



Maternal, Child, and Adolescent Health

The health of mothers, infants, and children is important, both as an indicator of population health and as a predictor of the next generation's health. Maternal and child health (MCH) indicators include those that affect pregnant and postpartum women, as well as the health and survival of their infants and children. This section covers key MCH indicators: infant mortality, low birth weight, prenatal care, births to teenagers, immunizations, and dental health.

Characteristics of Live Births

The average number of live births in Alameda County was 22,080 per year from 2000 to 2001. The birth rate has stabilized since 1995 at approximately 15.2 live births per 1,000 people in 2001. During the period 2000 to 2001, nearly 60% of all

births occurred among Whites and Latinos (29.0% and 28.7%, respectively), followed by Asians (24.5%), and African Americans (14.2%). A small remainder was to American Indians, Native Hawaiians/Other Pacific Islanders, those who identified themselves with two or more races, and others.

The highest birth rates were among Native Hawaiian/Other Pacific Islanders and Latinos (24.2 and 23.1 per 1,000 people, respectively). Mothers of two or more races had the lowest birth rate of all groups (6.3 per 1,000).

A majority of the births (73.2%) were to mothers 20 to 34 years of age. Over 7% of the births were to teenage mothers (19 and under), and 19.3% were to those 35 years and older.

In 2000, nearly half the births in Alameda County (47.8%) were to foreign-born mothers. Almost 81% of those giving birth had a high school degree. One out of four births was funded by Medi-Cal.

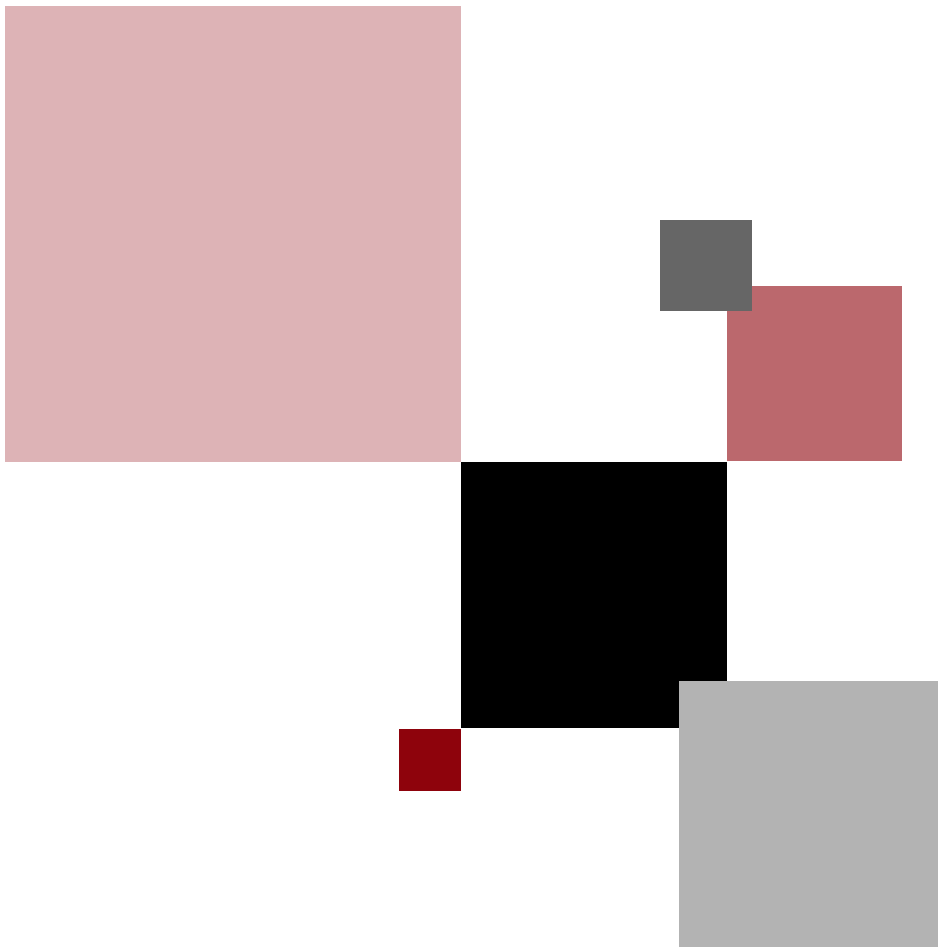
Figure 2A.1

Select Characteristics of Live Births to Alameda County Residents

2000-2001 Average Number of Births=22,080

	Births	%	Birth Rate*
Birth Rate by Year			
1990	23,315	—	18.1
1995	20,441	—	15.2
2000	22,164	—	15.4
2001	21,995	—	15.2
Race/Ethnicity of Mother			
African American	3,142	14.2%	14.9
American Indian	57	0.3%	10.7
Asian	5,401	24.5%	18.5
Latina	6,335	28.7%	23.1
Native Hawaiian & Other Pacific Islander	205	0.9%	24.2
White	6,407	29.0%	10.8
Two or more Races	357	1.6%	6.3
Other/ Unknown/ Withheld	177	0.8%	37.9
Age of Mother (years)			
19 and under	1,662	7.5%	—
20-34	16,166	73.2%	—
35 and older	4,252	19.3%	—
Mother 12 yrs education	17,446	80.9%	—
Medi-Cal Delivery	5,671	25.7%	—

*Birth rates are births per 1,000 population.



Infant Mortality

What is it?

Infant mortality is the death of a child less than one year of age. The infant mortality *rate* is the number of deaths of children less than one year old per 1,000 live births.

Why is it important?

Infant mortality is an important indicator of the health status of a community. It signifies the general health status of new mothers and their ability to access prenatal care.

