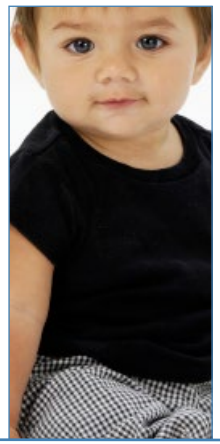
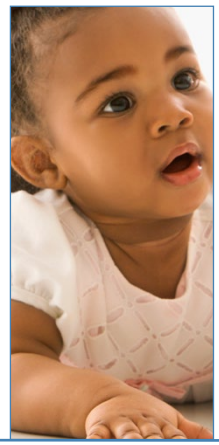
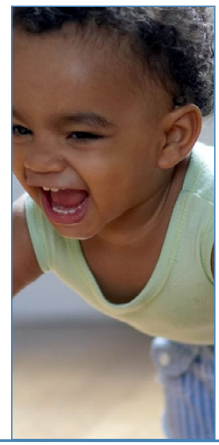
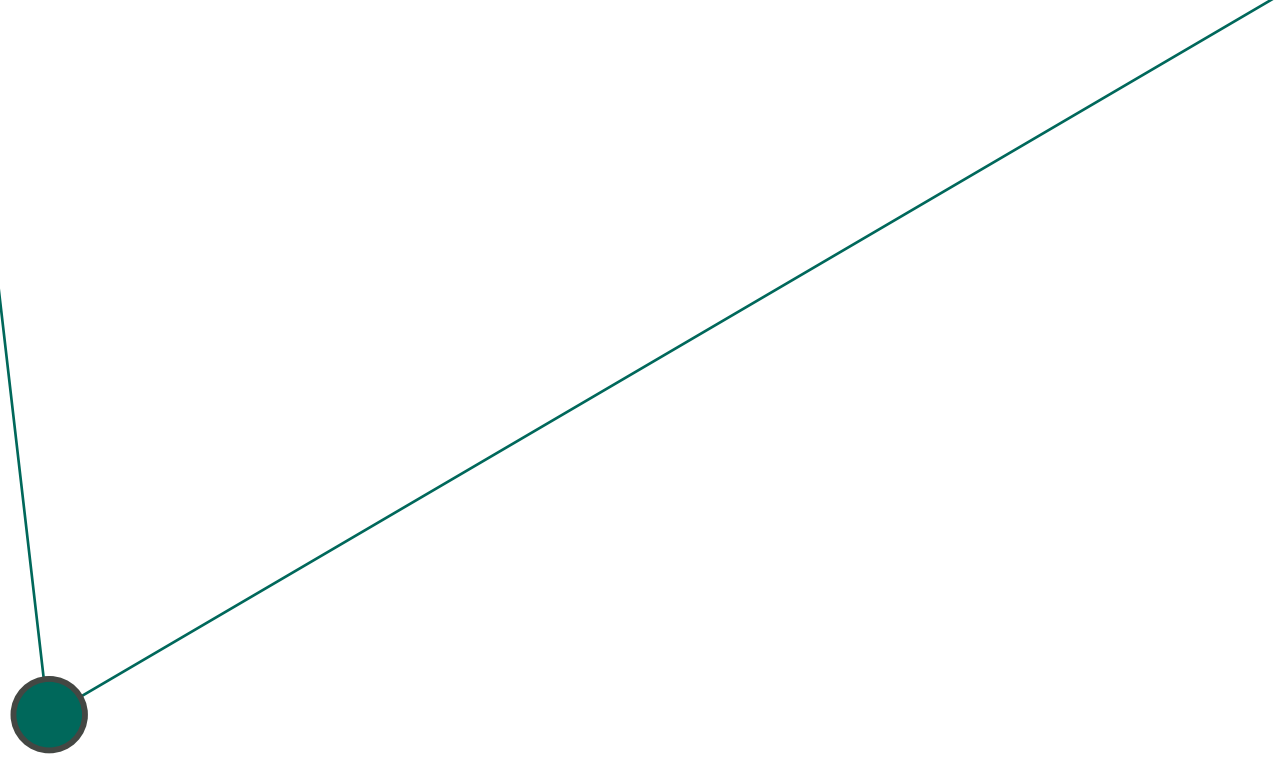
The *Youngest* Illinoisans:

A Statistical Look at Infants and Toddlers in Illinois

January 2014
by David Murphey, Mae Cooper, and Nicole Forry

ROBERT R. McCORMICK FOUNDATION
Child TRENDS



About Child Trends

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

Acknowledgements

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Contents

Key Findings

Illinois' youngest children—nearly half-a-million infants and toddlers—are at the leading edge of a demographic transformation. They herald a state, and a nation, more diverse with respect to race/ethnicity, country of origin, language, and family type than at any time in recent history.

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

Illinois' Bright Spots

- Illinois has an admirable record when it comes to **provision of health insurance** for its infants and toddlers, leaving only about two percent without coverage.
- **Preventive medical care,** particularly important for this age group, is received by nearly all.
- Compared with the national average, a smaller proportion of Illinois women miss getting **early prenatal care.**
- **Maternal mortality** in Illinois is significantly lower than the national average.

Economic Hardship

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

- **Nearly half** (45 percent) of Illinois' infants and toddlers **live in low-income families** (incomes less than twice the poverty line); one in five (20 percent) lives in a family below the official poverty line. In 2012, that threshold was $23,283 for a family of two adults and two children.
- **One in eight** (12 percent) **is living in deep poverty** (that is, their family's income is half or less than the poverty level).
- **Economic disadvantage is concentrated in the families of Illinois' black and Latino infants and toddlers**: two-thirds (62 and 66 percent, respectively) of these young children are in low-income families. Black infants and toddlers are six times as likely, and their Hispanic counterparts more than three times as likely, as whites are to live in areas of concentrated poverty
- **Nearly one-third (31 percent) of Illinois infants and toddlers live in households that are "food-insecure"** (a measure of inability to obtain sufficient healthy food), **or only "marginally secure."**

Multiple Inequities, Multiple Disadvantages

- **Black infants in Illinois are only half as likely as whites to survive to their third birthday.** Rates of low birthweight (a condition strongly associated with multiple adverse outcomes) are twice as high among black babies as among whites. Black children (through age 17) have the highest rates of substantiated maltreatment, among the tabulated racial/ethnic groups. Black infants and toddlers are nearly three times as likely as their white counterparts to be victims of homicide. They are three times as likely to suffer unintended fatal injuries.
- **Parents of nearly one in three Illinois infants and toddlers express concerns about their child that are indicative of developmental delays**. Illinois' young children face a higher-than-average risk of lead poisoning.
- A lower proportion of parents than in 2003 report their infants and toddlers are living in neighborhoods that are never or only sometimes safe. However, **nine percent of parents of Illinois infants and toddlers reported parental stress in 2011/12**, compared with seven percent nationally.
- **One in twelve of the youngest Illinoisans lives in a household where no adult speaks English only or very well, or no adult speaks English.**
- The deep inequities marked by income and race/ethnicity are often compounded by fragile family configurations. Increasing numbers of Illinois' youngest children (22 percent, in 2013) are raised by a single parent. A small but increasing number (17 percent) are in the care of grandparents. The available research tells us that these circumstances, on average, are riskier for children's optimal development. More troubling is that these children are also disproportionately in families where their parents or other caretakers are poor and poorly educated. The disadvantages of being poor, and with unmarried parents who lack the preparation that would allow them to join the middle class, converge for many of our youngest children, hobbling their progress virtually from their earliest days of life.

Introduction

Why focus on infants and toddlers?

The "achievement gap," variously identified as threatening our national performance in higher education, in high school graduation, third-grade reading achievement, or kindergarten readiness, in fact begins much earlier—in infancy.[1] The period of infancy and toddlerhood (conventionally defined as birth through two years of age) is a time of enormous potentiality. In all the major domains that comprise what it means to be human, development during this stage of life is rapid, dynamic, and keenly sensitive to inputs from the social, physical, and biological environments. Our knowledge of brain development, and of the complex interplay of genetic code and experience, has heightened appreciation of this time as one where fundamental predispositions (patterns of responses and behaviors), for better and worse, become established. These patterns can create trajectories of subsequent development that become increasingly resistant to change as children enter school-age, adolescence, and adulthood. Thus, the infant-and-toddler period is increasingly seen as the time during which opportunities to help set children on a path to flourish are greatest.

Unequal odds from the beginning.

To the extent that a society can be judged by how it cares for its most vulnerable members, the status of infants and toddlers can be taken as a measure of our commitment to human capital. Illinois has a great wealth of resources and, for many of its population, is able to provide top-flight medical care, excellent education, cutting-edge technology, and enviable recreational and cultural opportunities. However, progress as a state—and a nation—is, to a growing extent, held back by gaping disparities in opportunities and outcomes that jeopardize our productivity as well as our longstanding commitment to human rights.

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

Data on infants and toddlers.

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

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1 Halle, T., Forry, N., Hair, E., Perper, K., Wandner, L., Wessel, J., & Vick, J. (2009). Disparities in early learning and development: Lessons from the Early Childhood Longitudinal Study-Birth Cohort (ECLS-B). Washington, DC: Child Trends. Available at http://www.childtrends.org/Files/Child_Trends-2009_07_10_ES_DisparitiesEL.pdf

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

In this report, we present selected indicators that describe the status of infants and toddlers in the U.S. and Illinois. Where the data allow, we show trends for up to 10 years, in order to display a fuller picture of their direction. Of course, children in this group cannot report on their own well-being, so, apart from physiological measures, we must rely heavily on indicators that are indirect—for instance, information provided by parents.

