alcohol is the most commonly used psychoactive substance during adolescence. Its use is associated with motor vehicle crashes, injuries, and deaths; problems in school and the workplace; and fighting, crime, and other serious consequences. Early onset of binge drinking—defined in this indicator as five or more alcoholic beverages in a row or during a single occasion in the previous 2 weeks—may be especially problematic, potentially increasing the likelihood of these negative outcomes.⁷⁰



- In 2024, binge drinking was reported by 2% of 8th-graders, 5% of 10th-graders, and 9% of 12th-graders.
- From 2020 to 2024, binge drinking declined from 5% to 2% among 8th-graders, from 10% to 5% among 10th-graders, and from 17% to 9% among 12th-graders.
- In 2024, 1% of male and 2% of female 8th-graders reported binge drinking; 4% of male and 5% of female 10th-graders reported binge drinking; and 9% of male and 8% of female 12th-graders reported binge drinking.
- In 2024, 2% of Hispanic; 1% of White, non-Hispanic; and 1% of Black, non-Hispanic 8th-graders reported binge drinking. Among 10th-graders, 6% of White, non-Hispanic; 4% of Hispanic; and 3% of Black, non-Hispanic students reported binge drinking. Among 12th-graders, 11% of White, non-Hispanic; 8% of Hispanic; and 3% of Black, non-Hispanic students reported binge drinking.

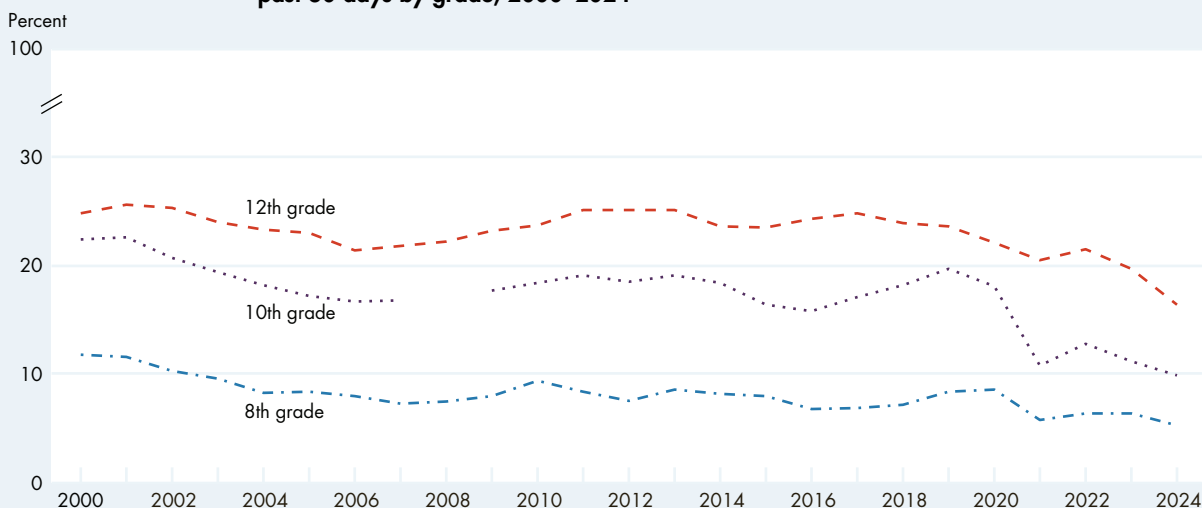
Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Illicit Drug Use

Drug use by adolescents can have immediate and long-term health and social consequences. Marijuana use may have a wide range of effects, both physical and mental, including cognitive risks.^{71,72} It is also the main driver of illicit drug use among teens, with an estimated one in six high school seniors (i.e., 12th-graders) reporting use in the past month. Other drug use, such as the misuse of prescription and over-the-counter drugs, can increase the risk of adverse health effects, including overdose—especially when taken in combination with other drugs, like alcohol. Hallucinogens, such as MDMA, can affect brain chemistry and may result in problems with memory and learning new information.⁷³ Any illicit drug use during adolescence is a risk-taking behavior that has potentially serious negative consequences. In this indicator, use of any illicit drug in 12th grade is defined as any use in the past 30 days of marijuana, LSD, other hallucinogens, crack, other cocaine, heroin, or any use of other narcotics, amphetamines, barbiturates, or tranquilizers not under a doctor's orders. In 8th and 10th grade, the use of other narcotics and barbiturates has been excluded because these younger respondents appear to overreport use.

Indicator BEH3.A

Percentage of 8th-, 10th-, and 12th-grade students who reported using illicit drugs in the past 30 days by grade, 2000–2024

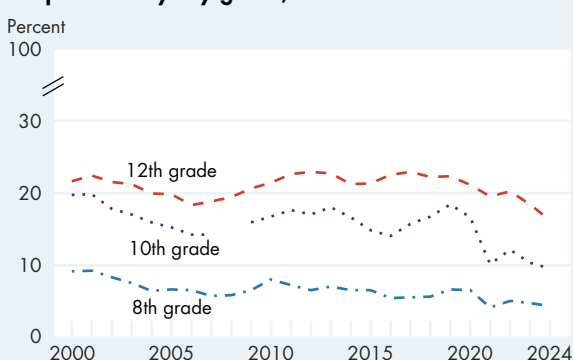


NOTE: Use of “illicit drugs” includes any use of marijuana, LSD, other hallucinogens, crack, other cocaine, or heroin or any use of other narcotics, amphetamines, barbiturates, or tranquilizers not under a doctor’s orders. For 8th- and 10th-graders, the use of other narcotics and barbiturates is excluded because younger respondents appear to overreport use (perhaps because they include the use of nonprescription drugs in their responses). Data for 10th-graders for 2008 are not included because estimates are considered to be unreliable due to sampling errors. See <https://monitoringthefuture.org/wp-content/uploads/2022/08/overview2009.pdf#page=9>. Some estimates have been revised from previous publications.

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

Indicator BEH3.B

Percentage of 8th-, 10th-, and 12th-grade students who reported using marijuana in the past 30 days by grade, 2000–2024



NOTE: Data for 10th-graders for 2008 are not included because estimates are considered to be unreliable due to sampling errors. See <https://monitoringthefuture.org/wp-content/uploads/2022/08/overview2009.pdf#page=9>.

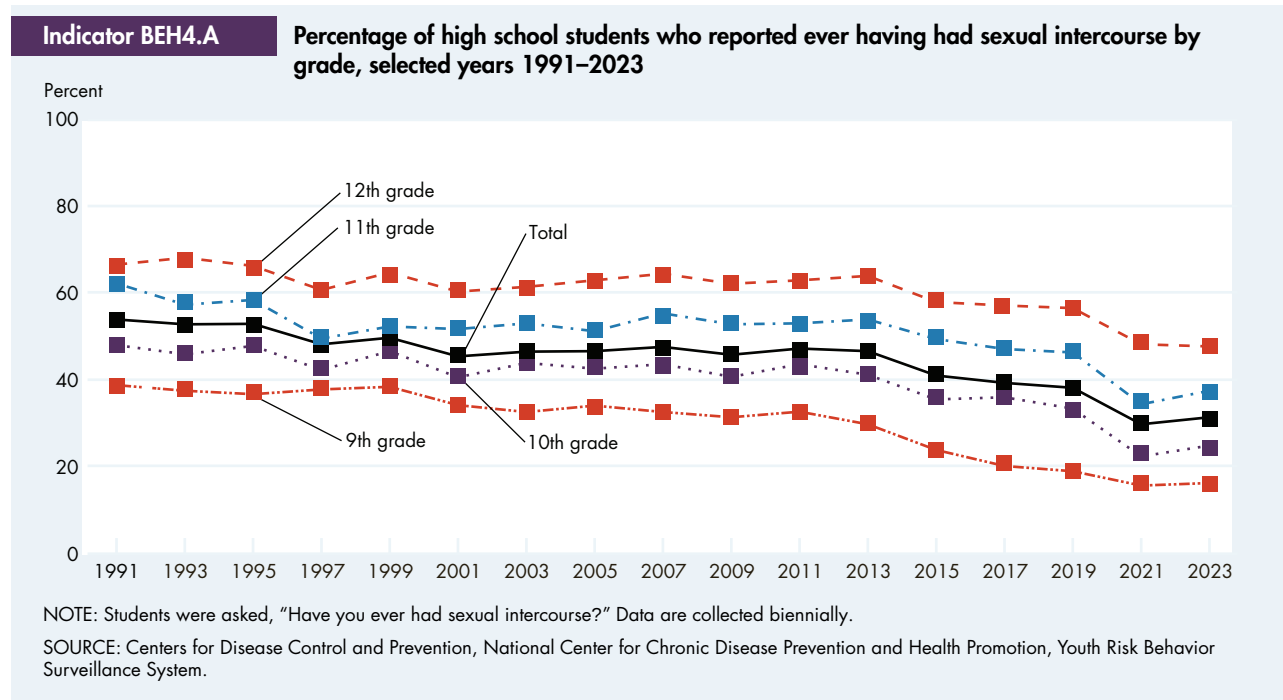
SOURCE: National Institute on Drug Abuse, Monitoring the Future Survey.

- In 2024, illicit drug use in the past 30 days was reported by 5% of 8th-graders, 10% of 10th-graders, and 17% of 12th-graders. These estimates were not significantly different from those in 2023 for 8th- and 10th-graders. For 12th-graders, the estimate reflects a significant decrease compared with 2023 (20%).
- In 2024, illicit drug use in the past 30 days was reported by 5% of both male and female 8th-graders, 10% of both male and female 10th-graders, and 15% of male and 16% of female 12th-graders.
- In 2024, marijuana use in the past 30 days was reported by 4% of 8th-graders, 10% of 10th-graders, and 16% of 12th-graders. Rates remained stable compared with 2023.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Sexual Activity

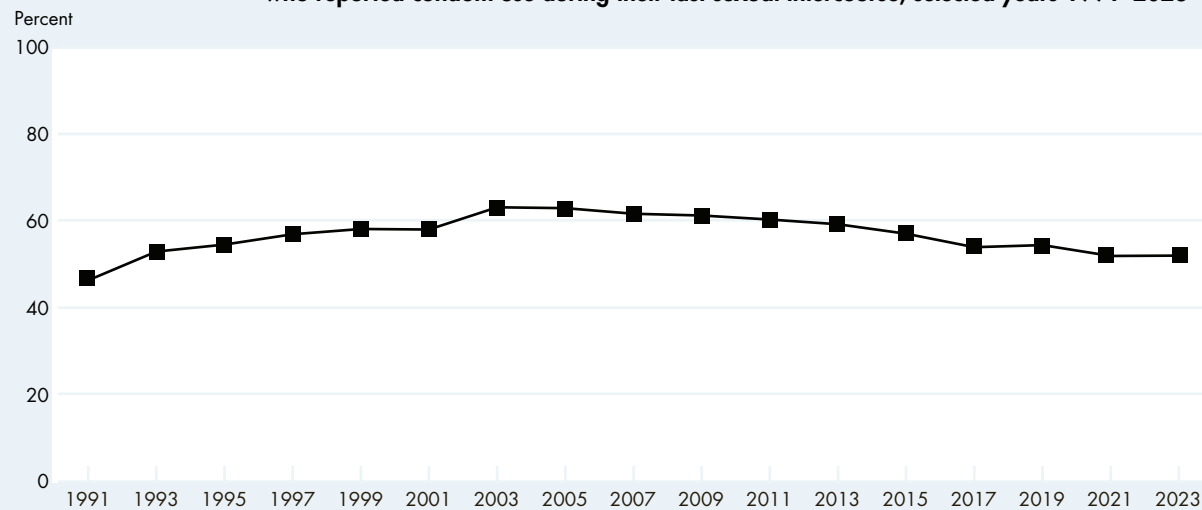
Early sexual activity is associated with several problematic behaviors, including adolescent substance use, academic underachievement, and emotional and physical health risks.⁷⁴ Youth who engage in sexual activity are at risk of contracting sexually transmitted infections (STIs) and becoming pregnant.⁷⁵ STIs, including HIV, can infect a person for a lifetime and result in severe health consequences.⁷⁶ Delayed sexual activity is associated with a decreased risk of contracting STIs.⁷⁵ In addition, teen pregnancy is associated with several negative risk factors for both the mother and her child (see FAM2).



- The percentage of high school students who reported ever having had sexual intercourse decreased from 54% in 1991 to 46% in 2001 and was relatively stable through 2013 (47%). The percentage then decreased to 38% in 2019 before stabilizing around 30% in 2021.⁷⁷ In 2023, 32% of high school students reported ever having had sexual intercourse.
- Between 1991 and 2023, the percentage of high school students who reported ever having had sexual intercourse decreased for all four grades: 9th grade (39% to 17%), 10th grade (48% to 25%), 11th grade (62% to 38%), and 12th grade (67% to 48%).

Indicator BEH4.B

Among high school students who had sexual intercourse in the past 3 months, the percentage who reported condom use during their last sexual intercourse, selected years 1991–2023

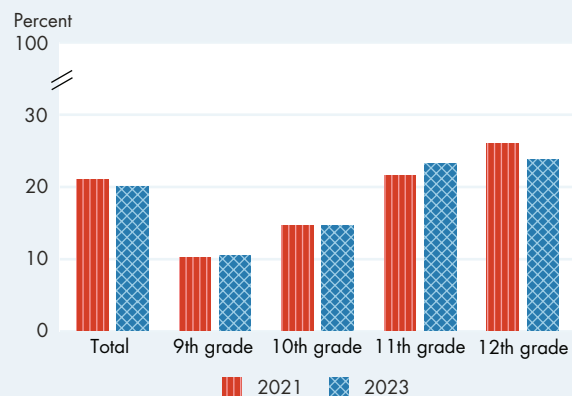


NOTE: Students were asked, “The last time you had sexual intercourse, did you or your partner use a condom?” Data are collected biennially.