Nationally, the infant mortality rate has declined steadily over the last decade, from 9.2 per 1000 live births in 1990 to 6.9 in 2000.¹ About half of all infant deaths are attributable to four causes: birth defects, disorders related to pre-term births and low birth weight, sudden infant death syndrome (SIDS), and maternal complications of pregnancy.²

Higher rates of infant mortality are associated with: young age of mother (<17 years), older age of mother (>43 years), substance abuse by mother, pre-term birth, low birth weight, exposure to second hand smoke, inadequate prenatal care, infections and other complications during pregnancy.³

What is Alameda County's Status?

The infant mortality rate in Alameda County in 2000 was 4.6 per 1,000 live births. This rate is only slightly higher than the new Healthy People 2010 national objective of no more than 4.5 infant deaths per 1,000 live births.

Alameda County's infant mortality rate is lower than California's and similar to those in neighboring counties.⁴

The infant mortality rate in Alameda County has declined significantly in the last decade, from 8.9 deaths per 1,000 live births in 1990 to 4.6 in 2000. A similar trend has been seen in every racial/ethnic group, as it has in the state as a whole.

The infant mortality rate among African Americans was 8.5 per 1,000 live births, two times the rate among Latinos and Whites (4.0 and 3.7, respectively).

Figure 2B.1

Infant Mortality Rate
Selected Counties and California, 2000

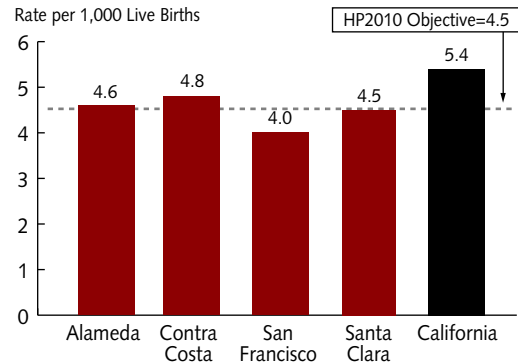


Figure 2B.2

Infant Mortality Rate
Alameda County and California, 1990-2000

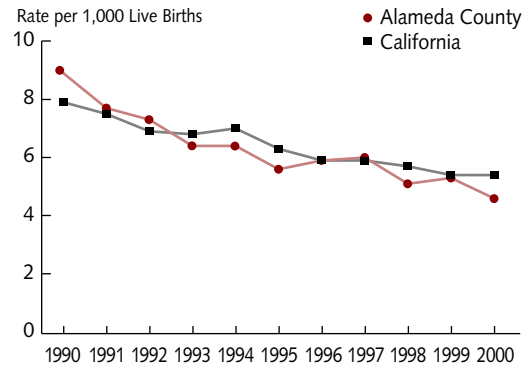


Figure 2B.3

Infant Deaths by Race/Ethnicity
Alameda County, 2000

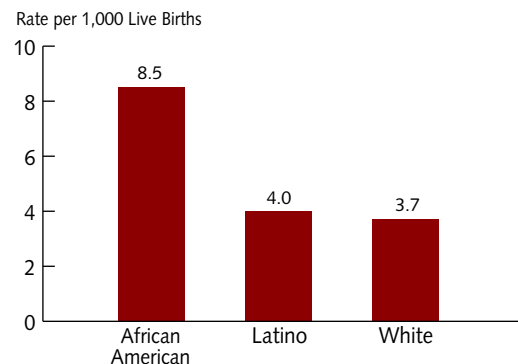
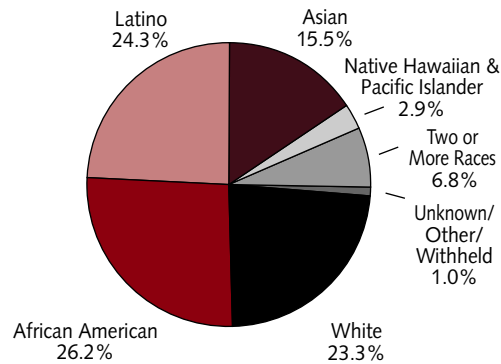


Figure 2B.4

Infant Deaths by Race/Ethnicity
Alameda County, 2000

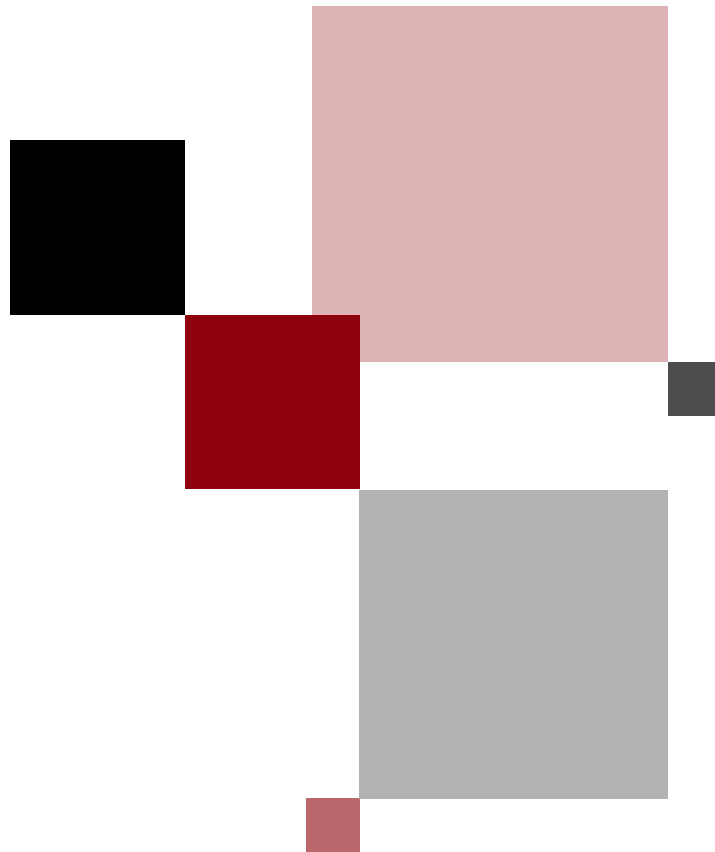


Total Infant Deaths = 103

In 2000, 103 Alameda County infants died before their first birthday. Nearly two-thirds of these deaths (66) occurred during the neonatal period, the first 27 days of life. The remaining one-third occurred during the post-neonatal period, from 28 days to one year after birth.