National- and state-level data, however, if not further disaggregated, can obscure important differences among sub-groups of the population. These divides may fall along any number of lines—race, ethnic origin, immigration status, income, education, gender, region of the country, and so on. Understanding these is critical to understanding the origins, and perseverance, of the various achievement gaps. Therefore, as the data allow, we break out the indicator trends by one or more of these factors. In some cases, state data are not available, primarily due to insufficient sample size at that level. For those indicators, national-level data provide the best-available estimates, and may still be useful to states' understanding of the issues affecting their own youngest residents.

The structure of this report.

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

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

Our final section describes the extent to which Illinois' array of formal supports for the youngest children and their families—from both the private and public sectors—is meeting their needs. While seemingly removed from the daily lives of families, the spere of policy and practice wields a great deal of influence, whether by commission or omission.

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

What indicators can (and can't) do.

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

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

Notes on terminology.

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

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

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

Demographics

by the numbers

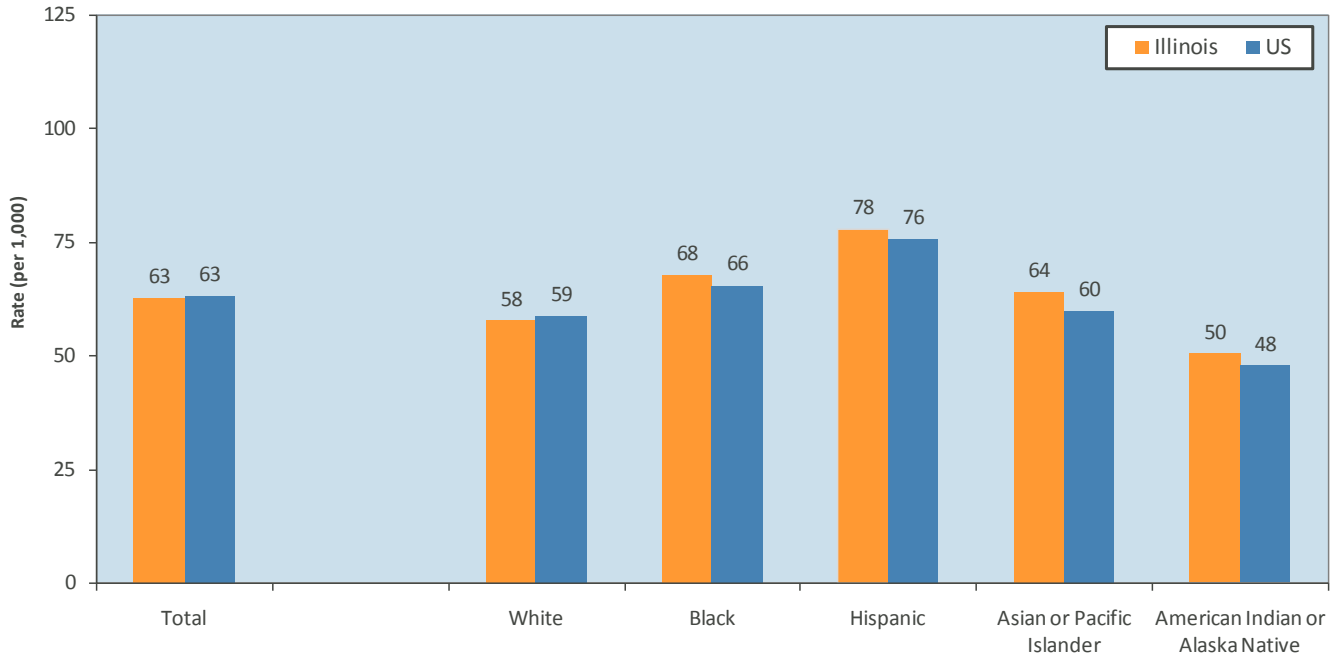
	Number	Percentage
Infants and toddlers: Total (2012)	486,360	
White	246,465	50.7
Latino	123,964	25.5
Black	74,083	15.2
Asian	23,365	4.8
Other	18,483	3.8
Living with one or more immigrant parents (2011)	120,861	25.7
Income & Poverty (2012)		
Living in low-income families	119,357	45.4
Living in non-low-income families	259,098	54.6
Living in poor families	96,022	20.2
Family structure (2013)		
Two parents	359,765	75.5
Single mother	94,906	19.9
Single father	10,743	2.3
No parent present	11,094	2.3
Living in grandparent-headed households (2011)	79,560	16.9

fertility

The U.S. fertility rate—the number of births per 1,000 women of childbearing age—is lower than at any time these data have been recorded. With fewer babies born, there are implications in a number of areas, not the least of which is a future workforce that will be smaller, yet responsible for supporting the needs of a growing elderly population.

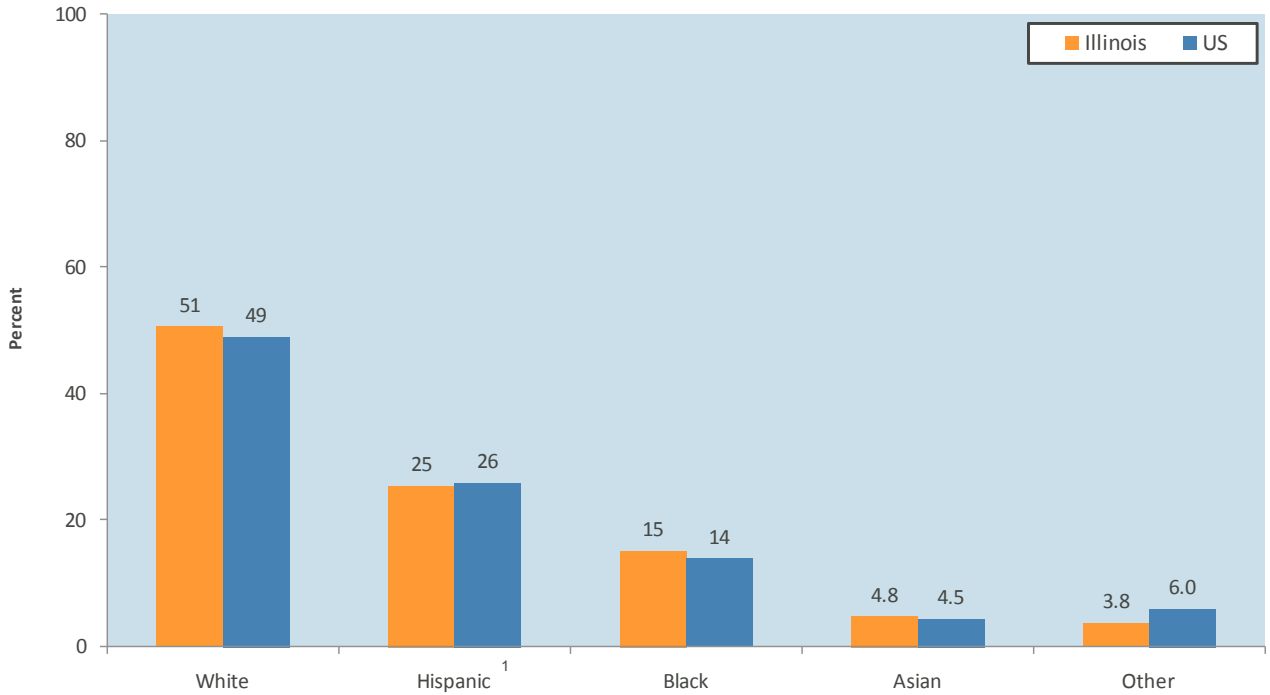
Illinois 2010 data closely track the national data; however, the state's fertility rates are slightly higher for non-white females.

Fertility Rates (per 1,000 women ages 15-44), by Race/Hispanic Origin, 2010



Sources: Number of births: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/. Population estimates: U. S. Census Bureau. (2012). *Intercensal estimtes (2000-2010): State.* Available at: http://www.census.gov/popest/data/intercensal/state/state2010.html.

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



number of children and selected sub-populations

[1] Hispanics may be any race

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

In 2012, Illinois infants and toddlers numbered just under half-a-million (486,000).