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

Indicator BEH4.C

Among high school students who had sexual intercourse in the past 3 months, the percentage who reported birth control pill use before their last sexual intercourse, 2021 and 2023



NOTE: Students were asked, “The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?” “Birth control pills” was one option. Data are collected biennially.

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

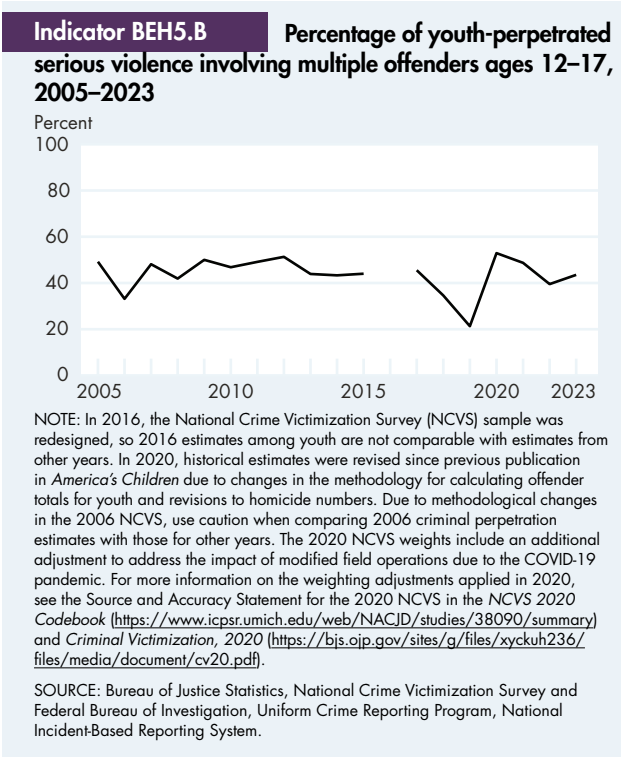
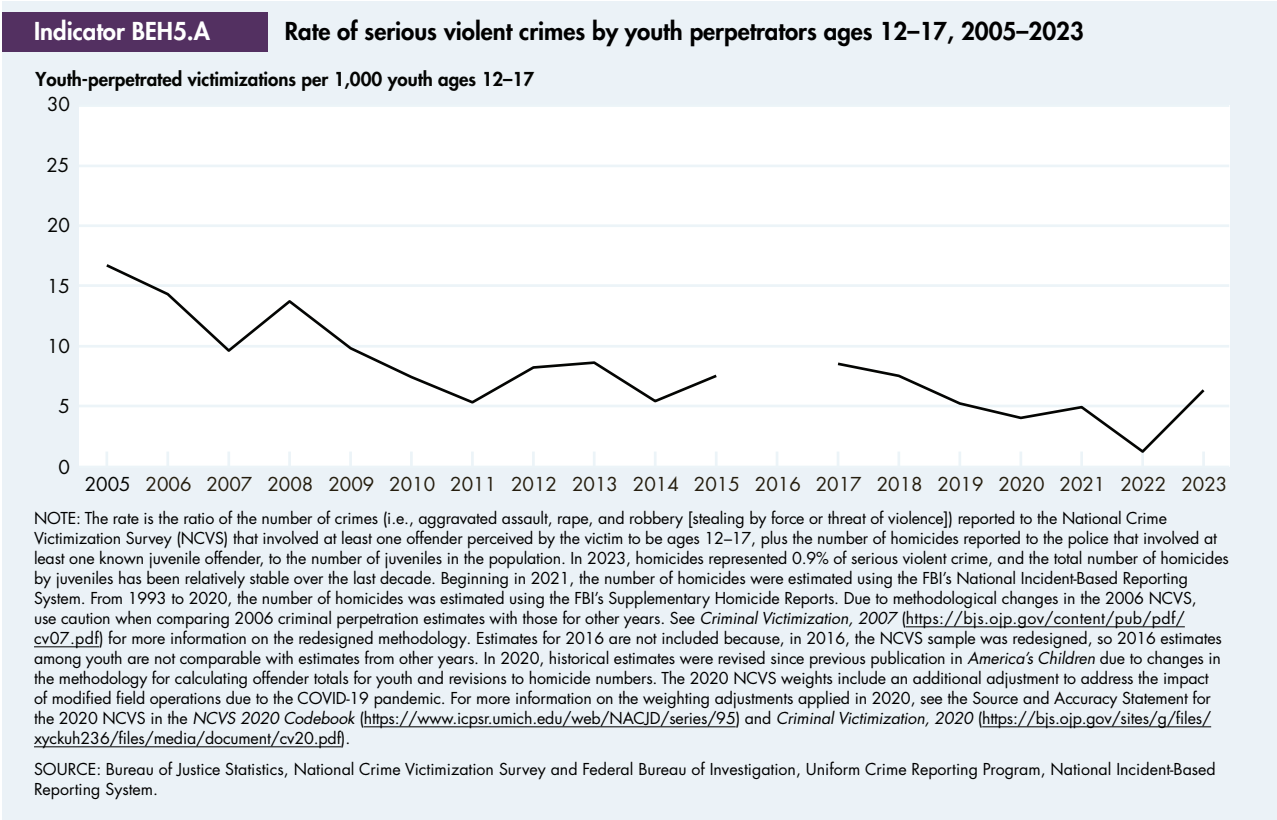
■ Among high school students who had sexual intercourse in the past three months, the percentage who reported they or their partner used a condom the last time they had intercourse increased from 46% in 1991 to 63% in 2003, decreased to 52% in 2021, and remained stable through 2023.

■ Among sexually active high school students, the percentage who used birth control pills to prevent pregnancy before the last time they had sexual intercourse (not counting emergency contraception such as Plan B or the “morning after” pill) was 21% in 2021 and remained stable through 2023 (20%), ranging from 10% in 9th grade to 24% in 12th grade.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Youth Perpetrators of Serious Violent Crimes

Youth who commit violent crimes tend to exhibit multiple problematic behaviors that affect their well-being, including drug use, risky sexual behaviors, and problems in school.⁷⁸ One measure of youth violence is the rate of serious violent crimes committed by juveniles. Because insufficient data exist to determine the ages of each individual offender when a crime is committed by more than one perpetrator, the number of additional juvenile offenders cannot be determined. Therefore, this rate of serious violent crime offending does not represent the number of juvenile offenders in the population but rather the rate of crimes perpetrated by juveniles as perceived by victims.



- In 2023, the serious violent crime offending rate for youth ages 12–17 was 6 crimes per 1,000. There were a total of 162,100 serious violent crimes involving juvenile offenders. This was not significantly different from the rate in 2022.
- From 2005 to 2023, the serious violent crime offending rate for juveniles ages 12–17 declined 62% from 17 to 6 crimes per 1,000.
- In 44% of all serious violent crimes perpetrated by juveniles ages 12–17 in 2023, more than one offender was involved in the incident.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

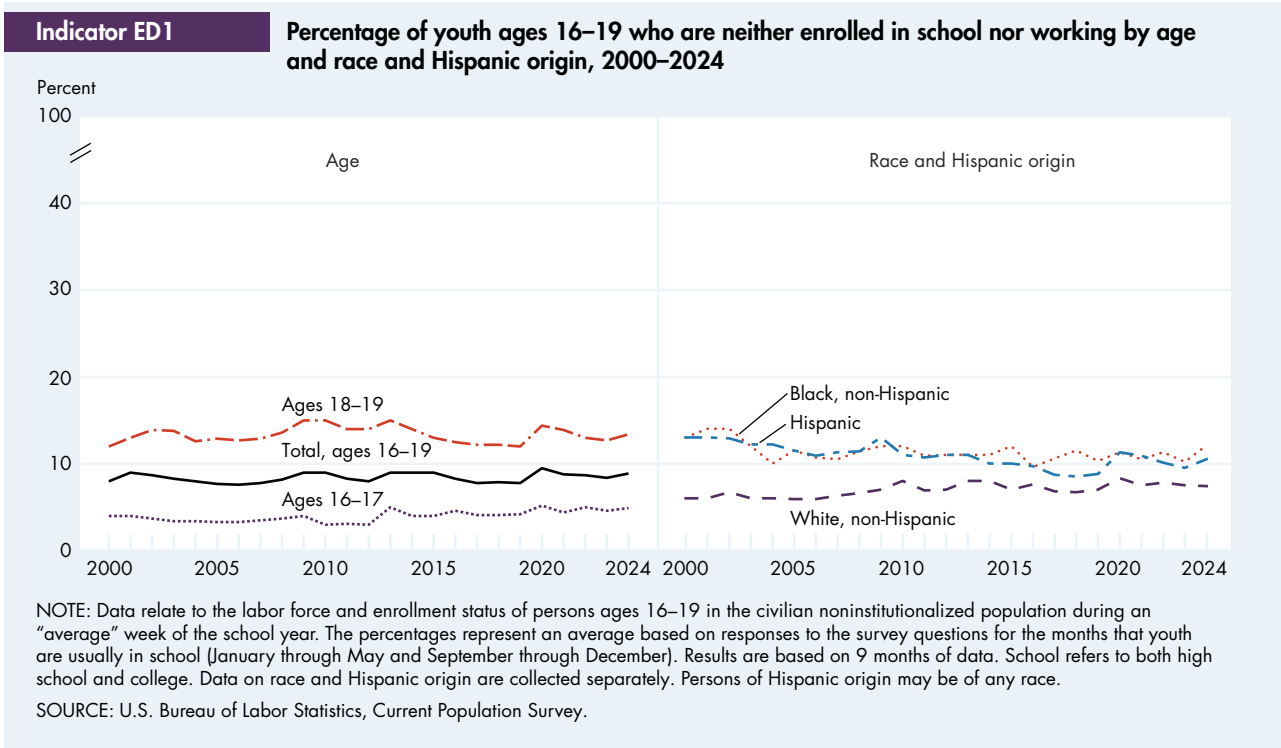
The background of the entire page is a close-up, slightly blurred image of the American flag. The stars and stripes are visible, with the stars appearing as white five-pointed shapes on a blue field. The stripes are in shades of blue and white, creating a wavy, textured effect.

Education

This section presents information on two key education topics: youth who are neither enrolled in school nor working and young children's school readiness.

Youth Neither Enrolled in School nor Working

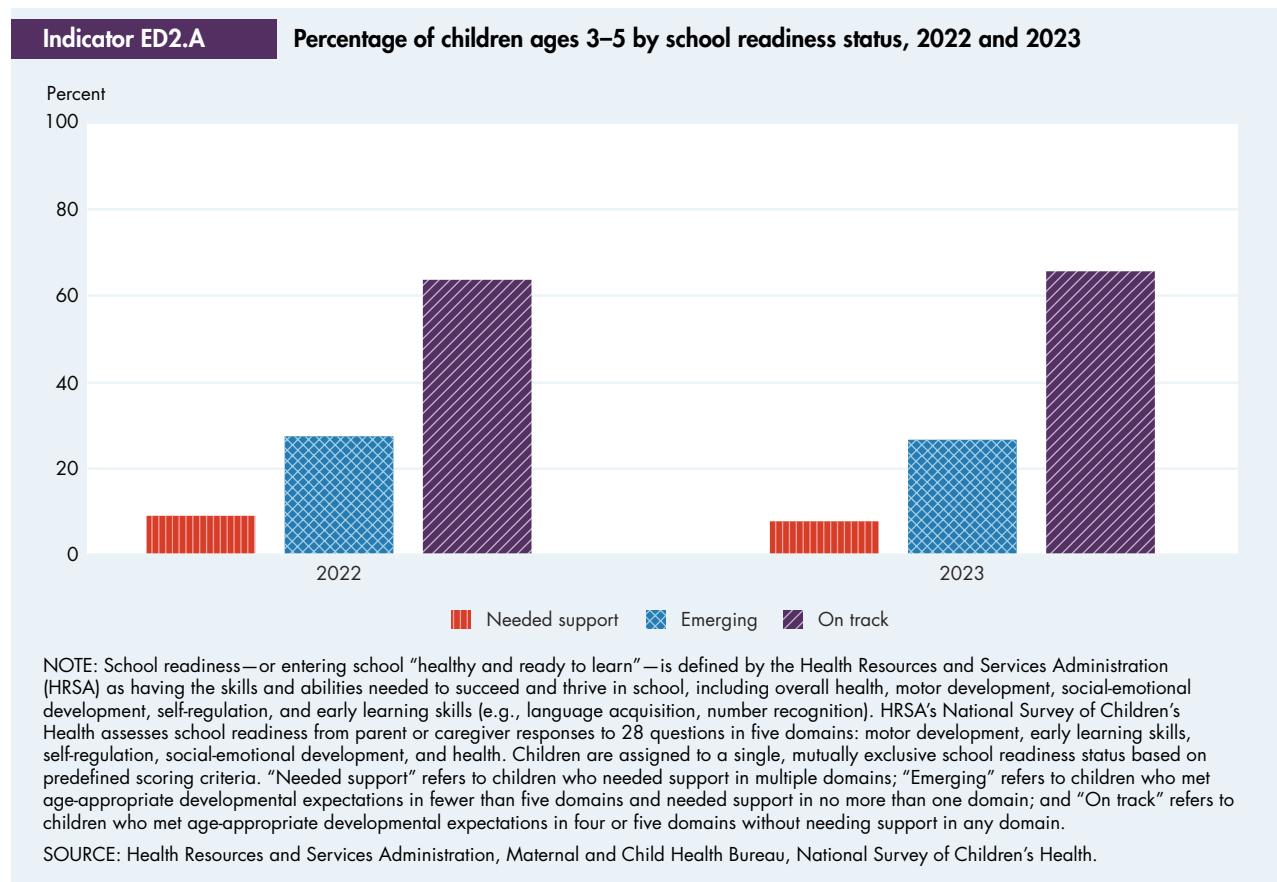
Youth ages 16–19 who are neither in school nor working are detached from core activities that play an important role in the transition from adolescence to adulthood. Research shows that “a disconnected youth will suffer an earnings penalty of over \$30,000 per year in middle adulthood as compared to someone who came from a family with the same income but who was in school or working during those critical, transitional years to adulthood.”⁷⁹ 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.