Of the infants who died, 26.2% were African American, 24.3% Latino, 23.3% White, 15.5% Asian, and 2.9% Native Hawaiian and Other Pacific Islander. Nearly 7% of the infants were identified as two or more races.

On average, during the years 1999 and 2000, nearly half of all infant deaths were attributable to four causes: 24.5% were related to birth defects, 10.4% for each of low birth weight and SIDS, and 4.2% for respiratory distress syndrome.



Low Birth Weight

What is it?

Infants weighing less than 2,500 grams (5 lbs 8 oz) at birth are considered low birth weight (LBW).

Why is it important?

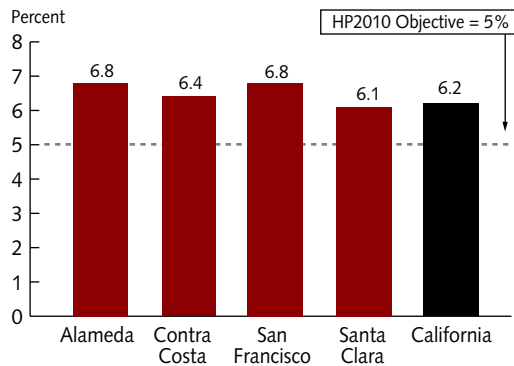
Achieving a healthy weight is crucial for a newborn's survival. Low birth weight is the most com-

mon cause of death during the neonatal period, the first 28 days of life. Thus, improvements in infant birth weight can contribute substantially to reducing infant mortality. In addition, low birth weight infants who survive their first year are at greater risk of long-term physical and developmental complications than are infants of normal birth weight.

Many factors increase the risk of low weight at birth. Most important among these are pre-term delivery, maternal smoking and illicit drug use, poor maternal nutrition, young maternal age, low maternal educational attainment, low family income, late or no prenatal care, and pregnancy-associated hypertension.^{3, 5}

Figure 2C.1

Percent Low Birth Weight
Selected Counties and California, 1998-2000 Average



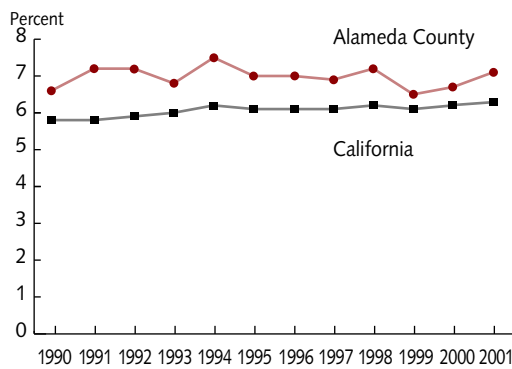
What is Alameda County's Status?

Based on a three-year average, 1998-2000, the rate of low birth weight in Alameda County was 6.8%, one of the highest rates among California's 58 counties.⁷ This rate exceeds the Healthy People 2010 national objective of no more than 5%.³

More recent data (2000-2001) show that an average of 6.9% (1,525) of the 22,080 live births in the county were low birth weight. Of the low birth weight births, 276 (18%) were very low birth weight (<1,500 grams).

Figure 2C.2

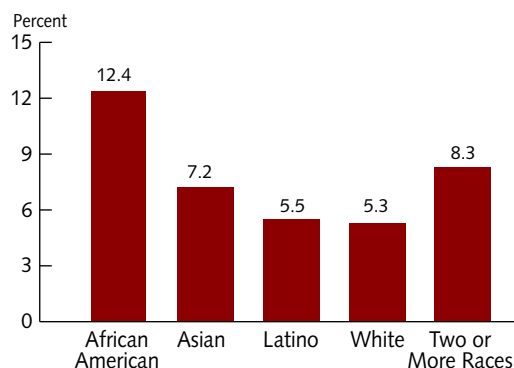
Percent Low Birth Weight
Alameda County and California, 1990-2001



During the 1990s, the proportion of low birth weight births remained relatively stable in Alameda County at approximately 7%, a rate consistently higher than the state rate of approximately 6%.