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

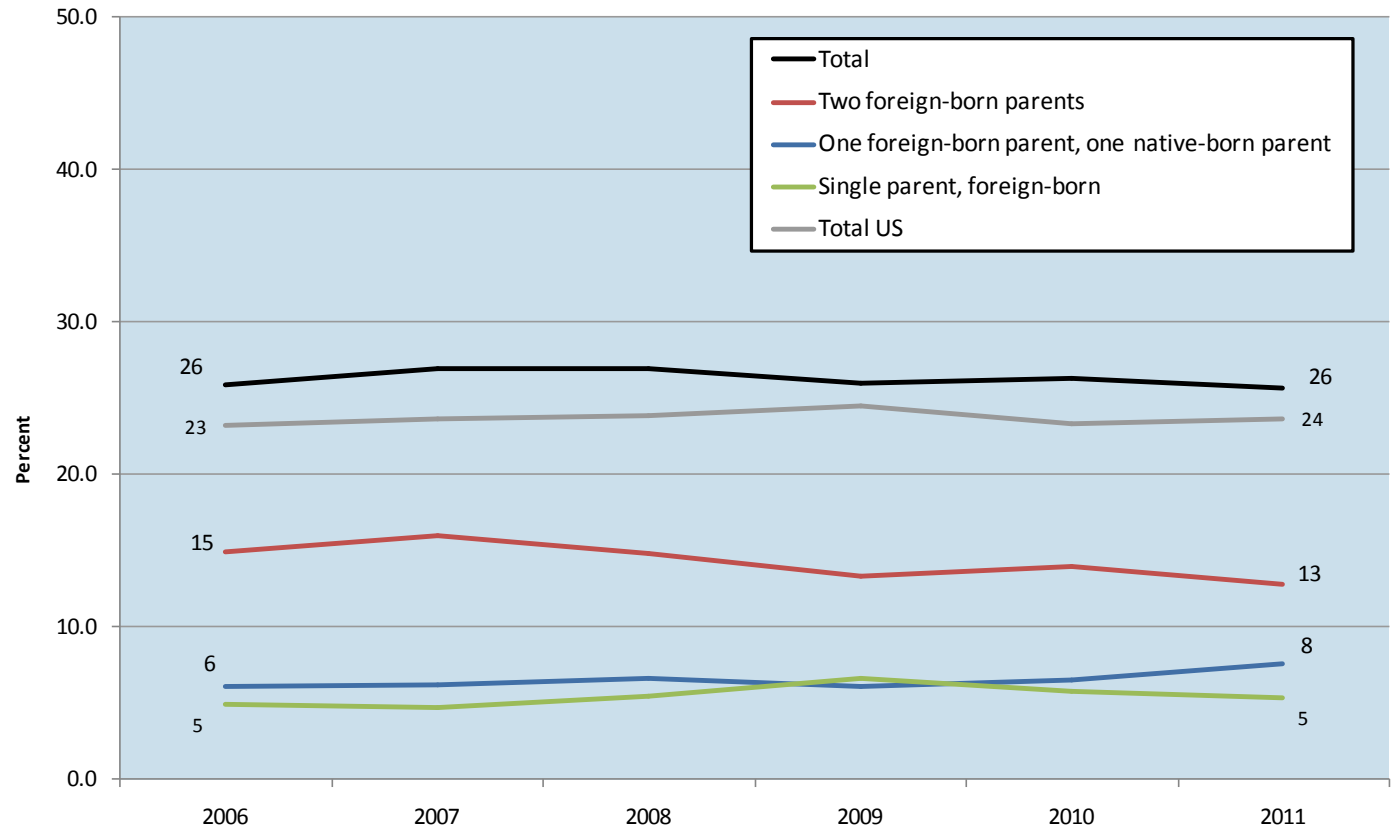
Illinois infants and toddlers reflect very closely the national pattern with respect to race and Latino origin: a bare majority (51 percent) is non-Latino white, followed by Latino (25 percent), black (15 percent), and Asian (five percent). Nearly four percent of infants and toddlers were of more than one race.

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

Ours has always been a nation of immigrants. Nationally, nearly six in ten of this group are Hispanic/Latino. Following an often-used definition of "immigrant children," as of 2011 more than one in four Illinois infants and toddlers had at least one parent who was born outside the U.S.

In Illinois, 13 percent of all infants and toddlers lived with two foreign-born parents; and five percent lived with one parent who was foreign-born. One in four immigrant children in Illinois is poor, and half (53 percent) live in low-income families.

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



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

poverty

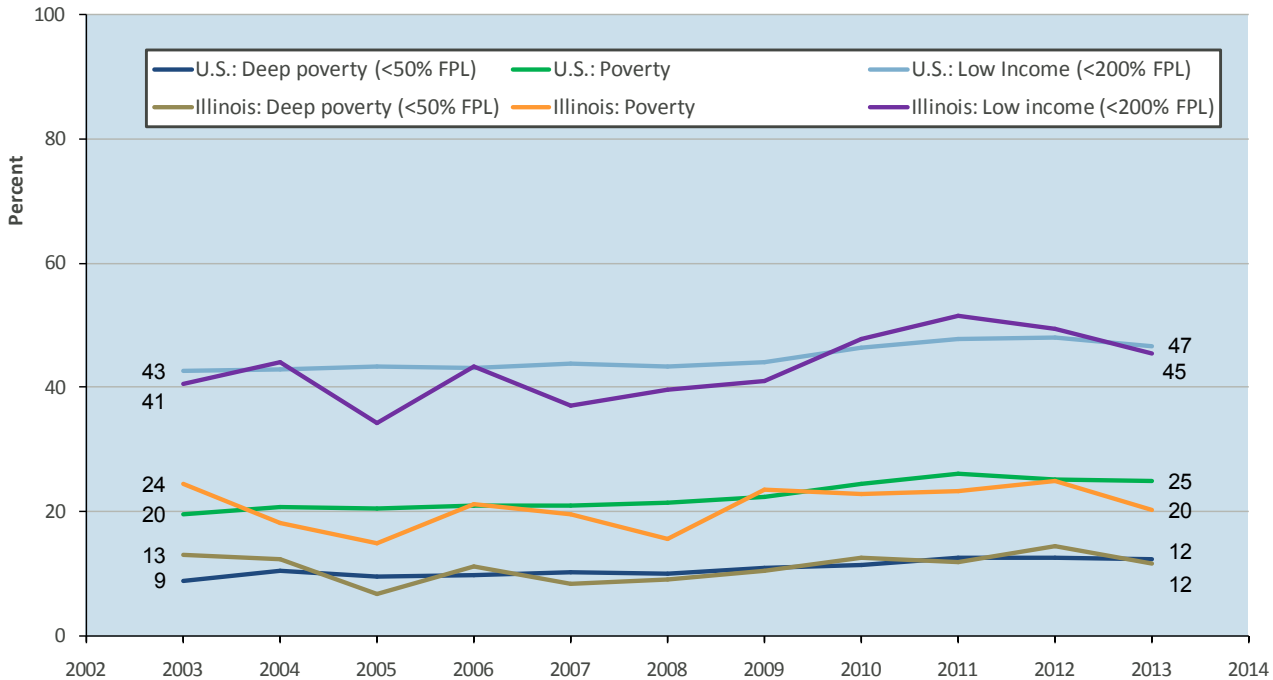
Children are the age group most likely to live in poverty, and the youngest children are even more likely to be poor, in part because their parents are often younger adults at the outset of their earnings careers.

As a group, Illinois infants and toddlers are slightly less poor than the national average: in 2013, about one in five (20 percent) were living in families in poverty; 45 percent of the under-three population were in low-income families; and about one in eight (12 percent) was in deep poverty.

There are stark differences in these figures by race and Hispanic origin: black and Latino infants and toddlers are more than twice as likely as whites to be in poverty, deep poverty, or in low-income families. More than two-thirds (67 percent) of the youngest Latino Illinoisans are in low-income families, and nearly as large a proportion (62 percent) of black infants and toddlers are. In relation to the poverty threshold itself, black infants and toddlers are the group most likely to be poor (31 percent), followed by Latinos (26 percent) and whites (14 percent).

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

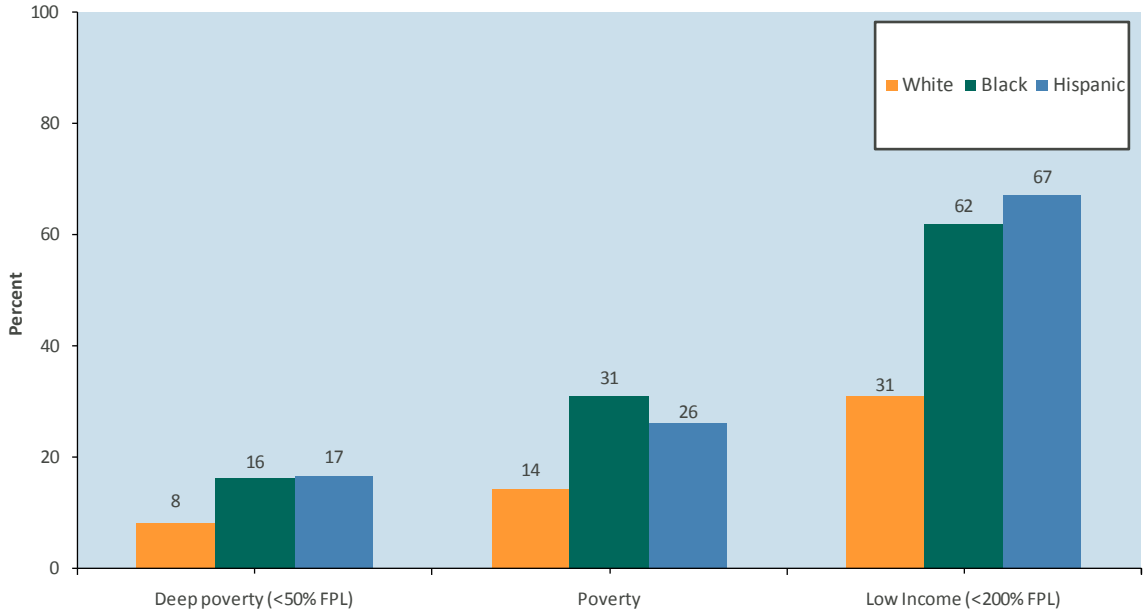
Percentage of Children, Ages Birth through Two, Living in Deep Poverty, Poverty, and with Low Income: Total US and Illinois, Selected Years, 2003-2013*



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

1 Evans, G. W. & Schamberg, M. A. (2009). Childhood poverty, chronic stress, and adult working memory. PNAS, 106(16), 6545-6549.
Melchior, M., Moffitt, T. E., Milne, B. J., Poulton, R., & Caspi, A. (2007). Why do children from socioeconomically disadvantaged families suffer from poor

Percentage of Illinois Children, Ages Birth through Two, Living in Deep Poverty, Poverty, and with Low Income, by Race and Hispanic Origin, 2013*



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

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

Conventionally, poverty in the U.S. is defined by income thresholds for families of varying sizes and configuration, annually updated by the Census Bureau. Though widely seen as flawed, the poverty measure remains the standard for most reporting, particularly for trend data.[3] Many experts believe that doubling the threshold figure provides a better estimate for the number of individuals who struggle to meet basic needs: children living in households with incomes less than 200 percent of the official poverty level are considered "low-income." Individuals who live with incomes less than half of the poverty level are considered to be in "deep" poverty. Occasionally, we will refer to the "near-poor" in relation to those with incomes above, but less than twice, the poverty level.[4]

health when they reach adulthood? A life-course study. American Journal of Epidemiology, 166(8), 3966-974.
Conroy, K., Sandel, M., & Zuckerman, B. (2010). Poverty grown up: How childhood socioeconomic status impacts adult health. Journal of Developmental & Behavioral Pediatrics, 31, 154-160.
Singh, G. K. & Siahpush, M. (2006). Widening socioeconomic inequalities in U.S. life expectancy, 1980-2000. International Journal of Epidemiology, 35, 969-979.