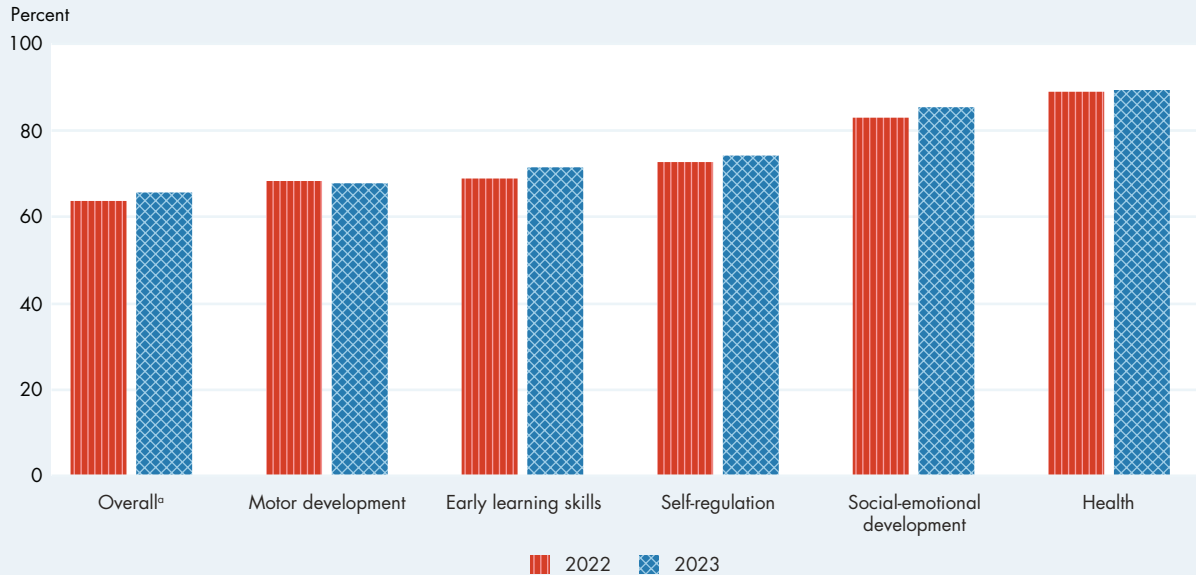
- In 2024, 9% of youth ages 16–19 were neither enrolled in school nor working. This rate has remained between 8% and 9% since 2000, with the exception of 2020 (when the rate was 10%).
 - Among youth ages 16–19, those who were Black, non-Hispanic and Hispanic had higher rates of detachment from work and school in 2024 than did those who were White, non-Hispanic. Specifically, 12% of Black, non-Hispanic youth and 11% of Hispanic youth were neither enrolled in school nor working, compared with 7% of White, non-Hispanic youth.
 - The percentages of Hispanic and Black, non-Hispanic youth ages 16–19 who were neither enrolled in school nor working in 2024 was not measurably different from the percentages in 2010.
 - Youth ages 18–19 were more than twice as likely as youth ages 16–17 to be detached from school and work. In 2024, 13% of youth ages 18–19 were neither enrolled in school nor working, compared with 5% of youth ages 16–17.
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.*

School Readiness

School readiness—or entering school “healthy and ready to learn”—is defined by the Health Resources and Services Administration as having the skills and abilities needed to succeed and thrive in school, including overall health, motor development, social-emotional development, self-regulation, and early learning skills (e.g., language acquisition, number recognition).⁸⁰ Early attainment of cognitive and social-emotional skills can have short- and long-term academic and health-related impacts, which can lead to better social, professional, and economic outcomes. Building such skills starts before kindergarten, highlighting the need for early investments in child development, particularly for those who may be at greater risk for poor outcomes.^{81,82}



- In 2023, among children ages 3–5, nearly two-thirds (66%) were on track and ready for school (i.e., met age-appropriate developmental expectations in four or five domains without needing support in any domain⁸³), about one-quarter (27%) were considered to have emerging skills (i.e., were on track in fewer than five domains and needed support in no more than one domain), and 8% needed support in multiple domains. There were no significant changes in school readiness between 2022 and 2023.

Indicator ED2.B**Percentage of children ages 3–5 who were developmentally on track by domain: 2022 and 2023**

^a On track overall is defined as meeting age-appropriate developmental expectations in four or five domains without needing support in any domain.

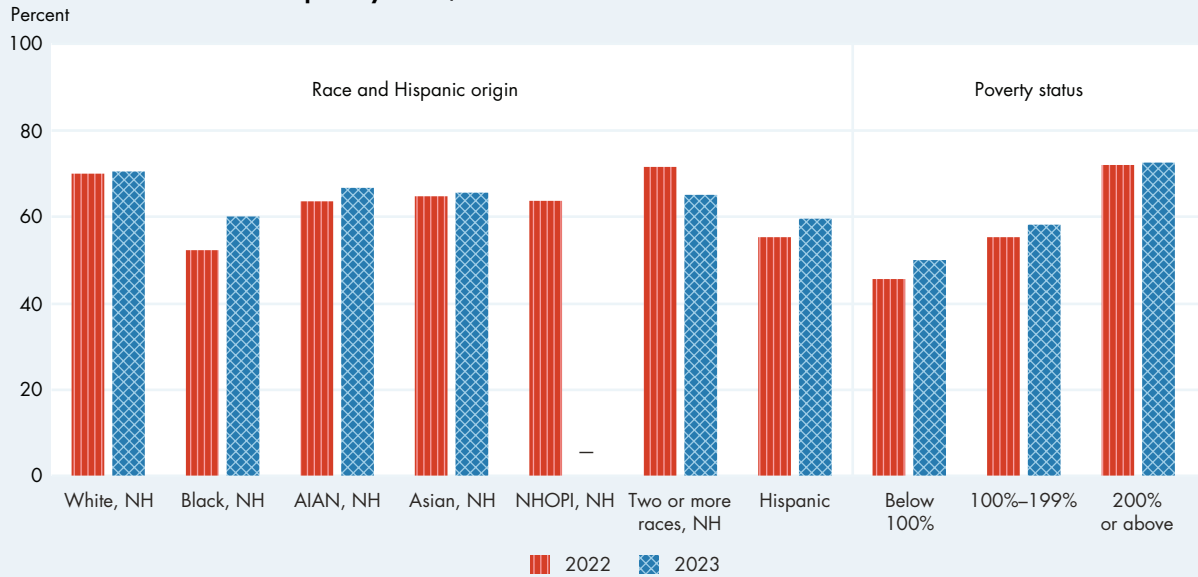
NOTE: The National Survey of Children's Health assesses school readiness from parent or caregiver responses to 28 questions in five domains: motor development, early learning skills, self-regulation, social-emotional development, and health. Children who were developmentally "on track" met age-appropriate developmental expectations in four or five domains without needing support in any domain.

SOURCE: Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.

- In 2023, the percentage of children ages 3–5 who were on track and ready for school varied by domain, ranging from 68% for motor development to 89% for health. There were no significant changes between 2022 and 2023 for any domain.

Indicator ED2.C

Percentage of children ages 3–5 who were developmentally on track by race and ethnicity and poverty status, 2022 and 2023



— Not available.

NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander. The National Survey of Children's Health assesses school readiness from parent or caregiver responses to 28 questions in five domains: motor development, early learning skills, self-regulation, social-emotional development, and health. Children who were developmentally "on track" met age-appropriate developmental expectations in four or five domains without needing support in any domain. NHOPI is not reportable in 2023 due to small sample size.

SOURCE: Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.

■ In 2023, the percentage of children ages 3–5 who were on track and ready for school ranged from about 60% for both Black, non-Hispanic and Hispanic children to 70% for White, non-Hispanic children. There were no significant changes between 2022 and 2023 for any racial/ethnic group.

■ In 2023, the percentage of children ages 3–5 who were on track and ready for school increased with increasing family income, ranging from 50% for children in families living below the poverty threshold to 73% for children in families living at or above 200% of the poverty threshold. There were no significant changes between 2022 and 2023 by poverty status.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

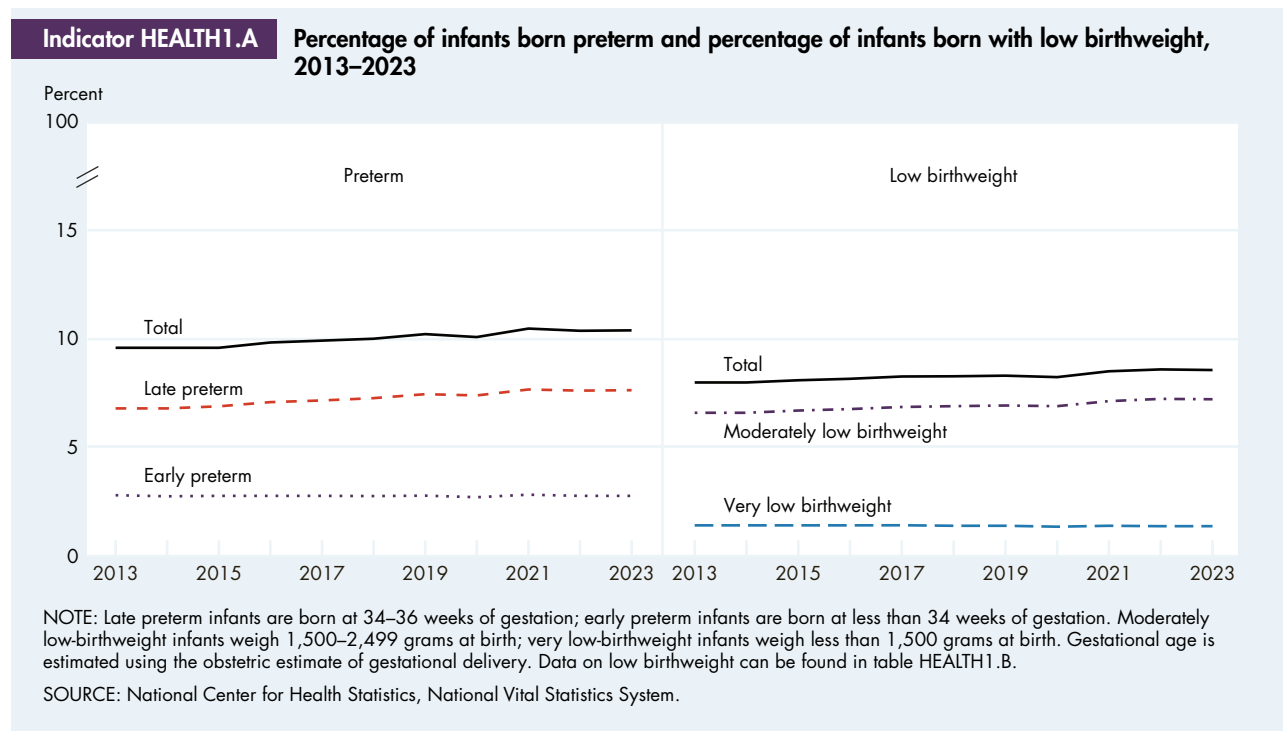


Health

This section presents information on several aspects or determinants of child health. Some relate to birth outcomes, such as preterm birth, low birthweight, and infant mortality. Others describe key health conditions, including emotional or behavioral difficulties, obesity, and asthma.

Preterm Birth and Low Birthweight

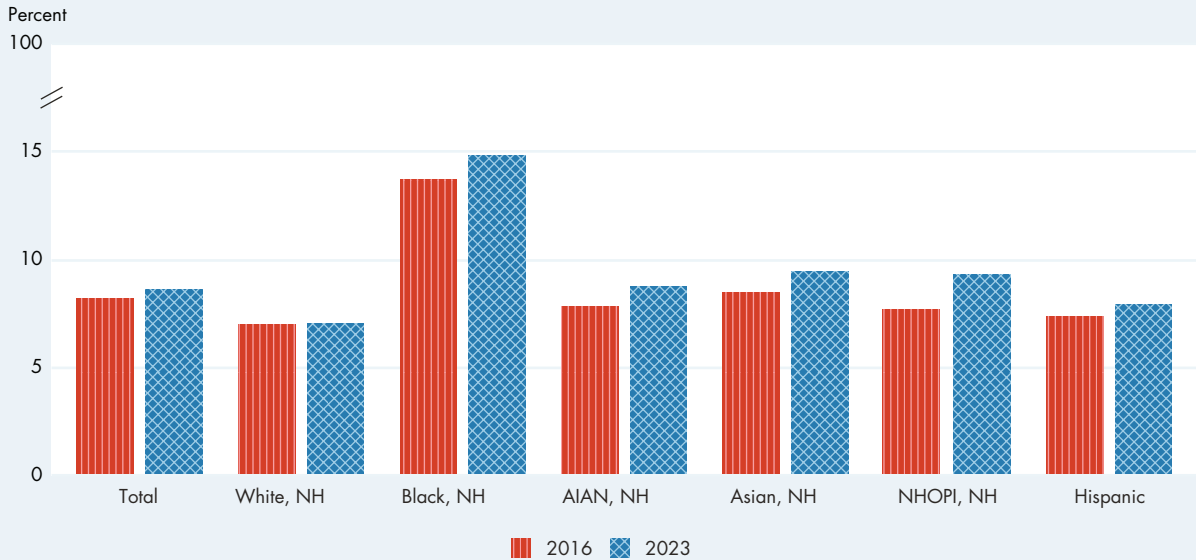
Infants born preterm (less than 37 completed weeks of gestation) or with low birthweight (less than 2,500 grams, or 5 lb 8 oz) are at higher risk of early death and long-term health and developmental issues than infants born later in pregnancy or at higher birthweights.^{5,84,85} Many but not all preterm infants also are low birthweight, and vice versa. Preterm infants born at less than 34 weeks (early preterm) are at high risk for poor outcomes, including chronic health conditions, long-term disability, and death.^{84,86} The majority of preterm births are infants born at 34–36 weeks (late preterm). Late preterm infants are at a lower risk of poor outcomes than infants born earlier but are at a higher risk than infants delivered at term or later.⁸⁴ The increasing multiple birth rate was a contributing factor to the rise in preterm birth and low birthweight in the past decade. However, preterm birth and low-birthweight levels also increased substantially among singleton births during this period.² Disorders related to preterm birth and low birth weight are the second leading cause of infant death in the United States.⁵



- The percentage of infants born preterm (less than 37 completed weeks of gestation) increased from 9.6% in 2013 to 10.4% in 2023.
- The percentage of infants born late preterm (34–36 completed weeks of gestation) increased from 6.8% in 2013 to 7.7% in 2021 and then remained stable through 2023 (7.6%).
- The percentage of infants born early preterm (less than 34 completed weeks of gestation) remained stable between 2013 and 2023 (2.8%).
- The percentage of infants born with low birthweight (less than 2,500 grams, or 5 lb 8 oz) increased from 8.0% in 2013 to 8.6% in 2023.
- From 2013 to 2023, the percentage of infants born with moderately low birthweight increased (7.2% in 2023), while the percentage of infants born with very low birthweight decreased (1.4% in 2023).