Figure 2C.3

Percent Low Birth Weight by Race/Ethnicity
Alameda County, 2000-2001 Average

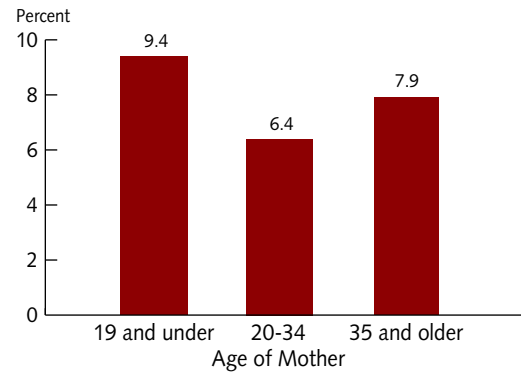


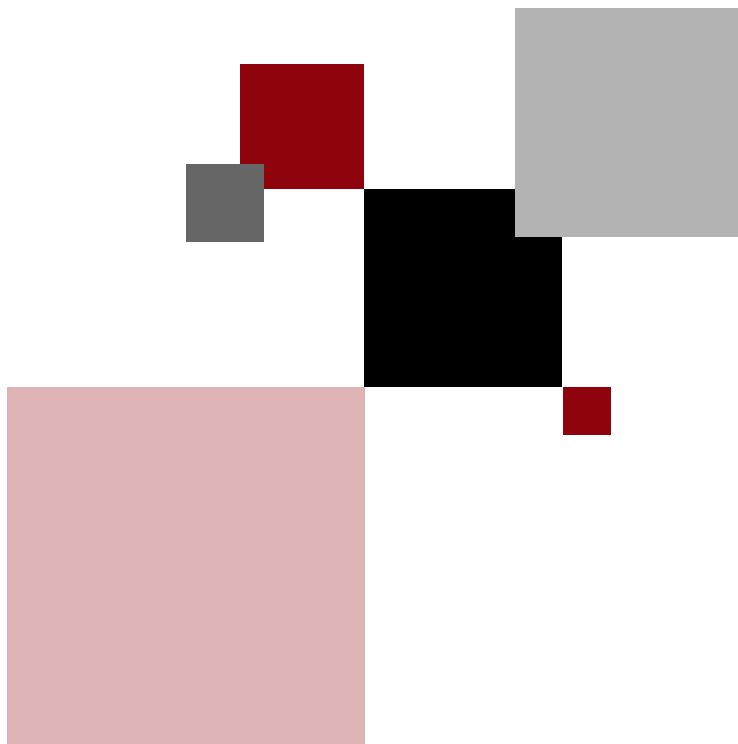
African Americans had the highest percentage of low birth weight births from 2000 to 2001 (12.4%), followed by those of two or more races (8.3%), Asian (7.2%), Latino (5.5%) and White (5.3%).

As a group, teen mothers 19 years of age and under had the highest percentage of low birth weight births (9.4%), followed by mothers 35 years of age and older (7.9%).

Figure 2C.4

Percent Low Birth Weight by Age of Mother
Alameda County, 2000-2001 Average





Prenatal care

What is it?

Prenatal care refers to pregnancy-related health care provided to a woman during pregnancy. It is recommended that a woman start receiving prenatal care in the first trimester (first 3 months) of her pregnancy.

Why is it important?

The use of timely, high-quality prenatal care can

help prevent poor birth outcomes by identifying treatable medical conditions, such as hypertension and sexually transmitted diseases, which may endanger the mother and/or fetus. Entry into prenatal care also provides an opportunity for education and intervention around diet and exercise, in addition to behavioral risks such as alcohol, tobacco and other drug use.

Risk factors for late entry into prenatal care include lack of culturally appropriate pregnancy testing sites, teenage pregnancy, less than a high school education, and a large number of children. Domestic violence, cultural beliefs, drug abuse, single parenthood, and poverty may also prevent women from receiving timely prenatal care.⁶

What is Alameda County's Status?

For the period 1998 to 2000, an average of 89.0% of the pregnant women in Alameda County began prenatal care during the first trimester.^a This percentage is higher than California's rate of 83.5%, and it is very close to the Healthy People 2010 national objective of at least 90.0%. Both Alameda and Contra Costa Counties rank second in the state for the highest percentage of pregnant women who enter prenatal care in the first trimester.⁷

Since 1990, there has been a gradual upward trend in Alameda County toward early entry into prenatal care. The proportion of pregnant women entering prenatal care in the first trimester increased from 82.0% in 1990 to 89.2% in 2001. A similar pattern is evident at the state level.

Between 1990 and 2001, the percentage of women who entered prenatal care in the first trimester increased among all racial and ethnic groups in the county. The increase was greatest among African American and Latina women.

For the period 2000 to 2001, Whites had the highest rate of early prenatal care (93.6%), followed by Asians (90.3%). Both groups met the the Healthy People 2010 national objective of at least 90%. Native Hawaiians and Other Pacific Islanders had the lowest rate of early entry into prenatal care (73.3%).

Women 35 years of age and older were most likely to start prenatal care during the first trimester (92.6%), whereas teenagers aged 19 and under were least likely (76.4%) to obtain timely prenatal care.

Figure 2D.1

First Trimester Entry into Prenatal Care
Selected Counties and California, 1998-2000 Average