2 Frank, D. A., Casey, P. H., Black, M. M., Rose-Jacobs, R., Chilton, M., Cutts, D., March, E., Heeren, T., Coleman, S., Ettinger de Cuba, S., & Cook, J. T. (20110). Cumulative hardship and wellness of low-income, young children: Multisite surveillance study. Pediatrics, 125(5), ee1115-e1123.

3 For discussion of the limitations of the federal poverty measure, see Blank, R. M. & Greenberg, M. H. (2008). Improving the measurement of poverty (discussion paper 2008-17). The Brookings Institution. Available at: http://www.brookings.edu/research/papers/2008/12/poverty-measurement-blank.

4 In 2012, the poverty threshold for a family of two adults and two children was $23,283.

Child Health and Development

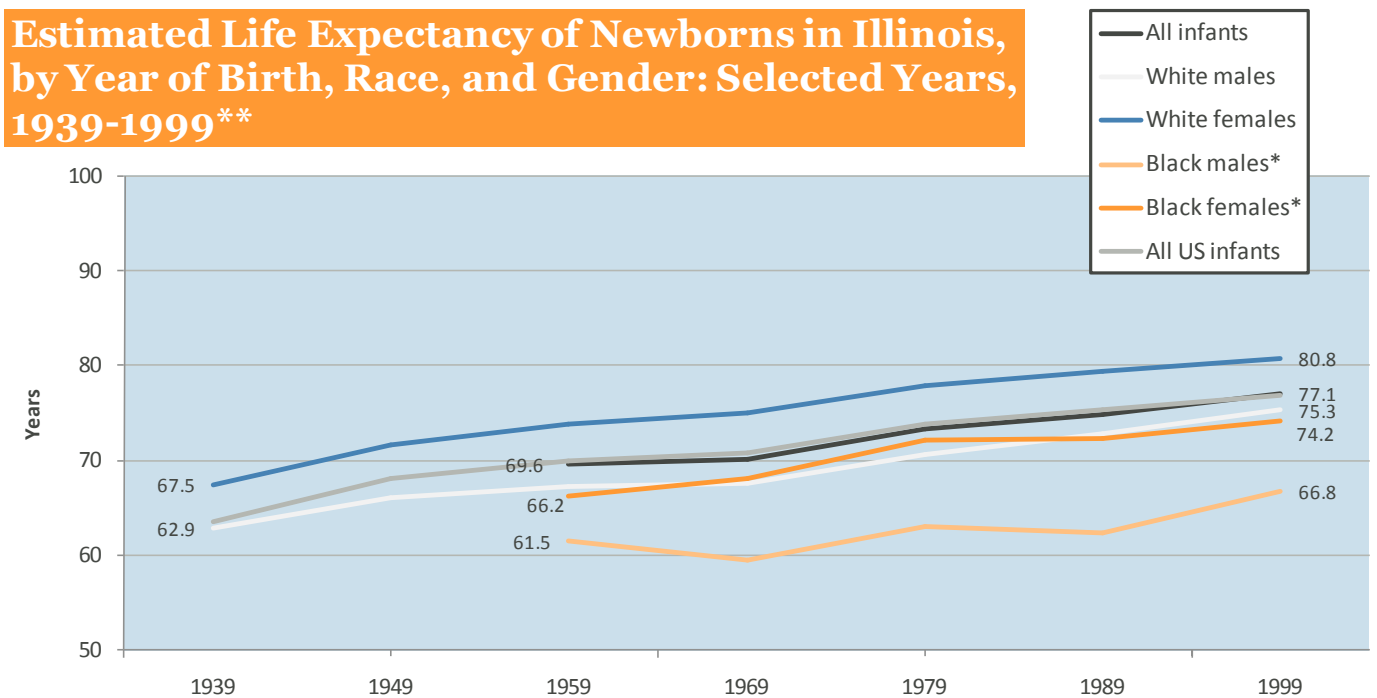
life expectancy

In Illinois, female babies were expected to live about six-and-a-half years longer than male babies in 2000. White infants were expected to survive, on average, seven-and-a-half years beyond their black counterparts. If we look just at survival until the third birthday, black infants are more than twice as likely as white infants are to not reach that milestone.

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

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

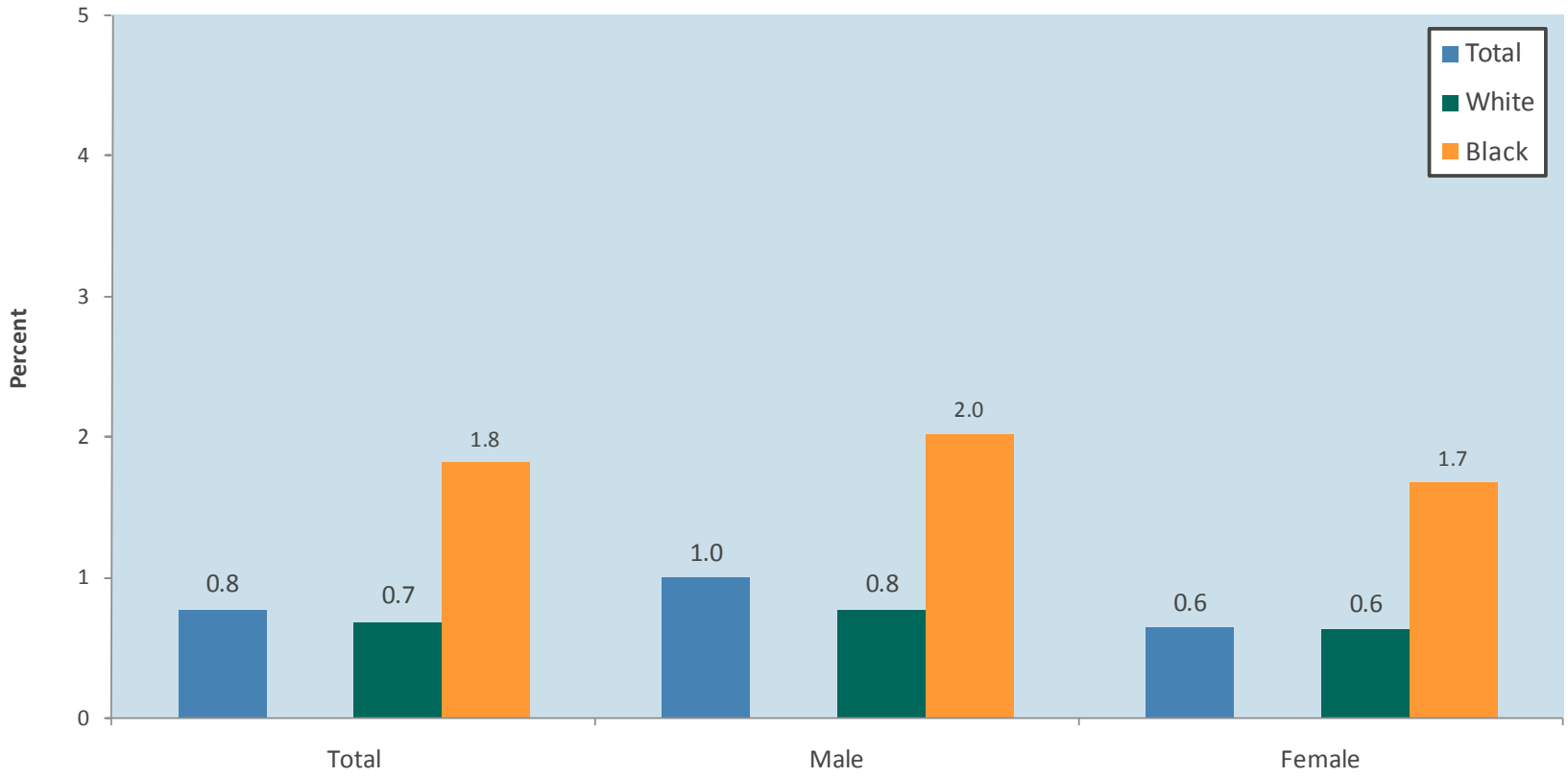
Estimated Life Expectancy of Newborns in Illinois, by Year of Birth, Race, and Gender: Selected Years, 1939-1999**