Indicator HEALTH1.B

Percentage of infants born with low birthweight by race and Hispanic origin of mother, 2016 and 2023



NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander. Race and Hispanic origin refer to the mother's race and Hispanic origin. The 1997 U.S. Office of Management and Budget standards for data on race and ethnicity were used to classify people into one of the following five racial groups: White; Black or African American; Asian; American Indian or Alaska Native; or Native Hawaiian or Other Pacific Islander. All categories are single race. Data on race and Hispanic origin are collected and reported separately. People of Hispanic origin may be of any race.

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

- In 2023, Black, non-Hispanic women were the most likely to have a low-birthweight infant (15%), compared with American Indian or Alaska Native, non-Hispanic (9%); Asian, non-Hispanic (9%); Native Hawaiian or Other Pacific Islander, non-Hispanic (9%); Hispanic (8%); and White, non-Hispanic (7%) women.

- Between 2016 and 2023, the percentage of low-birthweight infants increased for all race and Hispanic origin groups.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

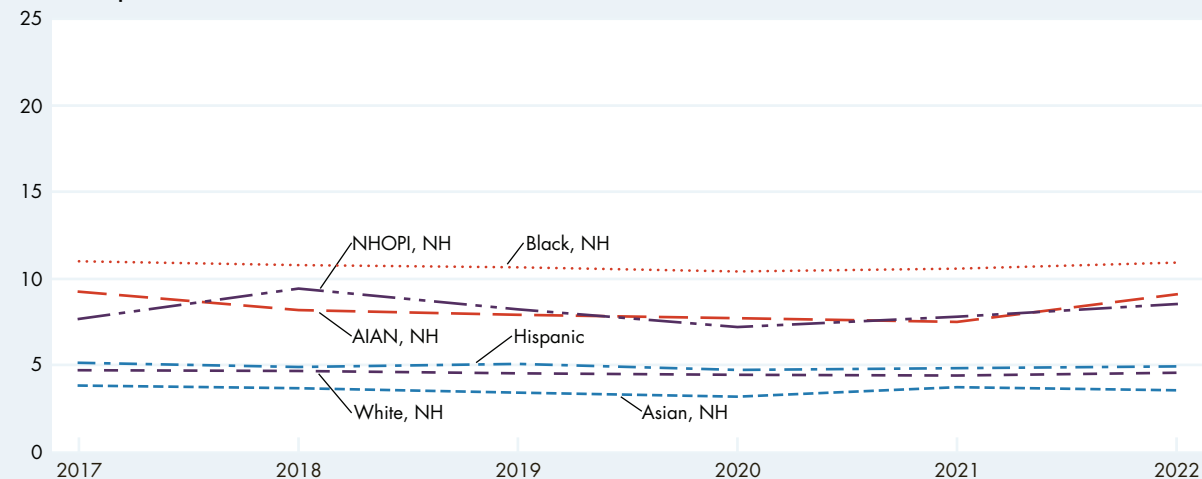
Infant Mortality

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 the availability and use of appropriate health care for infants and pregnant women.^{2,87} Despite medical advances and public health efforts, the mortality rates of Black, non-Hispanic; American Indian or Alaska Native, non-Hispanic; and Native Hawaiian or Other Pacific Islander, non-Hispanic infants have been consistently higher than the rates of other racial and ethnic groups.^{88,89} Higher rates of infants born preterm or at low birthweight account for most of the deaths among Black, non-Hispanic infants.⁸⁸ Higher rates of birth defects account for many of the deaths among American Indian or Alaska Native, non-Hispanic infants.⁸⁸

Indicator HEALTH2

Death rates among infants by race and Hispanic origin of mother, 2017–2022

Infant deaths per 1,000 live births



NOTE: NH = non-Hispanic origin; AIAN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander. Infant deaths are deaths before an infant's first birthday. Race and Hispanic origin refer to the mother's race and Hispanic origin. The 1997 U.S. Office of Management and Budget standards for data on race and ethnicity were used to classify people into one of the following five racial groups: White; Black or African American; Asian; American Indian or Alaska Native; or Native Hawaiian or Other Pacific Islander. All categories are single race. Data on race and Hispanic origin are collected and reported separately. People of Hispanic origin may be of any race.

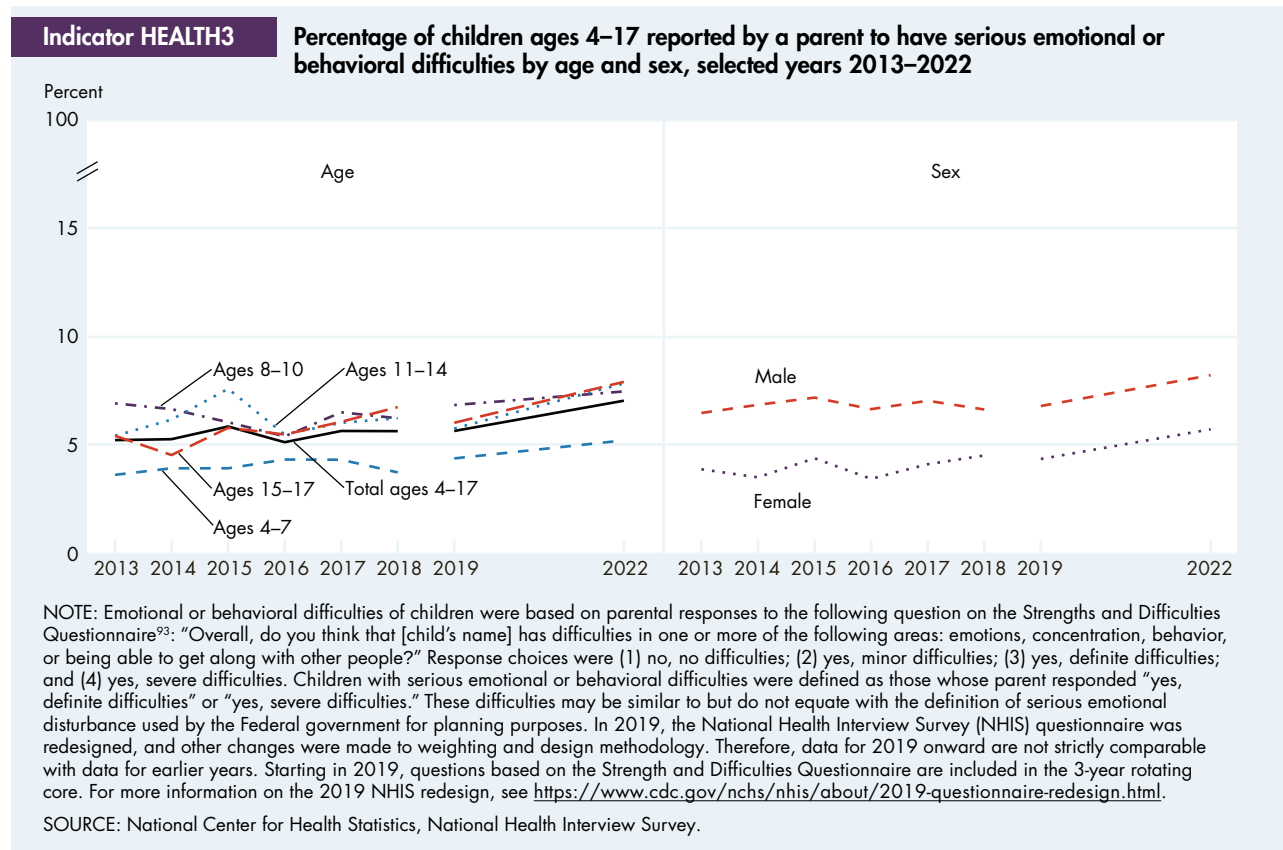
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- The infant mortality rate did not significantly change from 2017 to 2022. In 2022, the mortality rate was 6 infant deaths per 1,000 live births.
- From 2017 to 2022, the mortality rate did not significantly change for infants of any race or Hispanic origin group.
- In 2022, the mortality rate was highest for infants of Black, non-Hispanic women (11 per 1,000), followed by infants of American Indian or Alaska Native, non-Hispanic (9 per 1,000) and Native Hawaiian or Other Pacific Islander, non-Hispanic (8 per 1,000) women. The mortality rate was lowest for infants of Hispanic (5 per 1,000); White, non-Hispanic (5 per 1,000); and Asian, non-Hispanic (4 per 1,000) women.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Emotional and Behavioral Difficulties

Positive emotional and behavioral health is an integral part of healthy development and enhances a child's sense of well-being, supports rewarding social relationships with family and peers, and facilitates achievement of full academic potential.⁹⁰ Children with emotional or behavioral difficulties may experience problems managing their emotions, focusing on tasks, interacting with family and peers, or controlling their behavior. These difficulties, which may persist throughout a child's development, can lead to lifelong problems.⁹¹ Parents play a crucial role in informing health professionals about a child's emotional or behavioral difficulties and obtaining mental health services.⁹²

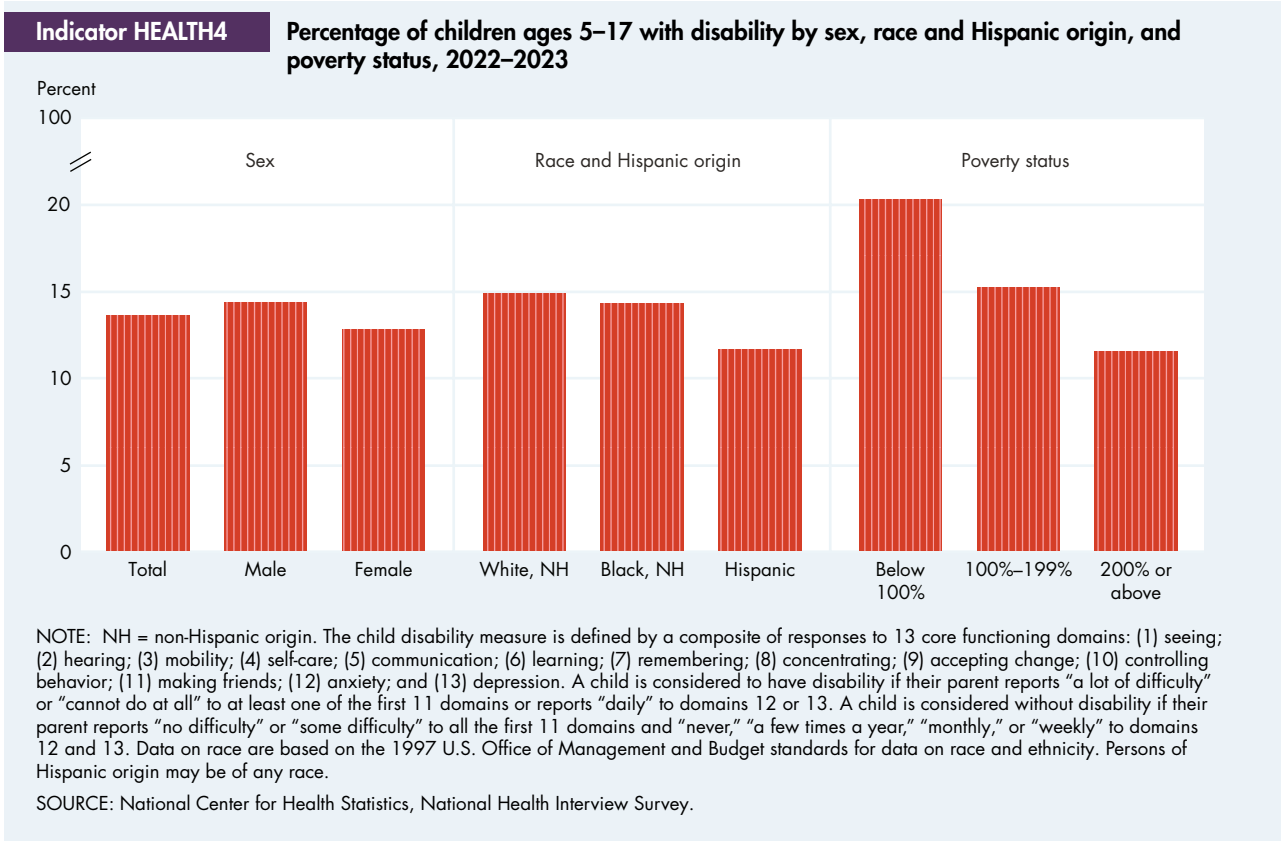


- From 2019 to 2022, the percentage of children ages 4–17 who were reported by a parent to have serious difficulties with emotions, concentration, behavior, or getting along with other people increased from 6% to 7%. Prior to this period, the percentage was stable, ranging from 5% to 6% between 2013 and 2018.
- In 2022, the percentage of children who were reported by a parent to have serious emotional or behavioral difficulties was higher for children ages 8–10 (7%), 11–14 (8%), and 15–17 (8%) than for children ages 4–7 (5%).
- From 2019 to 2022, the percentage of children ages 4–17 who were reported by a parent to have serious emotional or behavioral difficulties increased for females (from 4% to 6%) but did not significantly change for males (8% in 2022).
- In 2022, the percentage of children ages 4–17 who were reported by a parent to have serious emotional or behavioral difficulties was higher for males (8%) than for females (6%). This pattern was reflected among children ages 4–7 (7% for males and 3% for females) and 8–10 (9% for males and 6% for females); for children ages 11–14 and 15–17, there was no statistically significant difference between males and females.
- In 2022, the percentage of children ages 4–17 who were reported to have serious emotional or behavioral difficulties was higher for children living with a relative or guardian who was not a parent (16%) than for children living with a single mother (8%), a single father (7%), and two parents (6%).