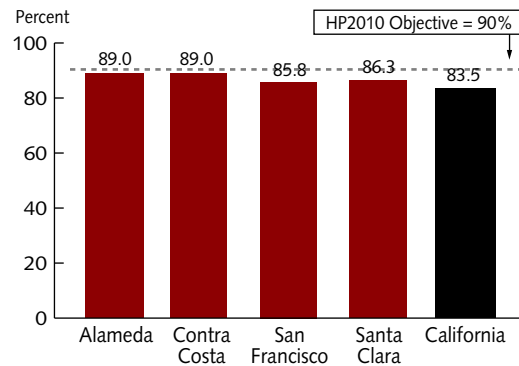


Figure 2D.2

First Trimester Entry into Prenatal Care
Alameda County, 1990-2001

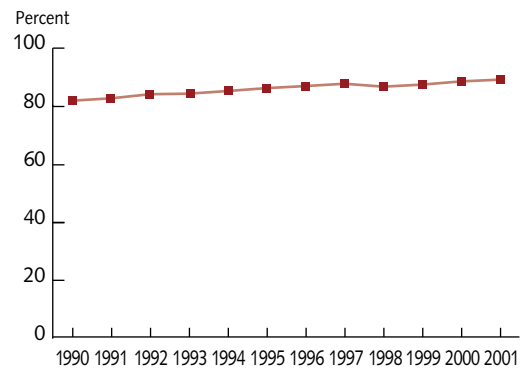
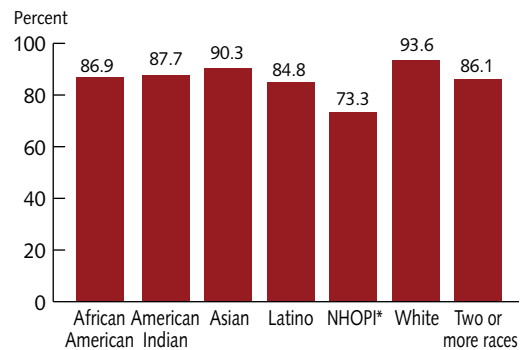
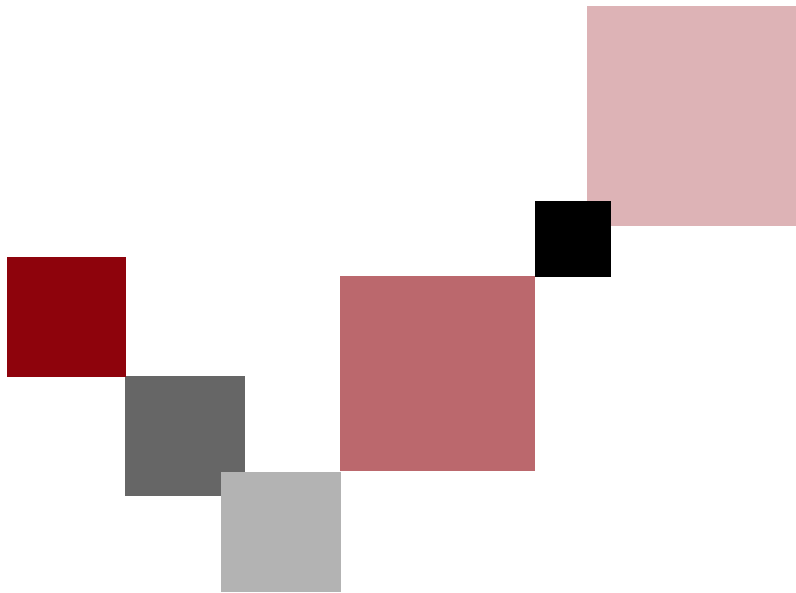


Figure 2D.3

First Trimester Entry into Prenatal Care
by Race/Ethnicity
Alameda County, 2000-2001 Average



*Native Hawaiian/Other Pacific Islander



Births to Teens

What is it?

The teen birth rate is defined as the number of live births to mothers aged 15-19 years per 1,000 females 15-19 years of age in the population. The percentage of teen births is defined as the number of births to mothers aged 15-19 years per 100 live births.

The number of teen births is not the same as the number of teen pregnancies. It is estimated that 51% of teen pregnancies end in birth, 35% in abortion and 14% in miscarriage.⁸ Thus the teen pregnancy rate may be twice the teen birth rate.

Why is it important?

Teen mothers typically have more difficulty completing their education, have fewer employment opportunities, and are more likely to require public assistance and to live in poverty than their peers. They also are at high risk for poor birth outcomes and for having another pregnancy while still in their teens. Infants born to teen mothers are at greater risk of child abuse, neglect,

and behavioral and educational problems at later stages.

Adolescence is a time of increased vulnerability to social influences, which may seriously compromise the health of young people. This time is characterized by experimentation, risk-taking, and an increased dependence on peers. Youth are at significant risk for unplanned pregnancies and sexually transmitted diseases.⁹ Unintended pregnancies are serious and costly. With an unwanted pregnancy, a teenager is less likely to seek prenatal care in the first trimester, and is more likely to expose the fetus to harmful substances such as tobacco or alcohol.

Nationally, the birth rate for U.S. teenagers declined steadily throughout the 1990s, from 62.1 births per 1000 females 15-19 years in 1991 to 48.5 in 2000. In fact, the decline in teen birth rates during the last decade was seen in every state in the nation.⁵

Many factors increase the risk for teen pregnancy. Among the most important are poor access to birth control and health care in general, low income, lack of financial and emotional support, lack of education/positive role models, unsatisfactory adult relationships, lack of after school and community activities, substance abuse, and low self-esteem.⁸

What is Alameda County's status?

From 1998 to 2000, the average rate of birth to teens 15-19 years of age in Alameda County was 37.7 per 1,000 females, higher than in neighboring counties but lower than the state rate of 50.3 per 1,000 females 15-19 years.⁷

Reflecting state and national trends, the teen birth rate among 15 to 19 year-olds in Alameda County declined steadily during the years 1990 to 2001, from 55.7 to 34.5 births per 1,000 females in that age group.

Latinas 15-19 years of age had the highest teen birth rate in Alameda County (73.8 per 1,000) followed by African Americans (63.8). Birth rates in both these groups were three to five times higher than teen birth rates among Asians, Whites, and those of two or more races.

Figure 2E.1

Birth Rates for Teenage Females 15-19 Years of Age Selected Counties and California, 1998-2000 Average