*Before 1979, data for "black" infants include all non-whites.
** Each data point is the average of three years of data, starting with the listed year.
Sources: Sources: Data for 1999-2001: Wei, R., Anderson, R. N., Curtin, L.R., Arias, E. (2012). U.S. decennial life tables for 1999–2001: State life tables. National vital statistics reports, 60 (9). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_09.pdf. Data for 1989-1991: National Center for Health Statistics. (1998). U.S. decennial life tables for 1989–91, vol II, State life tables no. 14, Illinois. Hyattsville, Maryland. Available at: http://www.cdc.gov/nchs/data/lifetables/life89il.pdf. Data for 1979-1981: National Center for Health Statistics. (1985). State life tables, Alabama-Wyoming. U.S. Decennial Life Tables for 1979-81, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life79ilacc.pdf. Data for 1969-1971: National Center for Health Statistics. (1975). Illinois: State life tables: 1969-71. U.S. Decennial Life Tables for 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life69_2_12-6.pdf. Data for 1959-1961: National Center for Health Statistics. (1966). Illinois: State life tables: 1959-61. Life Tables: 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life59_2_1-26.pdf. Data for 1949-1951: U. S. Department of Health, Education, and Welfare. (1956). State life tables: 1949-51. Vital Statistics-Special Reports 41(12). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life49-51_41supp.pdf. Data for 1939-1941: U. S. Public Health Service. (1948). State and regional life tables: 1939-41. Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life39-41.pdf.

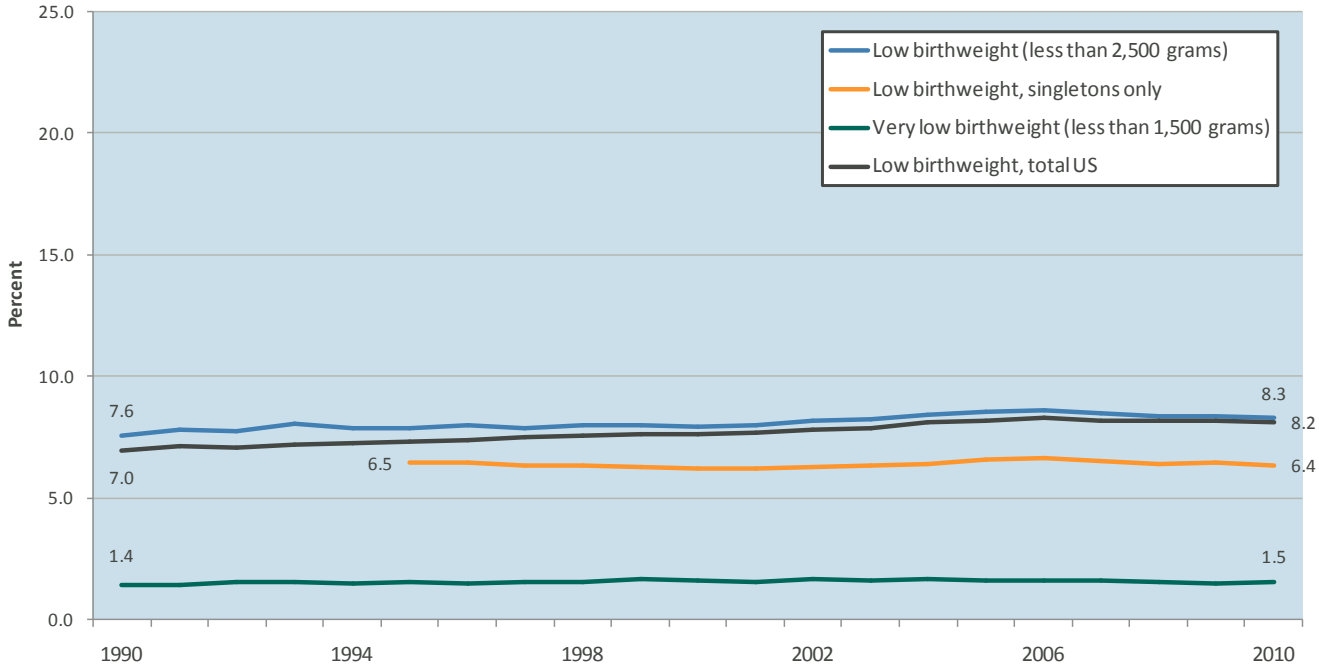
1 Child Trends DataBank. (2012). Life expectancy. Retrieved from http://www.childtrends.org/?indicators=life-expectancy
2 Ibid.

Of Infants Born in Illinois between 1999 and 2001, Percentage Expected to Die Before Reaching Age 3, by Race and Gender



Source: Derived from Wei, R., Anderson, R. N., Curtin, L.R., Arias, E. (2012). U.S. decennial life tables for 1999–2001: State life tables. *National vital statistics reports, 60* (9). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/dvs/le wk4_illinois.pdf

Percentage of Illinois Infants Born at a Low or Very Low Birthweight, 1990-2010



Sources: Sources: Data for 1990-1994: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Available at http://www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm Data for 1995-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

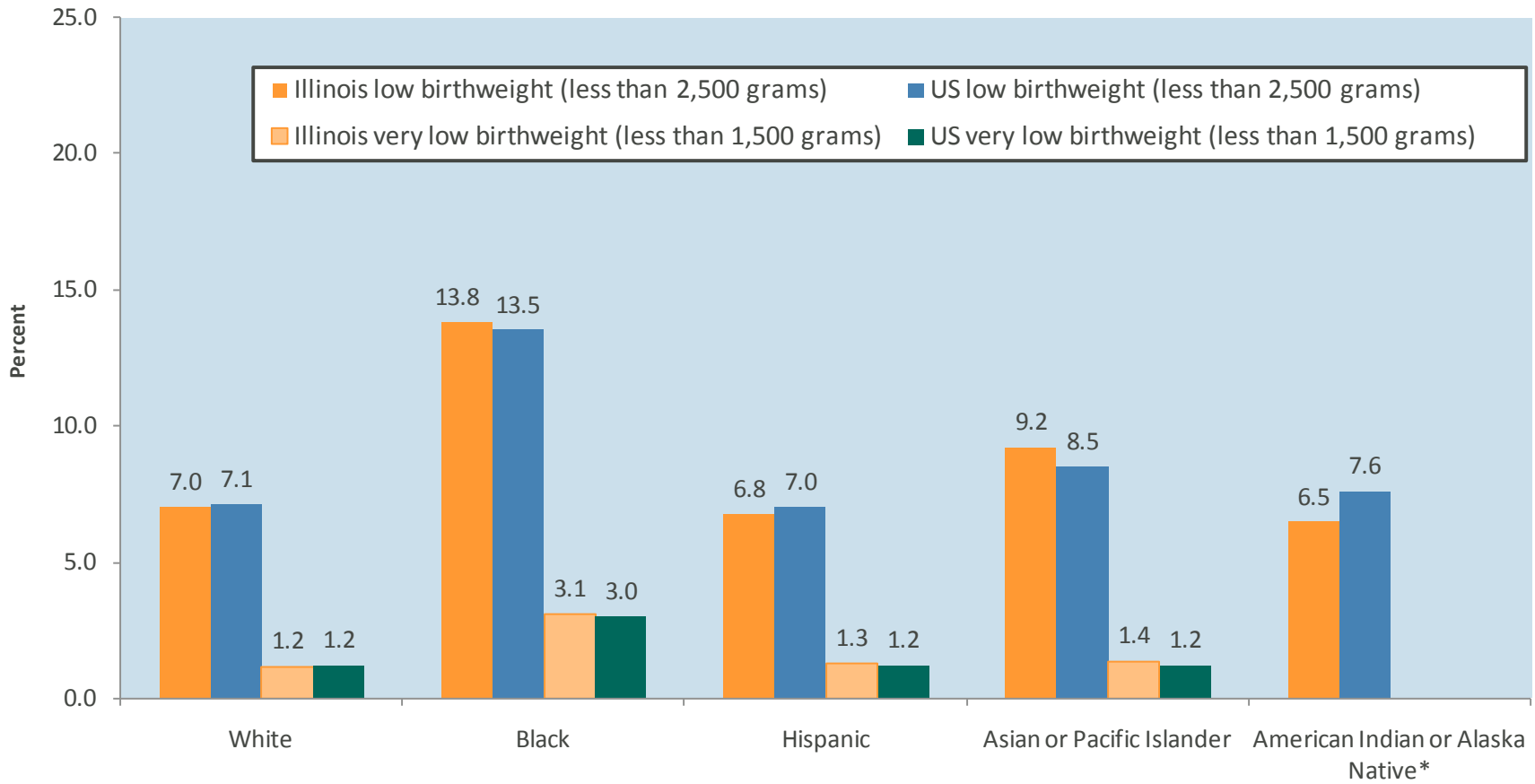
Low birthweight (defined as less than 5.5 pounds) is an indicator strongly associated with poor developmental outcomes in infancy, and even into adult life. Low weight is often associated with babies delivered pre-term, but can occur also with full-term births. According to research, a number of factors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

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

Black infants are more likely than Illinois babies of other races to have low birthweight. In 2010 (the most recent data available), 13.8 percent of black infants had low birthweight, compared with 6.5 percent of American Indian and Alaska Native, 6.8 percent of Hispanic infants, 7.0 percent of white, and 9.2 percent of Asian and Pacific Islander infants. Black infants are also more than twice as likely as other infants to be very low birthweight: 3.1 percent, compared with between 1.2 and 1.4 percent among the other major groups.