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Disability

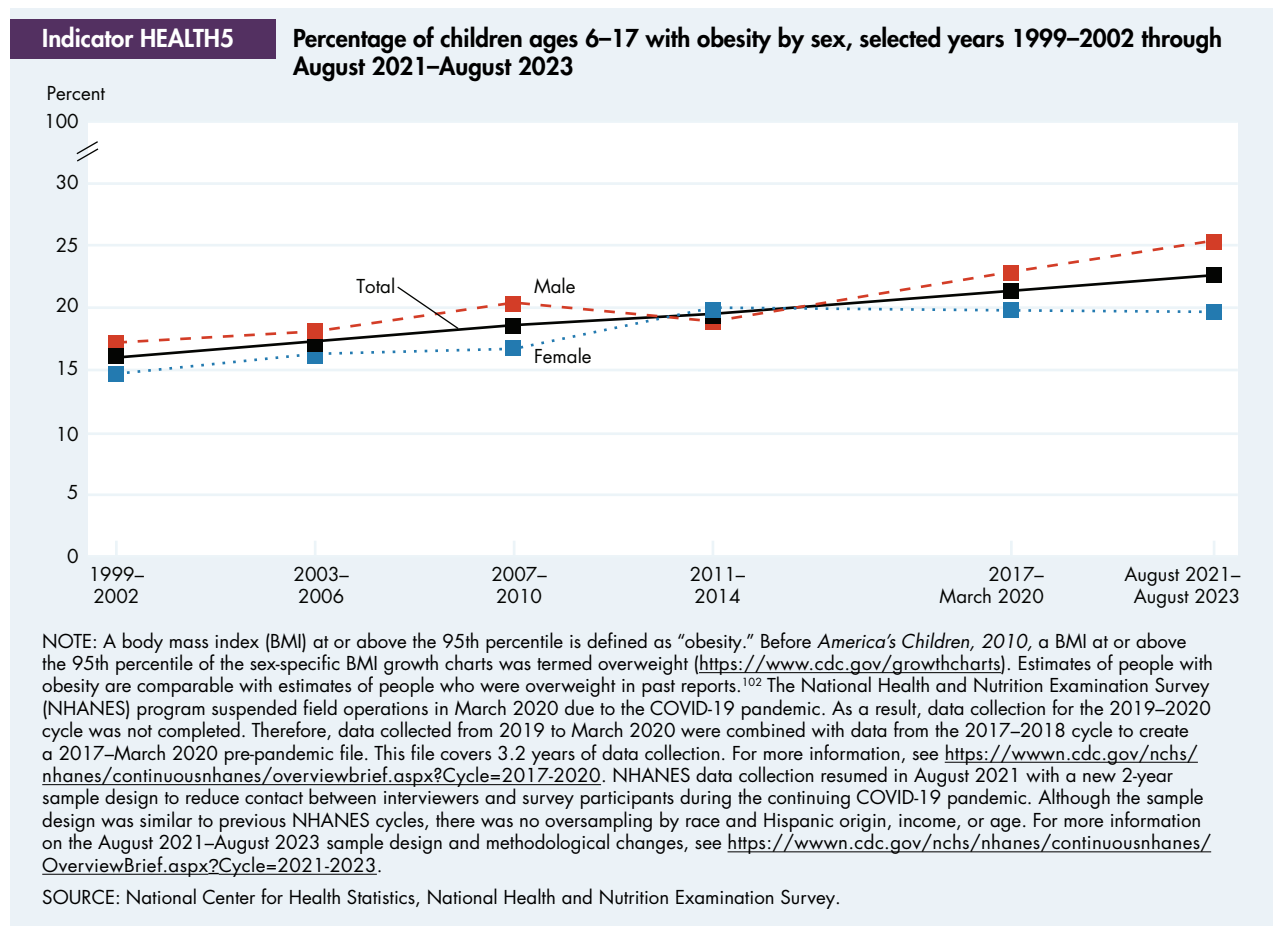
Disability affects all aspects of a child’s life, and the impacts of disability in childhood extend into adulthood.⁹⁴ Children with disability may be disproportionately exposed to risk factors that can affect their survival and development, such as poverty; stigma and discrimination; institutionalization; abuse and neglect; and limited access to services, programs, and educational opportunities.⁹⁵



- In 2022–2023, 14% of children (defined as ages 5–17 in this indicator) were reported to have disability.
 - Male children (14%) were more likely than female children (13%) to have disability.
 - White, non-Hispanic children (15%) were more likely than Hispanic children (12%) to have disability. There were no significant differences in the percentages of reported disability between Black, non-Hispanic (14%) and Hispanic children or between Black, non-Hispanic and White, non-Hispanic children.
- The percentage of children with disability increased with decreasing family income level. Children with family incomes below the poverty threshold (20%) were the most likely to report disability, followed by children with family incomes at 100%–199% of the poverty threshold (15%) and children with family incomes at or above 200% of the poverty threshold (11%).
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on [childstats.gov](https://www.childstats.gov).*

Obesity

Obesity is a complex condition that has many contributors at both the individual level (e.g., genetics, diet, physical activity) and the societal level (e.g., social, economic, and environmental factors).^{96,97} Children with obesity often become adults with obesity and have increased risks for a variety of poor health outcomes, including diabetes, heart disease, and certain cancers.^{98,99} Since 1980, the prevalence of obesity in U.S. children has increased.^{100,101}

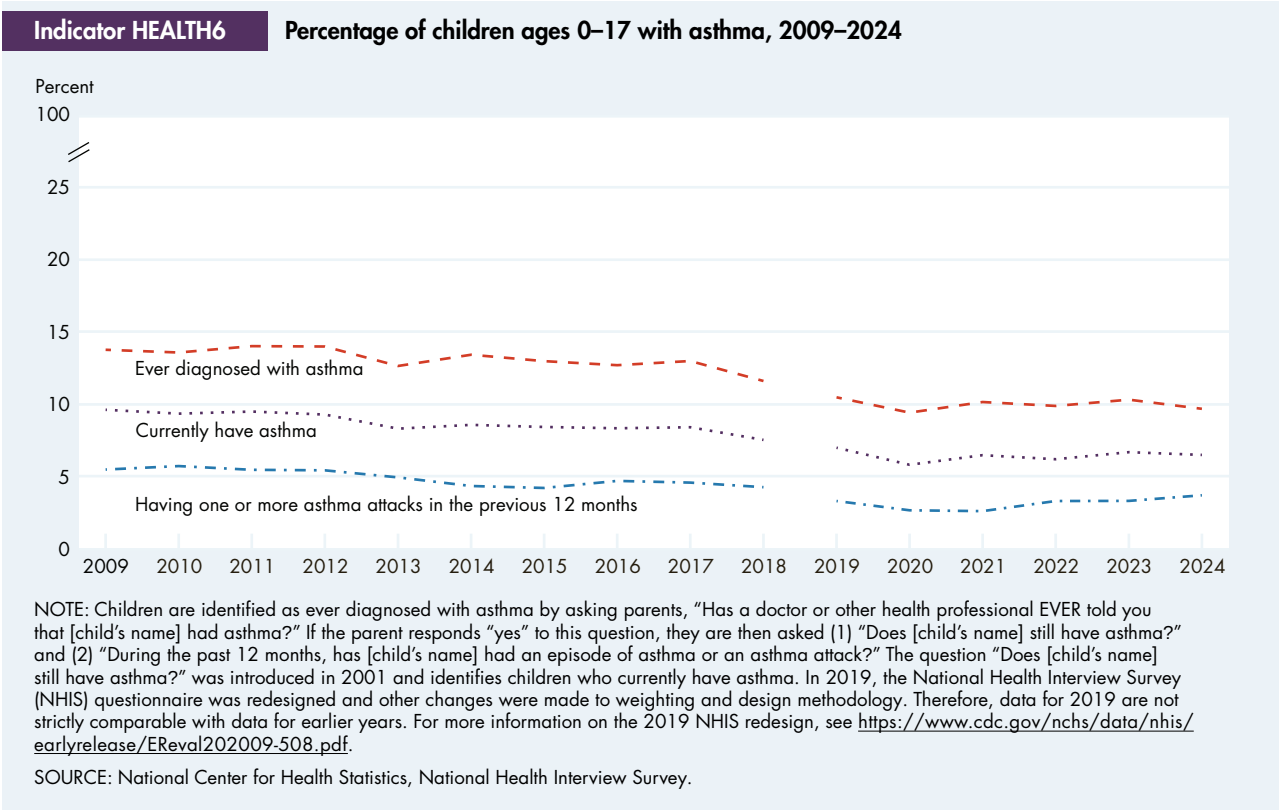


- The percentage of children ages 6–17 with obesity increased from 16% in 1999–2002 to 23% in August 2021–August 2023.
- The percentage of male children with obesity increased from 17% in 1999–2002 to 25% in August 2021–August 2023, while the percentage of female children with obesity increased from 15% to 20% over this period.
- In August 2021–August 2023, male children were more likely than female children to have obesity.

Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.

Asthma

Asthma is a disease of the lungs that can cause wheezing, difficulty breathing, and chest pain. It is one of the most common chronic diseases among children. Asthma varies greatly in severity. Some children who have been diagnosed with asthma may not experience any serious respiratory effects. Other children may have mild symptoms or may respond well to the management of their asthma, typically through the use of medication. However, some children with asthma may suffer serious attacks that greatly limit their activities; result in visits to emergency rooms or hospitals; or, in rare cases, cause death. Environmental factors such as air pollution and secondhand tobacco smoke, along with infections, exercise, and allergens, can trigger asthma attacks in children who have the disease.^{37,38,41,103,104,105}



- In 2024, 10% of children ages 0–17 had ever been diagnosed with asthma at some point in their lives. This percentage has remained steady since 2019, when 11% of children had ever been diagnosed with asthma.
 - In 2024, 4% of children had one or more asthma attacks in the past year. This percentage has remained steady since 2019, when 3% of children had one or more asthma attacks in the past year.
 - In 2024, 7% of children currently had asthma. This percentage was highest among Black, non-Hispanic children (10%), followed by children who were Hispanic (7%); White, non-Hispanic (6%); and Asian, non-Hispanic (4%).
 - In 2024, 8% of children living below the poverty level had asthma, compared with 6% of children with family incomes at or above 200% of the poverty level.
- Endnotes begin on page 51. Bullets contain references to data that can be found in detailed tables on childstats.gov.*



Data Topics

The Federal Interagency Forum on Child and Family Statistics recognizes the need to review current indicators and monitor data topics to ensure that America's Children continues to be a valuable resource for policymakers and the general public. To highlight these activities and encourage public feedback, we have expanded the description of our ongoing data development work in this new section, "Data Topics."

Data Topics

This section follows the overall structure of the report and addresses data topics currently at some phase of assessment or development—either as an indicator, a special feature, or some other future Forum product.

Family and Social Environment

The continually changing nature of children's lives creates many new variations and forms of family and living arrangements that may be challenging to describe in an indicator format using large national omnibus surveys. More data analysis and data presentation considerations are needed on the following topics:

- *Time use.* Currently, no regular Federal data source examines time spent on the whole spectrum of children's activities. In 2003, the U.S. Bureau of Labor Statistics began the American Time Use Survey (ATUS), which measures the amount of time teens spend doing various activities, such as paid work, child care, volunteering, and socializing. The National Assessment of Educational Progress (NAEP) provides information about the time 4th-, 8th-, and 12th-grade students spend on homework and internet use. ATUS and NAEP are promising sources that can help us better understand aspects of youth time use.
- *Social connections and engagement.* The formation of close attachments to family, peers, school, and community has been linked to healthy youth development in numerous research studies. Although various Federal surveys, such as those sponsored by the National Center for Education Statistics (including the National Household Education Surveys [NHES]) and other longitudinal studies programs, contain important research information on these domains, they lack the periodicity needed to support a permanent *America's Children* indicator in this complex domain. More research is needed to either determine a more suitable indicator metric and data source or identify another indicator structure for data development.
- *Parental incarceration.* An increasing body of research shows that children's overall health and well-being is adversely affected by parental incarceration. The Bureau of Justice Statistics (BJS) is currently addressing data on this topic.

Economic Circumstances

Economic security depends on the interaction of a range of financial measures; therefore, development of a composite measure is needed. Although this year's report continues to provide information on parental employment and food security as well as dimensions of income, additional measures are needed on the following:

- *Economic well-being.* Economic well-being over time should be anchored in a broader range of financial health measures rather than just annual income. Multiple measures of family income or consumption, some of which might incorporate

estimates of family wealth and various assets, could produce more reliable estimates of changes in children's economic well-being over time. An additional consideration would be to examine the effect of local economic conditions, which could jeopardize or build economic well-being over time. The U.S. Census Bureau expects that the Survey of Income and Program Participation (SIPP) will provide valuable information about economic well-being.