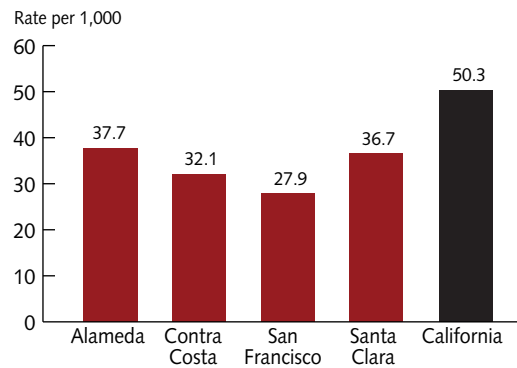


Figure 2E.2

Birth Rates for Teenage Females 15-19 Years of Age Alameda County, 1990-2001

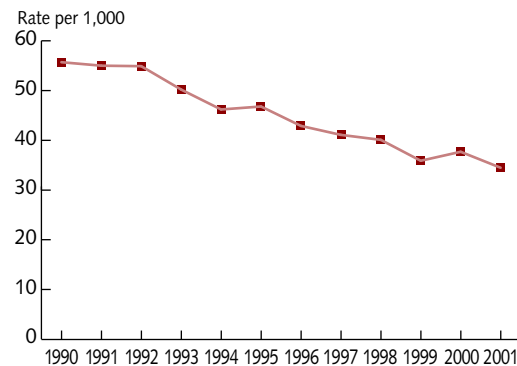
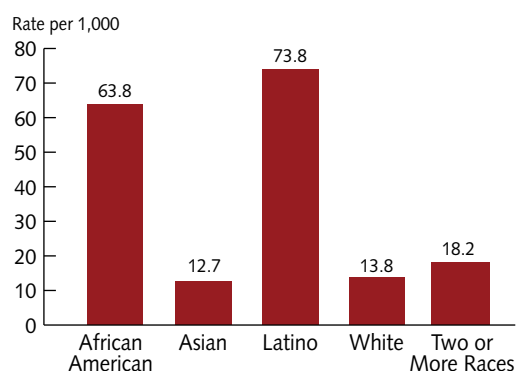


Figure 2E.3

Birth Rates for Teenage Females 15-19 Years of Age by Race/Ethnicity, Alameda County, 2000-2001 Average





Childhood Immunization

What is it?

Immunizations are given to children to protect them from serious infectious diseases. California requires that children be up-to-date on their shots before enrolling in licensed child-care programs, kindergarten, and 7th grade.

Why is it important?

The reduction in incidence of infectious diseases is the most significant public health achievement of the past 100 years, and vaccination has played a key role in this progress. Immunization continues to be an important safe guard for child health. It is one of the safest and most effective preventive measures ever known. However, many infants do not start immunizations on time or complete the entire series.

Vaccines are the first-line of defense against dis-

eases such as polio, measles, pertussis and hepatitis. These biological substances cause the immune system to produce an immune response that is very similar to that produced by the natural infection, yet does not subject a person to “full blown” disease or complications. Vaccines not only protect the immunized individual, but the community as well. When immunization levels in a community are high, the few who cannot be vaccinated are protected because they are surrounded by immune people, thus their risk of exposure to disease is low. This phenomenon is called *herd immunity*.

Each year, the Immunization Branch of the State Department of Health Services conducts a survey of kindergartens within each county throughout the state. This survey is called the *Kindergarten Retrospective Survey*. It uses immunization records of kindergarten students at age five to estimate the percent of children who were up-to-date when they were two years old. Therefore, the 2002 retrospective survey of kindergarten students at age five is in fact estimating the immunization levels among two-year olds in 1999.

What is Alameda County's status?

According to estimates from the 2002 *Kindergarten Retrospective Survey*, 73.6% of Alameda County children were fully up-to-date on their immunizations by two years of age. This is similar to the statewide immunization rate of 72.2%, but is significantly below the Healthy People 2010 national objective of at least 90%.³ The immunization rate in the larger Bay Area is estimated to be 79.1%

During the period 1998 to 2002, the percentage of kindergarteners fully up-to-date on immunizations at age two improved from 60.0% in 1998 to 73.6% in 2002.

The percentage of fully immunized kindergarteners varied across racial/ethnic groups. The 2002 Kindergarten Retrospective Survey showed that African American children had the lowest rates of immunization (55.0%), followed by Latino children (65.5%), White children (78.7%), and Asian/Pacific Islanders children (86.7%). None of the groups have met the Healthy People 2010 national objective of at least 90%.

Figure 2F.1

Percent of Kindergarteners with Up-to-Date Immunizations at 2nd Birthday
Alameda County, 1998-2002

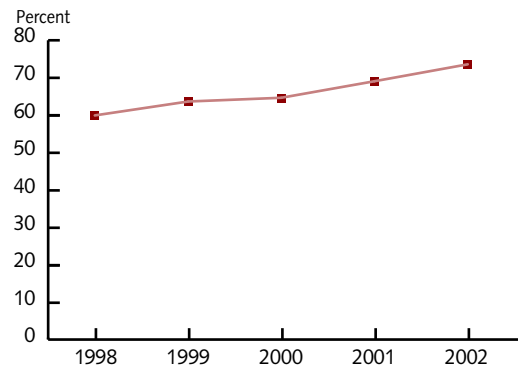
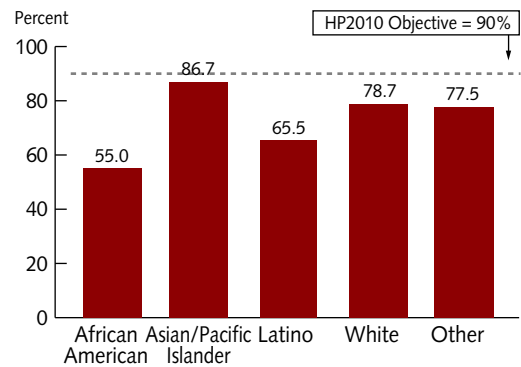
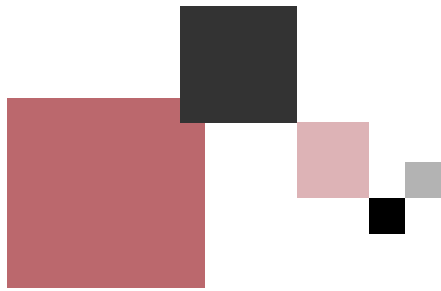


Figure 2F.2

Percent of Kindergarteners with Up-to-Date Immunizations by Race/Ethnicity,
Alameda County, 2002





Dental Caries

What is it?

Dental caries, or tooth decay, is the most common of all chronic and infectious diseases. It is caused by the bacteria, *Streptococcus mutans*. Foods such as refined carbohydrates or simple sugars can produce acidic plaque that feeds the bacteria and, over time, causes tooth decay.