1 Child Trends DataBank. (2012). Low and very low birthweight infants. Retrieved from http://www.childtrends.org/?indicators=low-and-very-low-birthweight-infants
2 UNICEF. (2008). The State of the world's children 2008. Retrieved from http://www.unicef.org/publications/files/The_State_of_the_Worlds_Children_2008.pdf

Percentage of Infants Born at a Low Birthweight, by Race and Hispanic Origin, 2010



* Too few births for meaningful data on very low birthweight.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

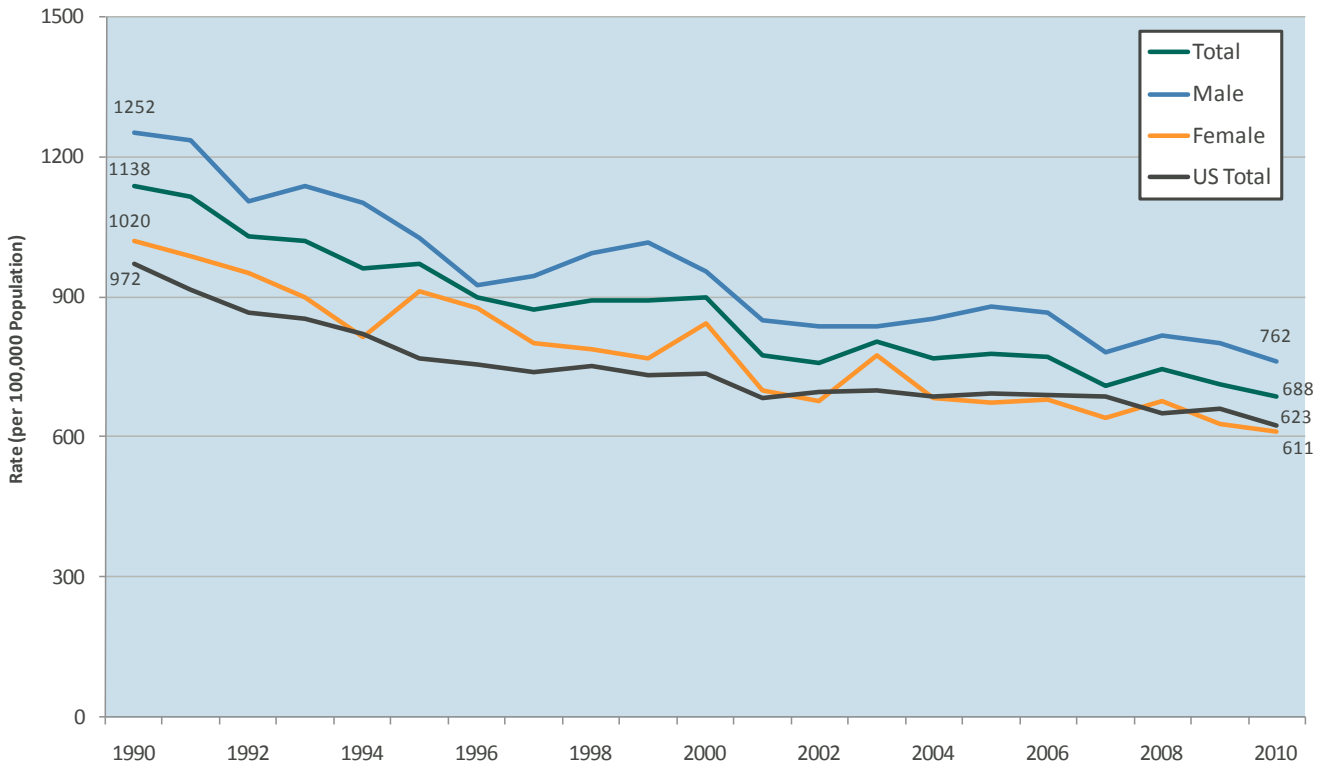
deaths among infants and toddlers

In 2010, Illinois was ranked 31st out of 51 states (where first is the lowest rate) for overall infant mortality, and, out of 36 states with significant black populations, Illinois was 28th for infant mortality among blacks, with 13.6 deaths per 100,000 live births.[1]

Children are much more likely to die during the first year of life than they are at older ages. For example, in 2010 (the most recent year for which we have these data) the death rate for children under age one was nearly 13 times higher than the death rate of children ages 15 to 19, the group with the next highest rate (623 and 49 per 100,000, respectively).[2]

A high rate of death can reflect underlying problems, such as poor access to prenatal care, violent neighborhoods, or inadequate child supervision. It can also point to inequities: for example, in access to health care or safe places to play, or exposure to environmental toxins. Among infants, the leading causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birthweight, and sudden infant death syndrome (SIDS).[3]

Death Rates for Infants in Illinois (Deaths per 100,000 Population), by Gender, 1990-2010



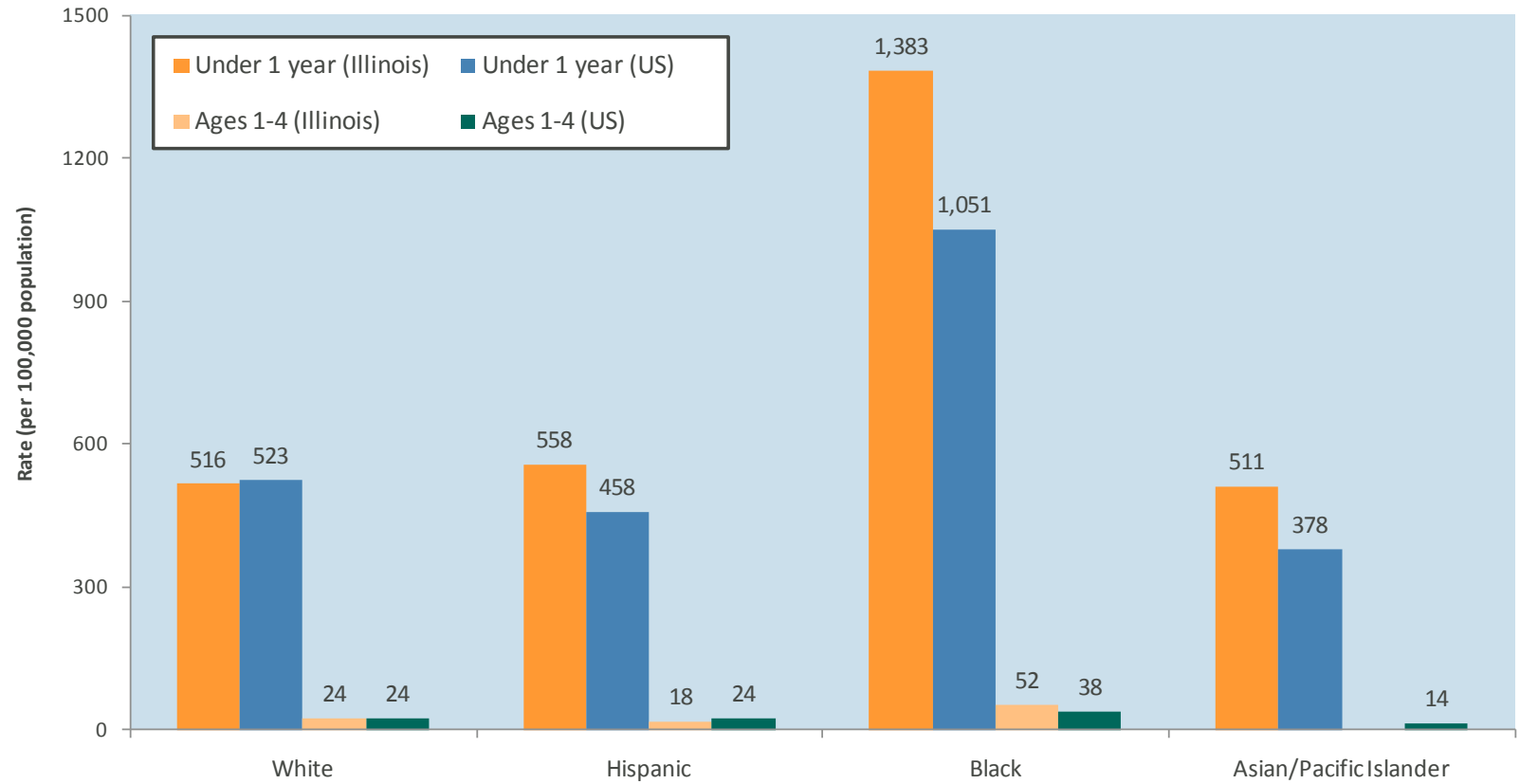
Sources: Number of deaths for 1990-1998 and all data for 1999-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Population estimates for 1990-1998: U. S. Census Bureau. (2003). State and county intercensal estimates by demographic characteristics (1990-1999) . Available at: http://www.census.gov/popest/data/intercensal/st-co/characteristics.html.