Health Care

This report provides information on a limited number of key indicators on health care. Information on more comprehensive aspects of health care is needed to better understand the effect of health care on children's well-being. Additional measures are needed on the following:

- *Adequacy of health insurance coverage.* This report contains information on whether children had health insurance coverage at the time of interview. Information is also needed on patterns of insurance coverage and the characteristics of the child's insurance plan to determine whether the plan is adequate to meet health care needs. The SIPP may be able to provide information about the source of insurance providers.

Physical Environment and Safety

More data than those presented in the current report are needed to better understand and monitor children's physical environment and safety. Additional information is needed on the following:

- *Exposure to violence.* Research suggests that witnessing violence can have detrimental effects similar to the effects of being a direct victim of violence. BJS and the Office of Juvenile Justice and Delinquency Prevention are developing new survey topics. BJS continues to evaluate these new data as potential sources for future indicators relating to exposure to violence.
- *Homelessness.* The scope of information on unsheltered and sheltered homelessness among households with children has improved significantly through the use of homeless service providers' administrative data found in the Annual Homeless Assessment Reports from the U.S. Department of Housing and Urban Development (HUD). Another HUD initiative seeks to develop survey methods to measure housing insecurity among those housed. These studies will offer new information about children lacking stable housing.

Behavior

Data that more adequately monitor the behaviors of youth are of interest to agencies. For example, agencies may explore the following topics further:

- *Activities promoting health and development.* Youth participation in a broad range of activities (e.g., volunteering,

part-time employment, afterschool activities) has been associated with positive developmental outcomes. Additional research is needed to ascertain how such activities relate to success in later life. The Forum is currently considering the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System and the U.S. Environmental Protection Agency's Exposure Factors Handbook as potential sources for future indicators that can broaden our understanding of this topic.

- *Youth in the justice system.* The Youth Perpetrators of Serious Violent Crime indicator has been updated in this year's *America's Children* report. BJS may explore additional data sources that contain data on the number and characteristics of youth arrestees and detainees prosecuted in both juvenile and adult courts and incarcerated in the Nation's jails, prisons, and juvenile facilities.

Education

It is vital to understand children's early development because what children experience at that stage has lasting implications for the rest of their lives. The Forum has specifically addressed the area of social-emotional development among young children through a contract awarded to Child Trends; deliverables for this project are posted on the Forum's website (<https://www.childstats.gov>).

- *Early childhood development.* A regular source of data is needed to track the cognitive, emotional, and social skills of preschoolers and young children over time. The 2023 edition of the NHES include several measures of young children's learning and development. Because of the limited periodicity for the NHES, new survey questions may be more suitable for special features in the *America's Children* report.

Health

Identifying key dimensions of health can be challenging because of difficulties in reaching consensus on relevant definitions and measurements.

- *Disability.* There is long-standing interest in developing an improved measure of child disability based on the functional difficulties experienced by children. In 2019, the National Health Interview Survey was redesigned, and other changes were made to weighting and design methodology. The redesign introduced a short set of questions from the Washington Group on Disability Statistics on child disability, which covers 13 core functioning domains—seeing, hearing, mobility, self-care, communication, learning, remembering, concentrating, accepting change, controlling behavior, making friends, anxiety, and depression. Reporting on child disability began in the *America's Children, 2023* report.

Taken together, these developmental efforts reflect both near-term objectives and long-term strategies in maintaining the value of *America's Children* reports. We welcome feedback in terms of these specific initiatives as well as on the value of the full *America's Children* report.

The background of the page is a close-up, slightly blurred image of the American flag. The stars are prominent in the upper left, and the stripes flow across the bottom and right. The overall color palette is dominated by the blue, white, and red of the flag, with a soft, ethereal quality.

Notes to Indicators

Notes to Indicators

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³ Livingston, G. (2015). For most highly educated women, motherhood doesn't start until the 30s. *Fact Tank: News in the numbers*. Pew Research Center. <http://pewrsr.ch/1DIplhX>

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¹¹ Christian, C. W., Block, R., & Committee on Child Abuse and Neglect. (2009). Abusive head trauma in infants and children. *Pediatrics*, 123(5), 1409–1411. <https://doi.org/10.1542/peds.2009-0408>

¹² Following U.S. Office of Management and Budget Statistical Policy Directive 14, poverty status is determined by comparing a family's (or an unrelated individual's) income to one of 48 dollar amounts called thresholds. The thresholds vary by the size of the family and the members' ages. In 2023, the poverty threshold for a family with two adults and two children was \$30,900. For further details, see <http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>.

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¹⁴ Anderson, S. A. (Ed.). (1990). Core indicators of nutritional state for difficult-to-sample populations. *Journal of Nutrition*, 120(11S), 1557–1600. https://doi.org/10.1093/jn/120.suppl_11.1555

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¹⁶ 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 <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security>.

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- ²⁷ Up to date is three doses of the HPV vaccine or two doses of the HPV vaccine when the first dose is received prior to age 15 years and there is at least 5 months minus 4 days between the first and second dose.
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- ³⁴ This measure does not differentiate between counties in which the Primary NAAQS are exceeded frequently or by a large margin and counties in which the standards are exceeded only rarely or by a small margin. It also must 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.

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The background of the page is a close-up, slightly blurred image of the American flag. The stars are prominent in the upper left, and the stripes flow across the bottom and right. The overall color palette is dominated by the blue, white, and red of the flag, with a soft, ethereal quality.

Appendix A: Data Source Descriptions

Data Source Descriptions

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Data Source Descriptions

Air Quality System

The Air Quality System (AQS) contains ambient air pollution data collected by the U.S. Environmental Protection Agency (EPA) and by state, local, and tribal air pollution control agencies. Data on criteria pollutants (particulate matter, ozone, carbon monoxide, nitrogen dioxide, sulfur dioxide, and lead) consist of air quality measurements collected by sensitive equipment at thousands of monitoring stations in all 50 states, plus the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands. Each monitor measures the concentration of a particular pollutant in the air. Monitoring data indicate the average pollutant concentration during a specified time interval, usually 1 hour or 24 hours. The AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and operator), and data quality assurance/quality control information. Data are available from AQS dating back to 1957. The system is administered by the EPA's Office of Air Quality Planning and Standards, Outreach and Information Division, in Research Triangle Park, North Carolina.

For the Outdoor Air Quality indicator, a county is considered to have a pollutant concentration above the level of the current Primary National Ambient Air Quality Standard (NAAQS) if the measured pollutant level was greater than the level of the standard at any monitor within the county during the year. The indicator is calculated as the sum of children living in counties with pollutant concentrations above the level of a standard divided by the total number of children in the United States. This calculation differs from the method for identifying areas in violation of an air quality standard. See *America's Children and the Environment* at <https://www.epa.gov/ace> (Indicator E1) for further discussion.

Information about AQS is available online at <https://www.epa.gov/aqs>.

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American Housing Survey

The American Housing Survey (AHS) is sponsored by the U.S. Department of Housing and Urban Development's Office of Policy Development and Research and is conducted by the U.S. Census Bureau. The survey provides data necessary for evaluating progress toward "a decent home and a suitable living

environment for every American family," a goal affirmed in 1949 and 1968 legislation. The AHS began as an annual survey in 1973 and has been conducted biennially in odd-numbered years since 1985. A longitudinal nationally representative sample of 60,000 housing units plus newly constructed units was surveyed during the period of 1985 to 2013, and a new sample was drawn in 2015. Transient accommodations, military and worker housing, and institutional quarters are excluded. AHS data detail the types, size, conditions, characteristics, costs and values, equipment, utilities, and dynamics of the housing inventory; they also provide some information about neighborhood conditions. Data include demographic, financial, and mobility characteristics of the occupants. Since 1997, the AHS has been conducted using computer-assisted personal interviewing.

Information about the AHS is available online at <https://www.census.gov/programs-surveys/ahs.html>.

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Current Population Survey

The Current Population Survey (CPS) is a nationwide survey conducted monthly for the U.S. Bureau of Labor Statistics by the U.S. Census Bureau. The survey is representative of the civilian noninstitutionalized population of the United States with a sample located in more than 2,000 counties and independent cities and coverage in every state and the District of Columbia.

The CPS sample is selected from a complete address list of geographically delineated primary sampling units, which are based on census addresses and updated using recent construction and other data. It is administered through field representatives, either in person or by telephone using computer-assisted personal interviewing (CAPI). Some CPS data also are collected through a centralized telephone operation called computer-assisted telephone interviewing (CATI). For more information about the CPS, its sampling structure, and estimation methodology, see <https://www2.census.gov/programs-surveys/cps/methodology/CPS-Tech-Paper-77.pdf>.

Core Survey

The CPS core survey, administered to about 60,000 households each month, is the primary source of information on employment and unemployment characteristics of the civilian noninstitutionalized population, released every month by the U.S. Bureau of Labor Statistics.

Annual Social and Economic Supplement (ASEC)

Administered since 1947, ASEC (formerly called the March Supplement) provides information that can be used to estimate the status and well-being of children.

The 2014 CPS ASEC (which refers to health insurance coverage estimates of the 2013 calendar year) is the first to use the improved measures of health insurance coverage. Following more than a decade of research, evaluation, and consultation with outside experts, the U.S. Census Bureau implemented an approach shown to improve the accuracy of health insurance coverage measurement. For a list of references, please see the U.S. Census Bureau director's statement on the improved set of health insurance coverage questions at <https://www.census.gov/newsroom/archives/2014-pr/cb14-67.html>. Due to these changes, data for the 2014 CPS ASEC are not comparable with data from earlier years.

The 2014 CPS ASEC included redesigned questions for income and health insurance coverage. All of the approximately 98,000 addresses were selected to receive the improved set of health insurance coverage items. The improved income questions were implemented using a split panel design. Approximately 68,000 addresses were selected to receive a set of income questions similar to those used in the 2013 CPS ASEC. The remaining 30,000 addresses were selected to receive the redesigned income questions. The source of data for tables in this volume is the CPS ASEC sample of 98,000 addresses.

There was an implementation of an updated processing system for the 2018 CPS ASEC. For more information, see technical documentation at <https://www2.census.gov/programs-surveys/demo/datasets/income-poverty/time-series/data-extracts/2018/cps-asec-bridge-file/2018-asec-bridge-file-documentation.pdf> and information on the updated processing system at <https://www.census.gov/data/datasets/time-series/demo/income-poverty/cps-asec-design.html>. Due to these changes, data for the 2018 CPS ASEC are not comparable with data from earlier years.

School Enrollment Supplement

The School Enrollment Supplement, which has also been administered since 1947, asks questions on school enrollment by grade and other school characteristics about each member of the household age 3 or over.

Food Security Supplement

Introduced in April 1995 and administered in December since 2001, the food security supplement contains a systematic set of questions validated as measures of the severity of food insecurity on a 12-month and a 30-day basis. Statistics presented in this report are based on 12-month data from the Food Security Supplement. The food security questions are based on material reported in prior research on hunger and food security and

reflect the consensus of nearly 100 experts at the 1994 Food Security and Measurement Conference, convened jointly by the National Center for Health Statistics and the Food and Nutrition Service of the U.S. Department of Agriculture. The supplement was developed, tested, and refined further by the conferees, members of a Federal interagency working group, and survey methods specialists for the U.S. Census Bureau's Center for Survey Methods Research. All households interviewed in the CPS in December are eligible for the supplement. Special supplement sample weights were computed to adjust for the demographic characteristics of supplement noninterviews.

Information about food security is available online at <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/>.

Information about the CPS is available online at <https://www.census.gov/cps>.

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Monitoring the Future

The Monitoring the Future (MTF) study is a continuing series of nationally representative surveys intended to assess the changing lifestyles, values, and preferences of American youth. Each year since 1975, high school seniors from a sample of public and private high schools have participated in this study. The 2024 survey is the 50th consecutive national survey of 12th-grade students and the 34th national survey of 8th- and 10th-grade students (who were added to the study in 1991). The study is conducted by the University of Michigan's Institute for Social Research under a grant from the National Institute on Drug Abuse. All grades are sampled independently, with no school representing more than one grade. The survey design currently uses a two-stage stratified random sampling procedure, where the stages include selection of schools randomly drawn from 70 grade-specific strata, and a sample of students in the target grade within each selected school. Data are collected in the spring of each year using questionnaires administered in the classroom by representatives from the

University of Michigan's Survey Research Center. The 2024 survey included a total of 24,257 students from 272 schools nationwide.

In 2020, data collection was halted earlier than usual due to the COVID-19 pandemic and subsequent stay-at-home orders. This resulted in smaller samples being obtained that year, but analyses show that these samples were nationally representative.

For more information, please see the following:

- Miech, R. A., Johnston, L. D., Patrick, M. E., & O'Malley, P. M. (2025). *Monitoring the Future Study annual report: National survey results on drug use, 1975–2024: Overview and detailed results for secondary school students*. Institute for Social Research, University of Michigan. <https://monitoringthefuture.org/wp-content/uploads/2024/12/mtf2025.pdf>
- Miech, R. A., Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E., & Patrick, M. E. (2021). *Monitoring the Future Study annual report: National survey results on drug use, 1975–2020: Volume I, Secondary school students*. Institute for Social Research, University of Michigan. https://monitoringthefuture.org/wp-content/uploads/2022/08/mtf-vol1_2020.pdf

Information about MTF is available online at <https://www.nida.nih.gov/DrugPages/MTF.html> and <https://monitoringthefuture.org>.