Early Childhood Caries (ECC) (also called Baby Bottle Tooth Decay) is a rapidly developing form of dental cavities affecting the baby teeth as soon as they erupt at 6-12 months of age. ECC is caused by frequent and prolonged exposure to milk, formula, juices or other sweet drinks in bottles.

Pit and Fissure Decay is the most common type of dental caries among school age children 5-17 years of age, accounting for 80% of all tooth decay in this age group. Pit and Fissure Decay primarily affects the chewing surfaces of molar teeth.

Why is it important?

Dental caries, both treated and untreated, is a pervasive public health problem affecting the quality of life for young children and others not able to care for themselves. Its impact can be measured in both human and economic terms: unnecessary pain and suffering, absence from school and work, difficulty speaking and chewing, and diminished self-esteem. It has even resulted in *failure to thrive* in the very young. In more extreme cases treatment is traumatic and costly. Dental caries has its greatest impact on

the very young, the elderly, the poor, minorities, and others who experience geographic, linguistic, or cultural barriers to accessing care.

The most recent figures available on the oral health of California's children come from the *California Oral Health Needs Assessment of Children* conducted in 1993-1994.¹⁰ There has never been a similar assessment in Alameda County, so we rely on state-level figures.

The *California Oral Health Needs Assessment* estimated that 27% of California preschoolers in urban areas with fluoridated water supplies (the type most common in Alameda County) have untreated tooth decay. The estimate jumps to 44% among preschool children from low income families. Among children 6-8 years of age, 36% may have untreated tooth decay. These levels of untreated tooth decay are substantially higher than those seen nationally.³

Dental caries is almost entirely preventable. Key strategies for the primary prevention of dental caries include fluoridated water (or fluoride supplements where community water is not fluoridated) and dental sealants. Community water fluoridation is the most cost effective means of delivering fluoride ion to our teeth. Topical fluoride may be applied directly to teeth by a dental professional, or it may be self-applied through the use of toothpaste with fluoride. Dental sealants, which are applied by dental professionals, prevent Pit and Fissure Decay and are best applied as soon as molars erupt into the mouth at ages 6-8 and 12-14 years.

Individuals can prevent tooth decay by reducing the amount and type of foods that cause tooth decay and by thorough cleaning with a toothbrush and dental floss. Tooth decay among infants and young children can be prevented by encouraging healthy parental feeding practices.

What is Alameda County's status?

To estimate the number of children in Alameda County with untreated tooth decay, we used the percentages of untreated tooth decay found by the *California Oral Health Needs Assessment* among children in urban areas with fluoridated water supplies.¹⁰

Latino and African American children from 2-5 years of age had the highest levels of untreated tooth decay in California (44.0% and 42.5%, respectively), followed by Asians (22.9%) and Whites (5.7%). For all races combined, 26.7% had untreated tooth decay. This figure is higher than the national estimate of 16.0% and three times higher than the Healthy People 2010 national target of no more than 9% of preschoolers with untreated tooth decay.^b

For school children 6-8 years of age, Asians had the highest levels of untreated tooth decay (55.5%), followed by Latinos (49.3%), African Americans (40.0%), and Whites (21.2%). For all races combined, 36.6% had untreated tooth decay. This figure is well above both the national estimate of 29.0% and the Healthy People 2010 national target of no more than 21% of children ages 6-8 with untreated tooth decay.^b

Based on these percentages approximately 21,500 children ages 2-5 in Alameda County have untreated tooth decay, and 23,000 children ages 6-8 have untreated tooth decay. In total, 44,500 children between 2 and 8 years of age are estimated to have untreated tooth decay in Alameda County. The true numbers may well be higher since one area of the county has a water supply that is not fluoridated. The magnitude of these numbers clearly suggests the need for an oral health needs assessment of Alameda County children in order to verify the level of need and address the gaps in dental health care.

Figure 2G.1

Percent of Preschool Children with Untreated Tooth Decay
Urban, Fluoridated Areas, California, 1993-1994

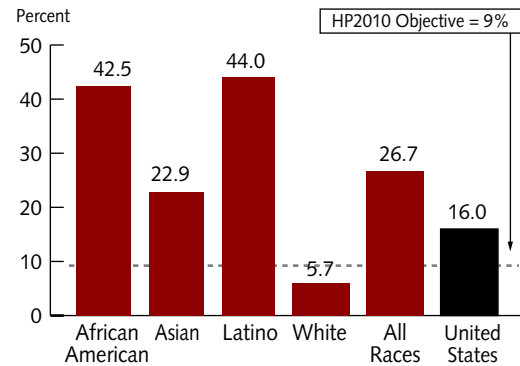
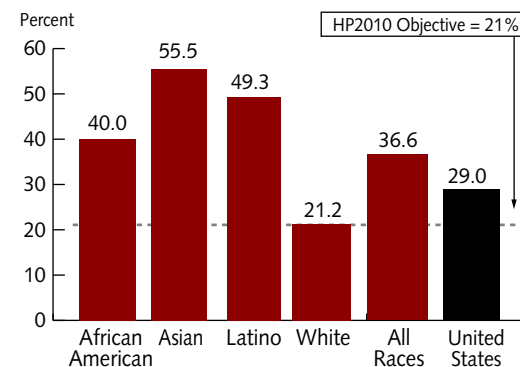


Figure 2G.2

Percent of Children Ages 6-8 with Untreated Tooth Decay
Urban, Fluoridated Areas, California, 1993-1994



*What are we doing?***Maternal, Child, and Adolescent Health**

The Maternal, Child, and Adolescent Health (MCAH) Program in the Family Health Services Division, Alameda County Public Health Department (ACPHD), provides a coordinated local effort to improve outreach and case finding activities for pregnant women and children including early and continuous perinatal, infant, and child care. The Program works to ensure the best possible start in life for infants and children in Alameda County. It does this through a variety of activities aimed at increasing prenatal care and preventing low birth weight, infant death and teen pregnancy:

- The Improving Pregnancy Outcomes Program (IPOP) offers case management services for eligible pregnant and parenting women to reduce infant mortality and improve pregnancy outcomes. The Black Infant Health (BIH) Program targets the African American community in its efforts to reduce premature birth and infant mortality through improving access to a comprehensive set of services for at-risk women and their children up to two years of age. The BIH program also works with local prenatal care providers to make education and resource materials available to those they serve regarding the need for adequate prenatal care, healthy lifestyle choices, and signs and symptoms of pre-term labor.
- The MCAH Program offers culturally appropriate perinatal outreach and education for women, infants and families through a multicultural Health Information Team. The aim is to encourage early entry into prenatal care and substance use cessation in addition to other healthy behaviors. The Program also provides referrals to the Women, Infants and Children (WIC) Program. The Family Care Network targets at-risk pregnant women and new mothers for HIV/AIDS prevention.
- The MCAH Program works with other county agencies and service providers to develop and implement a Countywide Strategic Plan for

addressing perinatal substance abuse and its effects. The program aims to reduce barriers to substance abuse treatment among pregnant women.

- The MCAH Program provides technical assistance and training to Comprehensive Perinatal Services Program (CPSP) providers to ensure they are providing prenatal care according to state regulations, as well as identifying and enrolling Medi-Cal eligible women.
- MCAH, through a Community Challenge Grant, works in partnership with Oakland schools, after-school programs, and in neighborhoods to provide health education, mentoring, and youth leadership opportunities to adolescents. The aim is to reduce the rates of teen births with the focus on abstinence, birth control, refusal skills, access to health care, and healthy relationships. The Grant also provides resources for a Regional Collaborative of youth health care providers and community members. This group has an additional health policy focus to improve access to care and health education for adolescents.
- The MCAH Program works with Alameda County delivery hospitals to conduct the Sudden Infant Death Syndrome (SIDS) Risk Reduction campaign. The Fetal Infant Mortality Review (FIMR) Program works with local agencies in a broad-based, comprehensive case review process to better understand and prevent fetal and infant deaths. The Child Care Health Linkages Program works with childcare providers, other health care providers and other community based organizations to decrease childhood injury and mortality through increased caregiver education and awareness.

Immunizations

The Immunization Assistance Project in the Division of Communicable Disease Control and Prevention, ACPHD, provides education and targeted outreach to families and community groups; training and technical assistance to physicians, nurses, and medical assistants; disease investigation and surveillance; vaccine distribu-

tion and management; and immunizations to children, adolescents, and seniors at risk of under-immunization. The Project also operates an immunization registry. Computerized assessments of the immunization status of two-year old children are conducted each year in county clinics and community health centers. The immunization status of children in childcare centers and kindergarten is monitored annually.

Dental Health

The Office of Dental Health in the Community Health Service Division, ACPHD, has organized a variety of age-related interventions designed to address both the primary and secondary prevention of dental caries. In brief, these include the following: *Healthy Kids*, *Healthy Teeth*, Early Childhood Caries Initiative for 0-5 year old Medi-Cal enrollees; the *California Children's Dental Disease Prevention Program*, which provides sealants and dental education in a school-based setting; *The Healthy Smiles Children's Dental Treatment Program* for children who require dental care and have no insurance; and *Dental Health Referral Services* for people of all ages who need dental referrals and information.

What else do we need to do?

- Promote full participation in Medi-Cal and other insurance options in order to assure access to prenatal care and vital medical and support services by providing information and advocacy services that increase enrollment.
- Develop and implement programs that would offer health services for women before and during pregnancy. Participate in action-oriented community processes that lead to improvement of services and resources for women, infants and families of Alameda County.
- Collaborate with local obstetric providers and delivery hospitals to prevent preterm labor through intensive patient education. Collaborate with community agencies to develop and implement aggressive outreach programs targeting

high-risk pregnant women.

- Target high-risk geographic areas for intensive parent education including parenting skills, safety precautions, nutrition, and healthy lifestyles.
- Increase the number and capacity of school based clinics and other youth-centered clinics to provide primary care, referrals, counseling, health education, and youth development services to both adolescent boys and girls.
- Increase outreach and education to young men to provide job training, health education, and other types of classes to improve personal relationships and promote anger management and responsible fatherhood.
- Collaborate with public and private organizations to conduct a representative County-wide Oral Health Needs Assessment at 3-year intervals in order to 1) measure oral/dental health, 2) evaluate prevention and intervention efforts, 3) make comparisons with state and national data.
- Expand successful elements of the *Healthy Kids*, *Healthy Teeth* Demonstration project to other low income families beyond those enrolled in Medi-Cal.
- Continue the *Healthy Smiles* Dental Treatment Program strengthening outreach and follow-up services to facilitate access to care and insurance resources.
- Actively support the statutory change that would require Child Health and Disability Program physicians to refer all children beginning at age 1 to the dentist.

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Endnotes

^a Early prenatal care figures reported for Bay Area counties in Figure 2D.1 chart reflect slightly higher estimates of the percent of mothers receiving prenatal care in their first trimester of pregnancy than those shown in the remainder of the section. This is due to a small difference in how the California Department of Health Services computes the figures. The State's figures are based on a live birth count from which those with unknown prenatal care status were removed, yielding a higher estimate of early prenatal care.

^b The United States estimate of untreated tooth decay (16% among 2-5 year-olds and 29% among 6-8 year-olds) is not directly comparable to the California figures because they are from a health survey conducted during a different time period, 1988-1994, and they are based on the full sample. Water fluoridation and urban/rural status is not taken into account in the U.S. estimates. However, we would expect the observed differences between the California and U.S. figures to be even greater if the U.S. estimates were based on an urban sample with a fluoridated water supply.