1 Child Trends' calculations based on Murphy, S. L., Xu, J., & Kochanek, K. D. (2013). Deaths: Final data for 2010. National Vital Statistics Reports, 61(4). Table 22. Retrieved from: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

2 Child Trends DataBank. (2012). Infant, child, and teen mortality. Retrieved from http://www.childtrends.org/?indicators=infant-child-and-teen-mortality

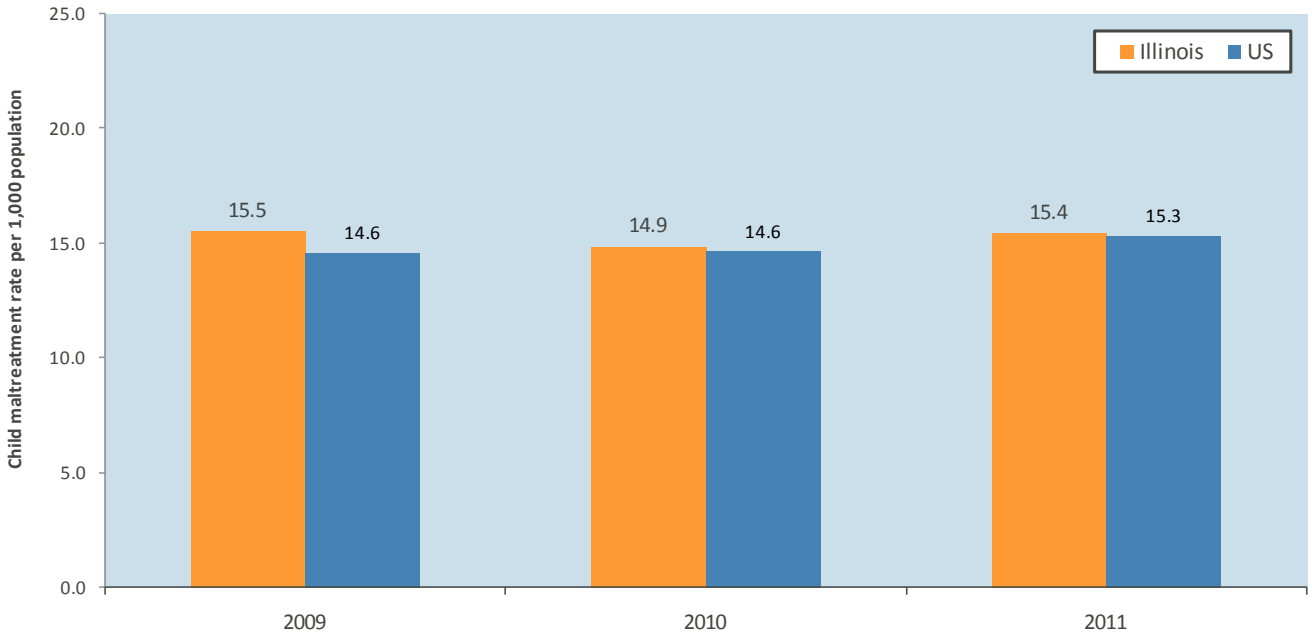
3 Ibid.

Death Rates for Children Ages Birth through Four, by Race/Hispanic Origin, 2010



Sources Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

Child Maltreatment Rates (Unique Substantiated Victims per 1,000 Population), Ages Birth Through Two: 2009-2011



Sources: Data for 2009: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2010) Child Maltreatment 2009. Washington, DC: U.S. Government Printing Office. Table 3-10. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2009. Data for 2010: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2011) Child Maltreatment 2010. Washington, DC: U.S. Government Printing Office. Table 3-11. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2010. Data for 2011: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2012) Child Maltreatment 2011.

In Illinois in 2011, about 7,600 infants and toddlers were reported as substantiated victims of maltreatment.

The youngest children—infants and toddlers—are the age group most likely to suffer abuse and neglect. Children one year and younger account for one in five incidents of maltreatment, and, together with children ages two to five, comprise nearly half of all cases.[1]

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

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

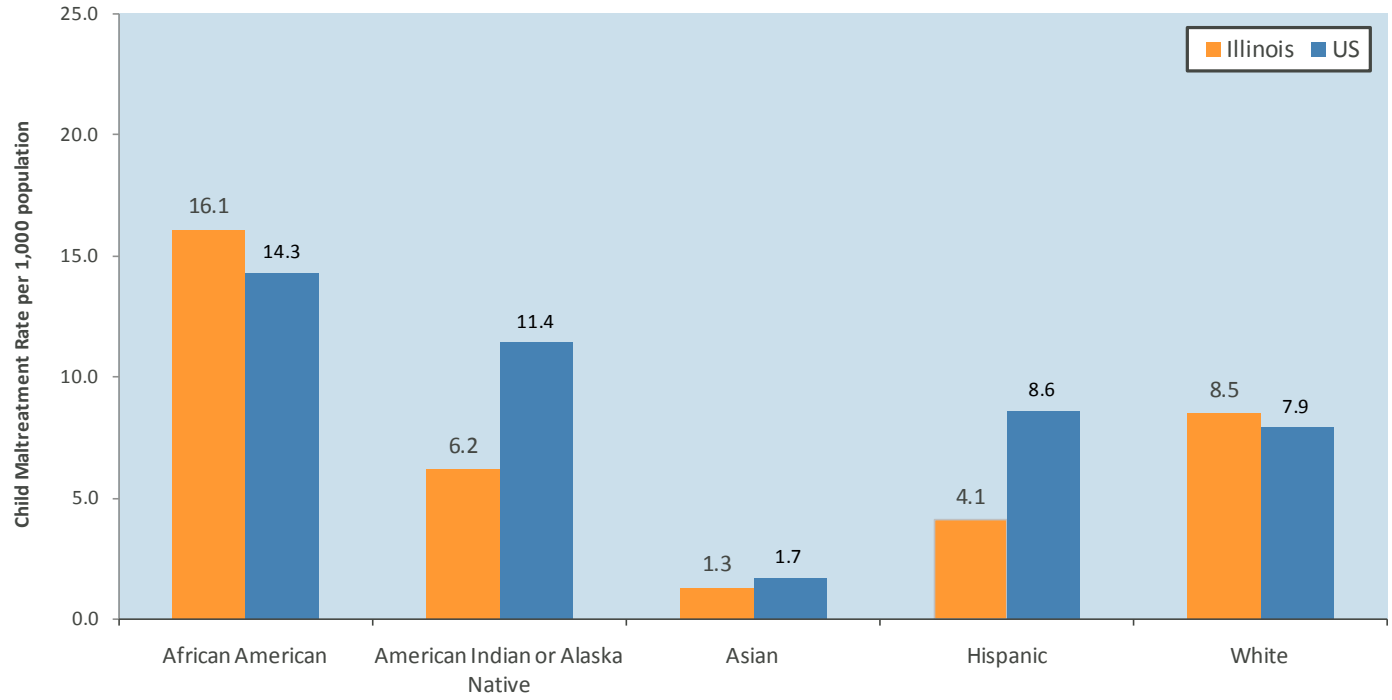
Child maltreatment is influenced by a number of factors, including poor knowledge of child development, substance abuse, other forms of domestic violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse and especially neglect are more common in poor and extremely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

In Illinois, black children (through age 17) have the highest rates of substantiated maltreatment, followed by white, American Indian or Alaskan Native, Latino, and Asian children.

Nationally, rates of abuse and neglect have fallen in recent years, though less rapidly in the case of infants and toddlers than for older children. In Illinois, the rates for infants and toddlers have been essentially unchanged over the past three years.

4 Child Trends DataBank, op. cit.

Child Maltreatment Rate (Unique Substantiated Victims per 1,000 Population), Ages Birth Through 17, by Race/Ethnicity: 2011



Source: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2012) Child Maltreatment 2011. Washington, DC: U.S. Government Printing Office. Table 3-6. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

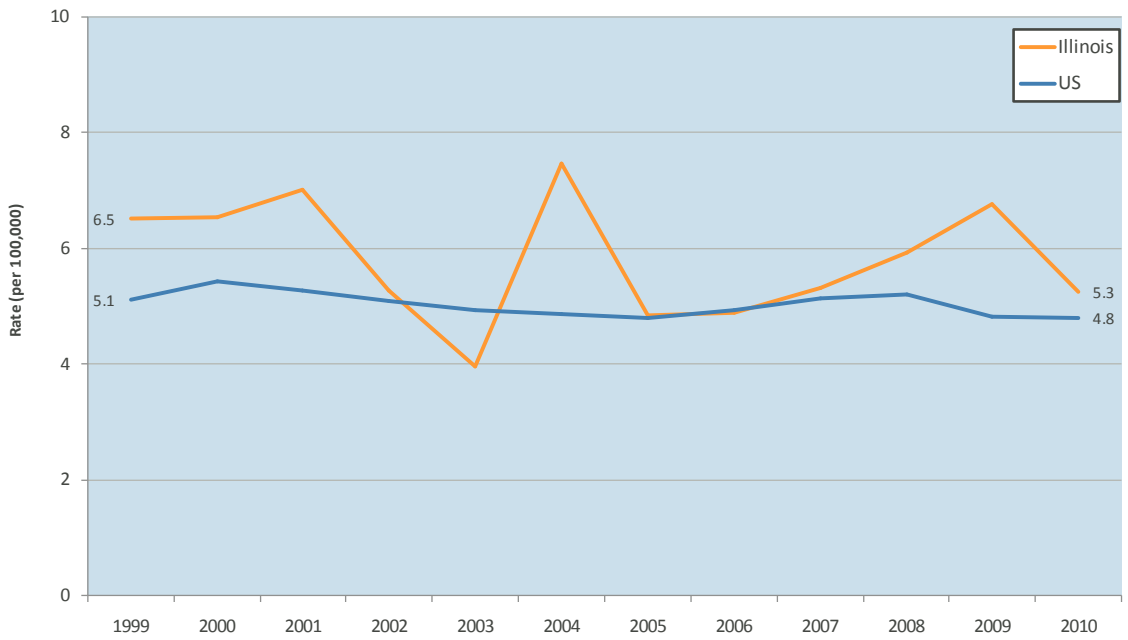
homicide

About five in 100,000 Illinois infants and toddlers were victims of homicide in 2010 (the most recent year of data available). Nationally, males are more likely than females to be killed during infancy and toddlerhood. Black infants and toddlers are nearly three times as likely as whites to be victims of homicide. However, homicide rates for black infants and toddlers have also declined the most in recent decades—down by nearly 30 percent since 1990, compared with an overall eight-percent decline for all races, and a 40-percent increase in rates for white infants and toddlers.