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National Child Abuse and Neglect Data System

The National Child Abuse and Neglect Data System (NCANDS) annually collects case-level data on reports alleging child abuse and neglect, as well as the results of these reports, from state child protective services agencies. The mandate for NCANDS is based on the Child Abuse Prevention and Treatment Act (CAPTA), as amended in 1988, which directed the Secretary of the Department of Health and Human Services (HHS) to establish a national data collection and analysis program that would make available state child abuse and neglect reporting information. HHS responded by establishing NCANDS as a voluntary national reporting system. In 1992, HHS produced its first NCANDS report based on data from 1990. The annual data report *Child Maltreatment* evolved from that initial report.

Every year, NCANDS data are submitted voluntarily by the 50 states, the District of Columbia, and the Commonwealth

of Puerto Rico. The NCANDS reporting year is based on the Federal fiscal year calendar that spans October 1 to September 30. States submit case-level data, referred to as a Child File, by creating an electronic file of child-specific records for each report of alleged child abuse and neglect that receives a Child Protective Services (CPS) response, in the form of an investigation or alternative response. Case-level data include information about the characteristics of the reports of abuse and neglect, the children involved, the types of maltreatment, the CPS findings, the risk factors of the child and the caregivers, the services provided, and the perpetrators.

The Child File is supplemented by agency-level aggregate statistics in a separate data submission called the Agency File. The Agency File contains data that are not reportable at the child-specific level and are often gathered from agencies external to CPS. Information collected in the Agency File includes receipt of prevention and postresponse services and caseload and workforce data. States are asked to submit both the Child File and the Agency File each year.

CAPTA (42 U.S.C. §5106a), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111–320), retained the existing definition of child abuse and neglect as, at a minimum:

Any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

Each state defines the types of child abuse and neglect in state statute and policy. CPS agencies determine the appropriate response for the alleged maltreatment based on those statutes and policies. The most common response is an investigation. The result of an investigation response is a determination (also known as a disposition) about the alleged child maltreatment.

In NCANDS, a victim is defined as a child for whom the state determined at least one maltreatment was substantiated or indicated and for whom a disposition of substantiated or indicated was assigned. It is important to note that a child may be a victim in one report and a nonvictim in another report. “Substantiation” is a case determination that concludes that the allegation of maltreatment or risk of maltreatment is supported by state law or policy. “Indicated” is a case determination that concludes that although maltreatment cannot be substantiated by state law or policy, there is reason to suspect that the child may have been maltreated or was at risk of maltreatment.

State statutes also establish the level of evidence needed to determine a disposition of substantiated or indicated. The local CPS agencies respond to the safety needs of the children who are the subjects of child maltreatment reports based on these state definitions and requirements for levels of evidence.

NCANDS data are a critical source of information for many publications, reports, child welfare personnel, researchers, and others. NCANDS data are used as a performance measure in several Federal programs.

NCANDS data also are used for the annual *Child Maltreatment* report series. Each report summarizes the major national and state-by-state findings for the given fiscal year and is a key resource for thousands of people and organizations across the world. The Children's Bureau has published an annual *Child Maltreatment* report since 1992. Reports are available on the Children's Bureau website at <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.

Rates are based on the number of states submitting data to NCANDS each year; states include the District of Columbia and the Commonwealth of Puerto Rico. Information about NCANDS is available online at <https://acf.gov/cb/research-data-technology/reporting-systems/ncands>.

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National Crime Victimization Survey

The National Crime Victimization Survey (NCVS) is the nation's primary source of information on criminal victimization. The NCVS is sponsored by the Bureau of Justice Statistics, and data are collected by the U.S. Census Bureau. The NCVS collects information on nonfatal victimizations, reported and not reported to the police, against persons age 12 or over from a nationally representative sample of U.S. households. Sample households are chosen using a multistage stratified sample design. All household members age 12 and over in selected households are interviewed to obtain information on the frequency, characteristics, and consequences of criminal victimization in the United States.

In 2023, there were 142,028 household interviews. Overall, 63% of eligible households completed an interview. Within participating households, 226,480 persons completed an interview in 2023, representing an 82% response rate among eligible persons from responding households.

The survey collects information on nonfatal personal crimes (rape or sexual assault, robbery, aggravated assault, simple assault, and personal larceny [purse snatching and pocket picking]) and household property crimes (burglary or trespassing, motor vehicle theft, and other types of theft). Survey respondents provide information about themselves, such as age, sex, race, Hispanic origin, and household income, and whether they experienced a victimization. Victims are also asked whether they reported the incident to the police. In instances of personal violent crimes, victims are asked about the characteristics of the perpetrator.

In addition to providing annual-level and change estimates on criminal victimization, the NCVS is the primary source of information on the nature of criminal victimization incidents. It has been ongoing since 1973 and was redesigned in 1992.

Due to changes in survey methodology in 2006, national-level estimates were not comparable with estimates based on NCVS data from previous years. See *Criminal Victimization, 2006* (<https://bjs.ojp.gov/library/publications/criminal-victimization-2006>) for more information on the redesigned methodology. In 2016, the NCVS sample was redesigned, and 2016 estimates among youth are not comparable with estimates from other years.

The 2020 NCVS weights include an additional adjustment to address the impact of modified Census Bureau field operations due to the COVID-19 pandemic. For more information on the weighting adjustments applied in 2020, see the Source and Accuracy Statement for the 2020 National Crime Victimization Survey in the *NCVS 2020 Codebook* (<https://www.icpsr.umich.edu/web/NAACJD/studies/38090/summary>) and *Criminal Victimization, 2020* (<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cv20.pdf>).

Information about the NCVS is available online at <https://bjs.ojp.gov/programs/ncvs>.

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National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is a major program of the National Center for Health Statistics (NCHS). NHANES is designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and health examinations. The NHANES interview includes demographic, socioeconomic, dietary, and health questions. The examination component consists of medical, dental, and physiological measurements, as well as laboratory tests administered by highly trained medical personnel. Findings from this survey are used to determine the prevalence of major diseases and risk factors for diseases among the civilian noninstitutionalized population of the United States and serve as the basis for national standards for such measurements as body mass index and blood pressure.

The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. In 1999, the survey became a continuous program that, in addition to a core focus on major chronic health conditions and nutrition, has flexible content to meet emerging public health concerns. Each year, the survey examines a nationally representative sample of about 5,000 persons located

in 15 counties across the country. Health interviews are conducted in respondents' homes. Health measurements are performed in specially designed and equipped mobile centers, which travel to the selected 15 counties during each survey year. The study team consists of medical and health technicians as well as dietary and health interviewers. Data collection is conducted with notebook computers. Survey information is available to NCHS staff within 24 hours of collection, which enhances quality assessment and increases the speed with which data are released to the public.

Since 1999, the sample design has consisted of multiyear stratified and clustered four-stage samples, with public-use data released in 2-year cycles. In March 2020, the 2019–2020 data collection was interrupted due to the COVID-19 pandemic. As a result, data collection for the 2019–2020 cycle was not completed, and the data collected for that period were not nationally representative. To create a nationally representative sample, the partial 2019–March 2020 data were combined with the full dataset from the previous cycle (2017–2018). The resulting files are referred to as the 2017–March 2020 prepandemic files. NHANES returned to the field in August 2021 with a 2-year sample design similar to past cycles, except that there was no oversampling by race and Hispanic origin and income. The August 2021–August 2023 cycle sampled 6,736 children and adolescents ages 1–19; interviewers collected information for 3,935 children and adolescents and completed 2,663 examinations. For children and adolescents, the unweighted response rates for interviews and examinations were 38.3% and 25.9%, respectively.

Starting with data updates for *America's Children, 2017*, the reliability of survey percentage estimates is assessed using the Clopper–Pearson confidence interval, which was adapted for complex surveys by Korn–Graubard, to determine if the estimate is unreliable and should be suppressed. This method has been applied to all NHANES estimates. The reliability of prior estimates for other indicators are evaluated based on relative standard error.

For more information about the survey methodology, see the following:

- Chen, T. C., Clark, J., Riddles, M. K., Mohadjer, L. K., & Fakhouri, T. H. I. (2020). National Health and Nutrition Examination Survey, 2015–2018: Sample design and estimation procedures. *Vital and Health Statistics*, 2(184). National Center for Health Statistics. https://www.cdc.gov/nchs/data/series/sr_02/sr02-184-508.pdf
- National Center for Health Statistics. (2021, May 27). *Brief overview and analytic guidelines*. <https://www.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2017-2020>
- National Center for Health Statistics. (2024, September 20). *Brief overview and analytic guidelines*. <https://www.cdc.gov/nchs/nhanes/continuousnhanes/overviewbrief.aspx?Cycle=2021-2023>

Information about NHANES is available online at <https://www.cdc.gov/nhanes>.

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National Health Interview Survey

The National Health Interview Survey (NHIS) is conducted by the National Center for Health Statistics (NCHS). NHIS monitors the health of the U.S. population by collecting and analyzing data on a broad range of topics. NHIS is a continuing nationwide sample survey of the civilian noninstitutionalized population in the United States, excluding patients in long-term care facilities, persons on active duty with the Armed Forces, prisoners, and U.S. nationals living in foreign countries. Data are collected through personal household interviews by trained interviewers. Before 1997, a paper-and-pencil questionnaire format was used. From 1997 onward, computer-assisted personal interviewing (CAPI) was used. Interviewers obtain information on personal and demographic characteristics, including race and ethnicity, through self-reports or reports by a member of the household. Interviewers also collect data on illnesses, injuries, impairments, chronic conditions, disability, utilization of health services, and other health topics. Each year, the survey is reviewed, and special topics are added or deleted. For most health topics, the survey collects data for an entire year.

The NHIS sample is designed to estimate the national prevalence of health conditions, health service utilization, and health behaviors of the civilian noninstitutionalized population of the United States. From 2006 to 2015, it included an oversample of Asian, Black, and Hispanic persons; a new sample design was introduced in 2016, and Asian, Black, and Hispanic people are no longer oversampled. The NHIS core questionnaire items are revised every 10 to 15 years. The sample for the NHIS is redesigned and redrawn about every 10 years to better measure the changing U.S. population and to meet new survey objectives.

In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users, the Centers for Disease Control and Prevention, and the Department of Health and Human Services. Starting with the 2019 survey, the NHIS annual data release only includes the Sample Adult, Sample Child, Imputed Income, and Paradata files. Household, family, and person data files are no longer released. Starting with the 2019 survey, an interviewed household is defined as one where the household roster and a substantial portion of either the Sample Adult interview or the Sample Child interview is completed. Previous survey cycles defined an interviewed household as one where at least one family in the household completed a substantial

portion of the family interview. Due to changes in weighting and design methodology, direct comparisons between estimates before 2019 and estimates from 2019 onward should be made with caution, as the impact of these changes has not been fully evaluated at this time.

In 2022, 7,464 children under age 18 were sampled from 8,879 eligible households for a response rate of 45.8%. In 2023, 7,692 children under age 18 were sampled from 9,202 eligible households for a response rate of 44.9%.

Starting with data updates for *America's Children, 2017*, the reliability of survey percentage estimates is assessed using the Clopper–Pearson confidence interval, which was adapted for complex surveys by Korn–Graubard, to determine if the estimate is unreliable and should be suppressed. This method has been applied to all NHIS estimates. The reliability of prior estimates for other indicators are evaluated based on relative standard error.

For more information about the survey methodology, see the following:

- National Center for Health Statistics. (2020). *Survey description: National Health Interview Survey, 2019*. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2019/srwydesc-508.pdf
- National Center for Health Statistics. (2020, October 6). *2019 questionnaire redesign: National Health Interview Survey*. <https://www.cdc.gov/nchs/nhis/about/2019-questionnaire-redesign.html>
- National Center for Health Statistics. (2022). *Survey description: National Health Interview Survey, 2022*. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2022/srwydesc-508.pdf
- National Center for Health Statistics. (2022). *Survey description: National Health Interview Survey, 2023*. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2023/srwydesc-508.pdf

Information about NHIS is available online at <https://www.cdc.gov/nchs/nhis.htm>.

Summary health data for children are available online at <https://www.cdc.gov/nchs/nhis/products/data-query-systems.html>.

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National Hospital Ambulatory Medical Care Survey

The National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department (ED) Component was conducted by the National Center for Health Statistics. NHAMCS-ED collected data on ambulatory care visits to hospital emergency departments. Data were abstracted or electronically extracted from medical records by U.S. Census Bureau field representatives. Patient characteristics collected included age, sex, race, ethnicity, and expected source of payment. Visit characteristics collected included reasons for visit, diagnoses, tests and procedures, medications, providers seen, and disposition. Data were also collected on selected hospital characteristics, such as trauma level and electronic health record capabilities. Annual data collection began in 1992 and ended in 2022.

The survey was a nationally representative sample of in-person visits to EDs in non-Federal, short-stay, and general hospitals. NHAMCS used a four-stage probability sample design, involving samples of geographic primary sampling units (PSUs); hospitals within PSUs; EDs; and patient visits to EDs.

The hospital sample consisted of almost 500 hospitals. In 2021, 16,207 ED patient record forms were completed, and the ED hospital response rate was 89.4%. In 2022, 16,025 ED patient record forms were completed, and the ED hospital response rate was 82.6%.

For background information, see https://www.cdc.gov/nchs/data/series/sr_01/sr01_034acc.pdf.

Information about NHAMCS is available on the National Hospital Ambulatory Medical Care Survey website at <https://www.cdc.gov/nchs/nhamcs/about/index.html>.

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National Immunization Surveys

The National Immunization Surveys (NIS) are a family of telephone surveys used to monitor vaccination coverage among children ages 19–35 months (NIS-Child), adolescents ages 13–17 years (NIS-Teen), and influenza vaccination coverage among children/adolescents ages 6 months to 17 years (NIS-Flu). Data collection for NIS-Child began in April 1994 to assess vaccination coverage after measles outbreaks in the early 1990s. Similar to the NIS-Child, the NIS-Teen was launched in 2006. The NIS-Flu was added during the 2009–2010 flu season.

The NIS provide population-based, state, selected local area, and territorial estimates of vaccination coverage among children and adolescents using a standard survey methodology. The surveys collect data through telephone interviews with parents or guardians in all 50 states, the District of Columbia, and some cities or counties and U.S. territories. Cell phone numbers are randomly selected and called to identify one or more age-eligible children or adolescents from the household. The parents and guardians of eligible children for NIS-Child and adolescents for NIS-Teen are asked during the interview for the names of their children's or teen's vaccination providers and permission to contact them. With this permission, a questionnaire is mailed to each child's vaccination provider(s) to collect the information on the types of vaccinations, number of doses, dates of administration, and other administrative data about the health care facility. Estimates of vaccination coverage are determined for vaccinations recommended by the CDC. Children and adolescents are classified as being up to date based on the CDC-recommended numbers of doses for each vaccine. All vaccination coverage estimates are based on provider-reported vaccination history.

Information about the NIS is available online at <https://www.cdc.gov/nis/about/index.html>.

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National Survey of Children's Health (NSCH)

The National Survey of Children's Health (NSCH) is a household survey that produces national and state-level data on the physical and emotional health and well-being of children ages 0–17 in the United States. The survey collects information on topics like access to and use of health care; family interactions; parental health; school and after-school experiences; and neighborhood characteristics. The NSCH is the only national and state-level survey on the health and well-being of children, their families, and their communities.

Information about the NSCH is available online at <https://mchb.hrsa.gov/data-research/national-survey-childrens-health>.

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National Vital Statistics System — Linked Birth/Infant Death Data Set

The National Center for Health Statistics' National Vital Statistics System collects and publishes data on births and deaths in the United States. The period-linked data set of the Linked Birth/Infant Death Data Set is used to produce the statistics presented in this report. In the period-linked data set, the numerator consists of all infant deaths occurring in a given year linked to their corresponding birth certificates from that calendar year or the previous year. The linked file includes all the variables in the national natality file, as well as medical information reported for the same infant on the death record and the age of the infant at death. The infant's race and Hispanic origin are classified based on the race and Hispanic origin of the mother reported on the birth certificate. This is preferred over race and Hispanic origin on the death certificate because information on the birth certificate is usually provided by the parents, while information on the death certificate may be completed by a third party (like the coroner or physician). Linked files are available starting with the birth cohort of 1983. Linked files were not produced for the 1992–1994 data years.

Race Reporting

The 2003 revision of the U.S. Standard Certificate of Live Birth uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003 revision permits reporting of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with the 2017 linked data set, single-race data are available for all 50 states and the District of Columbia. For data before 2017, bridged-race categories were presented to provide uniformity and comparability of data over time. Therefore, data for race groups for 2017 onward are not comparable with earlier data. The bridged population estimates can be found online at https://www.cdc.gov/nchs/nvss/bridged_race.htm.

For more information, see the following:

- Ely, D. M., & Driscoll, A. K. (2025). Infant mortality in the United States, 2023: Data from the period linked birth/infant death file. *National Vital Statistics Reports*, 74(7). National Center for Health Statistics. <https://dx.doi.org/10.15620/cdc/174592>

Information about the Linked Birth/Infant Death file is available online at <https://www.cdc.gov/nchs/nvss/linked-birth-htm>.

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National Vital Statistics System—Mortality

The National Center for Health Statistics' (NCHS's) National Vital Statistics System (NVSS) collects and publishes data on deaths in the United States. NCHS obtains information on deaths from the registration offices of all states, New York City, and the District of Columbia. Funeral directors and family members provide demographic information on death certificates. Medical certification of cause of death is provided by a physician, medical examiner, or coroner.

Cause of Death

For 1980–1998, cause of death is classified according to the International Classification of Diseases (ICD), 9th Revision. For 1999 onward, cause of death is classified according to the ICD, 10th Revision. The following ICD codes are used in the *America's Children* report:

Cause of Death	ICD-9	ICD-10
Birth defects	740–759	Q00–Q99
Cancer	140–208	C00–C97
COVID-19	...	U07.1
Heart disease	390–398, 402, 404–429	I00–I09, I11, I13, I20–I51
Homicide	E960–E969	*U01–*U02, X85–Y09, 87.1
Influenza and pneumonia	480–487	J09–J18
Injuries (intentional and unintentional)	E800–E869, E880–E929, E950–E999	*U01–*U03, V01–Y36, Y85–Y87, Y89
Drowning	E830.0–E830.9, E832.0–E832.9, E910.0–E910.9, E954, E964, E984	W65–74, X71, X92, Y21
Fall	E880.0–E886.9, E888, E957.0–E957.9, E968.1, E987.0–E987.9	W00–W19, X80, Y01, Y30
Fire and burns	E890–E899, E924.0–E924.9, E958.1, E958.2, E958.7, E961, E968.0, E968.3, E988.1, E988.2, 988.7	*U01.3, X00–X19, X76–77, X97–X98, Y26–Y27, Y36.3
Firearms	E922, E955.0–E955.4, E965.0–E965.4, E970, E985.0–E985.4	*U01.4, W32–W34, X72–X74, X93–X95, Y22–Y24, Y35.0

Cause of Death	ICD-9	ICD-10
Firearm homicide	E965.0–E965.4	*U01.4, X93–X95
Firearm suicide	E955.0–E955.4	X72–X74
Motor vehicle traffic	E810–E825	V02–V04, V09.0, V09.2, V12–V14, V19.0–V19.2, V19.4–V19.6, V20–V79, V80.3–V80.5, V81.0–V81.1, V82.0–V82.1, V83–V86, V87.0–V87.8, V88.0–V88.8, V89.0, V89.2
Pedestrian (nontraffic)	E800.2, E801.2, E802.2, E803.2, E804.2, E805.2, E806.2, E807.2, E820.7, E821.7, E822.7, E823.7, E824.7, E825.7, E826.0, E827.0, E828.0, E829.0	V01.0, V02.0, V03.0, V04.0, V05, V06, V09.0, V09.1, V09.3, V09.9
Suffocation	E911–E913.9, E953.0–E953.9, E963, E983.0–E983.9	W75–W84, X70, X91, Y20
Suicide	E950–E959	*U03, X60–X84, Y87.0
Unintentional injuries	E800–E869, E880–E929	V01–X59, Y85–Y86

... Category not applicable.

Population Denominators and Race Reporting

Population denominators are based on Census data. The 2003 revision of the U.S. Standard Certificate of Death uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003 revision permits reporting of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with 2018 data, all 50 states and the District of Columbia have adopted the 2003 certificate. Prior to 2018 data, to provide uniformity and comparability of data for trend comparison, bridged race categories were presented. Therefore, data for race groups for 2018 and subsequent years are not comparable with earlier data. The bridged population estimates can be found online at https://www.cdc.gov/nchs/nvss/bridged_race.htm. Prior to *America's Children, 2003*, rates were based on populations estimated from the 1990 Census.

For more information about these methodologies, see:

- Anderson, R. N., & Arias, E. (2003). The effect of revised populations on mortality statistics for the United States, 2000. *National Vital Statistics Reports, 51*(9). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_09.pdf
- Ingram, D. D., Weed, J. A., Parker, J. D., Hamilton, B. E., Schenker, N., Arias, E., & Madans, J. (2003). U.S. Census 2000 population with bridged race categories. *Vital Health*

Statistics, 2(135). National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/bridged_race.htm

- National Center for Health Statistics. (2015, November 6). Comparability of cause-of-death between ICD revisions. https://www.cdc.gov/nchs/nvss/mortality/comparability_icd.htm

For more information on national mortality data, see the following:

- National Center for Health Statistics. (2004). *Technical appendix. Vital statistics of the United States, 1999: Mortality*. <https://www.cdc.gov/nchs/data/statab/techap99.pdf>
- Xu, J., Murphy, S. L., Kochanek, K. D., & Arias, E. (2021). Deaths: Final data for 2022. *National Vital Statistics Reports*, 74(4). National Center for Health Statistics. <https://dx.doi.org/10.15620/cdc/174588>

Information about NVSS deaths data is available online at <https://www.cdc.gov/nchs/nvss/deaths.htm>.

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National Vital Statistics System—Natality

The National Center for Health Statistics' (NCHS's) National Vital Statistics System (NVSS) collects and publishes data on births in the United States. NCHS obtains information from the registration offices of all states, New York City, and the District of Columbia. The birth certificate must be filed with the local registrar of the district in which the birth occurs. Each birth must be reported promptly; the reporting requirements vary from state to state, ranging from 24 hours to as many as 10 days after the birth. Demographic information on birth certificates, such as race and ethnicity, is provided by the mother at the time of birth. Hospital records provide the base for information on birthweight.

Population Denominators and Race Reporting

Population denominators are based on Census data. The 2003 revision of the U.S. Standard Certificate of Live Birth uses revised race and ethnicity sections conforming to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. The 2003 revision permits reporting

of more than one race (multiple races). In 2003, states began adopting this new certificate on a rolling basis. Starting with 2016 data, all 50 states and the District of Columbia have adopted the 2003 certificate. For data before 2016, bridged-race categories were presented to provide uniformity and comparability of data over time. Therefore, data for race groups for 2016 onwards are not comparable with earlier data. The bridged population estimates can be found online at https://www.cdc.gov/nchs/nvss/bridged_race.htm. Prior to *America's Children, 2003*, rates were based on populations estimated from the 1990 Census.

For more information about these methodologies, see the following:

- Hamilton, B. E., Sutton, P. D., & Ventura, S. J. (2003). Revised birth and fertility rates for the 1990s and new rates for Hispanic populations, 2000 and 2001: United States. *National Vital Statistics Reports*, 51(12). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_12.pdf
- Ingram, D. D., Weed, J. A., Parker, J. D., Hamilton, B. E., Schenker, N., Arias, E., & Madans, J. (2003). U.S. Census 2000 population with bridged race categories. *Vital and Health Statistics*, 2(135). National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/bridged_race.htm
- Matthews, T. J., & Hamilton, B. E. (2019). Total fertility rates by state and race and Hispanic origin: United States, 2017. *National Vital Statistics Reports*, 68(1). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_01-508.pdf
- Ventura, S. J., Hamilton, B. E., & Sutton, P. D. (2003). Revised birth and fertility rates for the United States, 2000 and 2001. *National Vital Statistics Reports*, 51(4). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_04.pdf

For more information on national natality data, see the following:

- Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C. P. (2024). Births: Final data for 2022. *National Vital Statistics Reports*, 73(2). National Center for Health Statistics. <https://dx.doi.org/10.15620/cdc:145588>

Information about NVSS births data is available online at <https://www.cdc.gov/nchs/nvss/births.htm>.

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Safe Drinking Water Information System

The Safe Drinking Water Information System (SDWIS) is the national regulatory compliance database for the drinking water program of the U.S. Environmental Protection Agency (EPA). SDWIS includes information on the nation's more than 148,000 public water systems and data submitted by states and EPA regions in conformance with reporting requirements established by statute, regulation, and guidance.

The EPA sets national standards for drinking water. These requirements take three forms: maximum contaminant levels (MCLs; the maximum allowable level of a specific contaminant in drinking water), treatment techniques (specific methods that facilities must follow to remove certain contaminants), and monitoring and reporting requirements (schedules that utilities must follow to report testing results). States report any violations of these three types of standards to the EPA.

Water systems must monitor for contaminant levels on fixed schedules and report to the EPA when a maximum contaminant level has been exceeded. States also must report when systems fail to meet specified treatment techniques. More information about the maximum contaminant levels can be found online at <https://www.epa.gov/ground-water-and-drinking-water/table-regulated-drinking-water-contaminants>.

The EPA sets minimum monitoring schedules that drinking water systems must follow. These minimum monitoring schedules (states may require systems to monitor more frequently) vary by the type and size of the drinking water system, the source water (surface water or ground water), and contaminant. For example, at a minimum, all drinking water systems regularly monitor nitrate; community water systems that serve surface water monitor daily for turbidity; and ground water systems may monitor inorganic contaminants every 9 years.

SDWIS includes data on the total population served by each public water system and the state in which the public water system is located. However, SDWIS does not include the number of children served. In this report, the fractions of the population served by noncompliant public water systems in each state were estimated using the total population served by violating community water systems divided by the total population served by all community water systems. The numbers of children served by violating public water systems in each state were estimated by multiplying the fraction of the population served by violating public water systems by the number of children (ages 0–17) in the state.

Information about SDWIS is available online at <https://www.epa.gov/enviro/sdwis-overview>.

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Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) was developed in 1990 to monitor health risk behaviors and experiences that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States.

The YRBSS includes national, state, and local school-based surveys of representative samples of 9th- through 12th-grade students. These surveys are conducted every 2 years, usually during the spring semester. The national Youth Risk Behavior Survey (YRBS), conducted by the Centers for Disease Control and Prevention, provides data that are representative of high school students in public and private schools in the United States. The state and local surveys, conducted by departments of health and education, typically provide data that are representative of public high school students in each state or local school district. Survey procedures for the national, state, and local surveys are designed to protect students' privacy by allowing for anonymous and voluntary participation. Before survey administration, local parental permission procedures are followed. Students complete the self-administered questionnaire during one class period and record their responses directly on an electronic device, computer-scannable booklet, or answer sheet.

For the 2023 national YRBS, the sampling frame consisted of all public and private schools with students in at least one of grades 9–12 in the 50 states and the District of Columbia. A three-stage cluster sample design produced a nationally representative sample of students in grades 9–12 who attend public and private schools. All students in selected classes were eligible to participate. Schools, classes, and students that refused to participate were not replaced. In 2023, 20,103 questionnaires were completed in 155 schools. The school response rate was 73%, and the student response rate was 71%. The overall response rate (school response rate multiplied by the student response rate) was 35.4%.

Information about the YRBSS, including the 2023 national YRBS, is available online at <https://www.cdc.gov/yrbs>.

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