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

Key risk factors associated with infant homicides include the circumstances surrounding the birth of the child. Among homicides occurring on the first day of life, 95 percent of the victims were not born in a hospital. Other important risk factors include a second or subsequent infant born to an unmarried teenage mother (19 years of age or younger); no prenatal care, or care only after the sixth month of pregnancy; a history of maternal mental illness; a mother with 12 or fewer years of education; and premature birth (gestation of less than 28 weeks). Studies suggest that male caretakers (fathers or mothers' intimate partners), often acting impulsively, are the perpetrators of the majority of infant homicides.[2]

Infant and Toddler Homicide (deaths per 100,000), 1999-2010



Source: Centers for Disease Control and Prevention. (2013). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Available at: http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html

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

2 Ibid.

lead poisoning

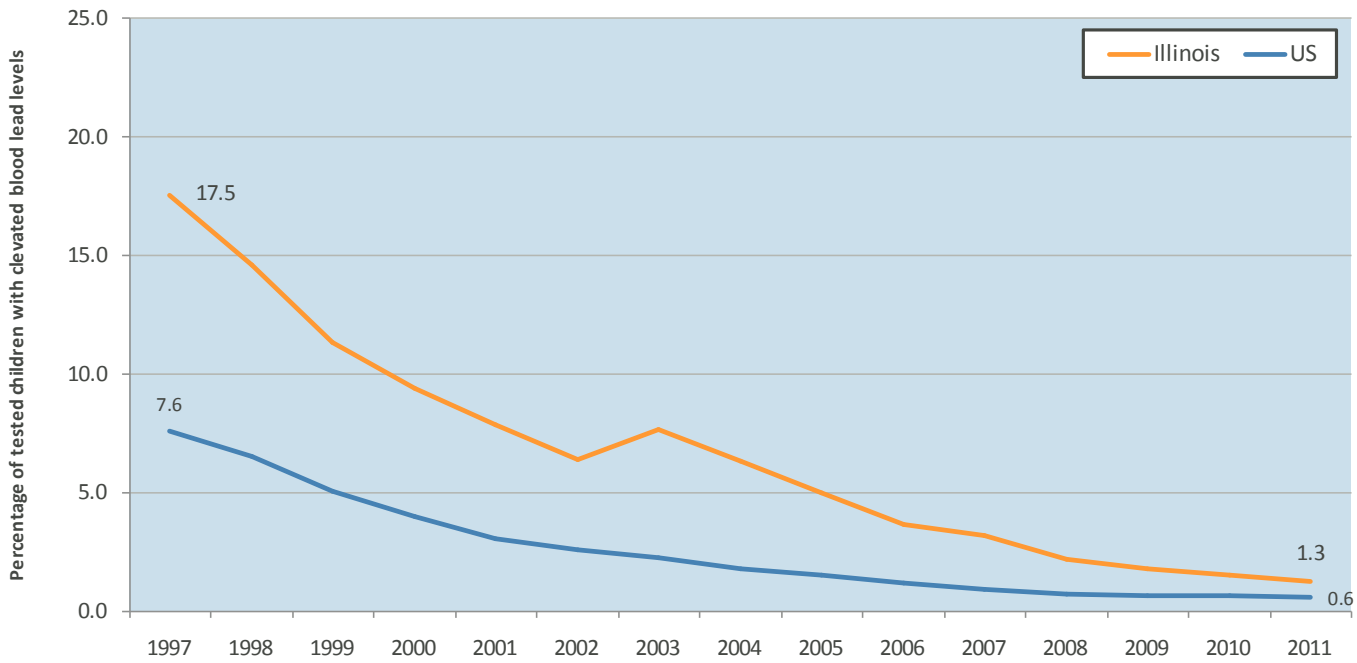
Lead risk levels for young children in Illinois have remained about twice as high as the national average, at 17.5 percent in 1997, and 1.3 percent in 2011.

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

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

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

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



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

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

asthma

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

Among children younger than three, about one in 18 (5.5 percent) have current asthma, a proportion that has changed little over the past ten years. Rates among young black children are more than twice as high as among white children, while rates for Latinos fall in between. Infants and toddlers living in poverty are three times more likely to have asthma as are those with family incomes at least double the poverty level. Boys are more likely than girls to have asthma.

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates of asthma prevalence for this age group; however, among children birth through 17, rates for Illinois are very close to the national average.[2]

1 Child Trends DataBank. (2013). Asthma. Retrieved from http://www.childtrends.org/?indicators=asthma
2 2011/12 National Survey of Children's Health. Data Resource Center for Child & Adolescent Health. www.childhealthdata.org

unintentional injuries

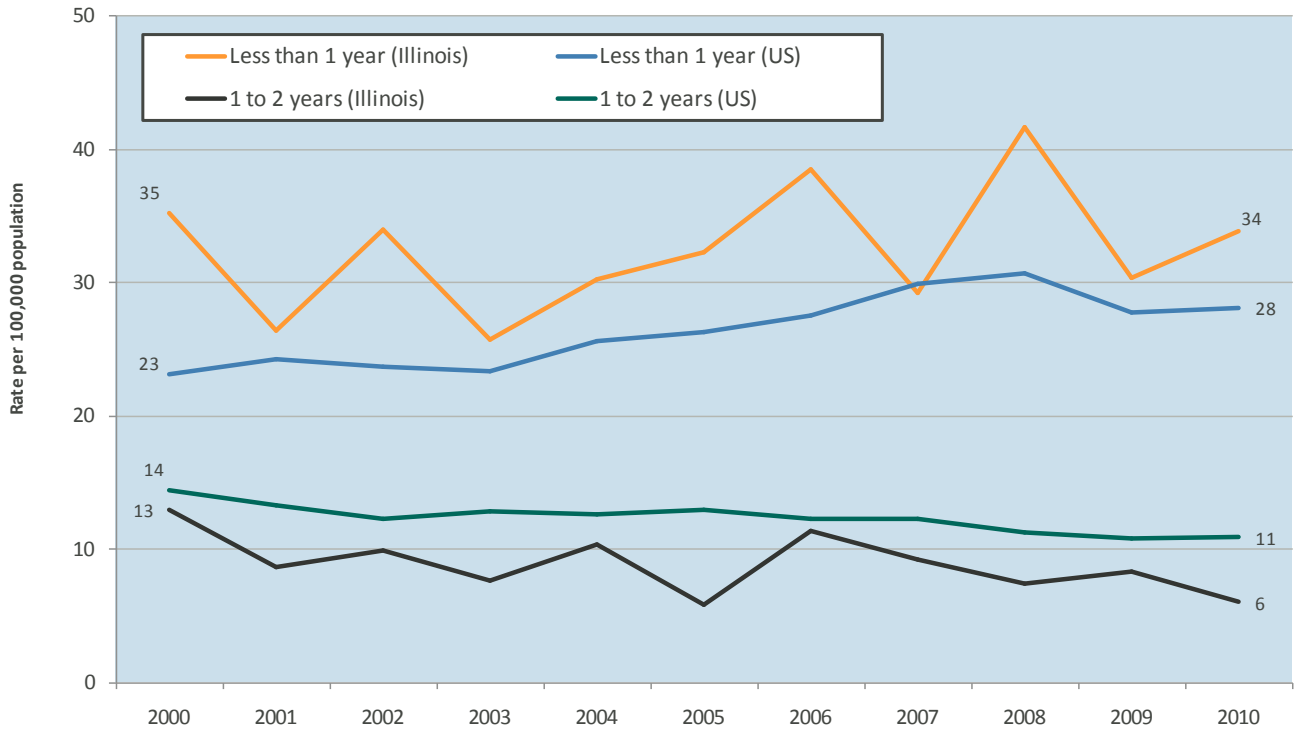
Seventy-five infants and toddlers in Illinois died in 2010 from unintentional injuries. Illinois infants are more likely, and toddlers less likely, than their counterparts nationally to suffer fatal unintentional injuries. Suffocation is by far the greatest cause of these deaths. Fatal injury numbers among the youngest children are generally too small to produce interpretable sub-group trends. However, **black infants and toddlers in Illinois are nearly three times more likely than whites to have unintended fatal injuries.**

Infants and toddlers are particularly prone to certain types of injuries, and are more likely to die from injuries than are older children. For infants, injuries are the fourth leading cause of death;[1] for toddler deaths, they lead all causes.

Non-fatal injuries are much more common than fatal ones. Falls lead all other causes of non-fatal injuries in infants and toddlers, accounting for close to half of all these injuries in both groups.[2]

There is no comprehensive source of data for state-level analysis of non-fatal injuries.

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



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

1 Suffocation is the cause in 82 percent of infant deaths.

2 Child Trends DataBank. (2012). Unintentional injuries. Retrieved from http://www.childtrends.org/?indicators=unintentional-injuries

overweight

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

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

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates of overweight prevalence for this age group.

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

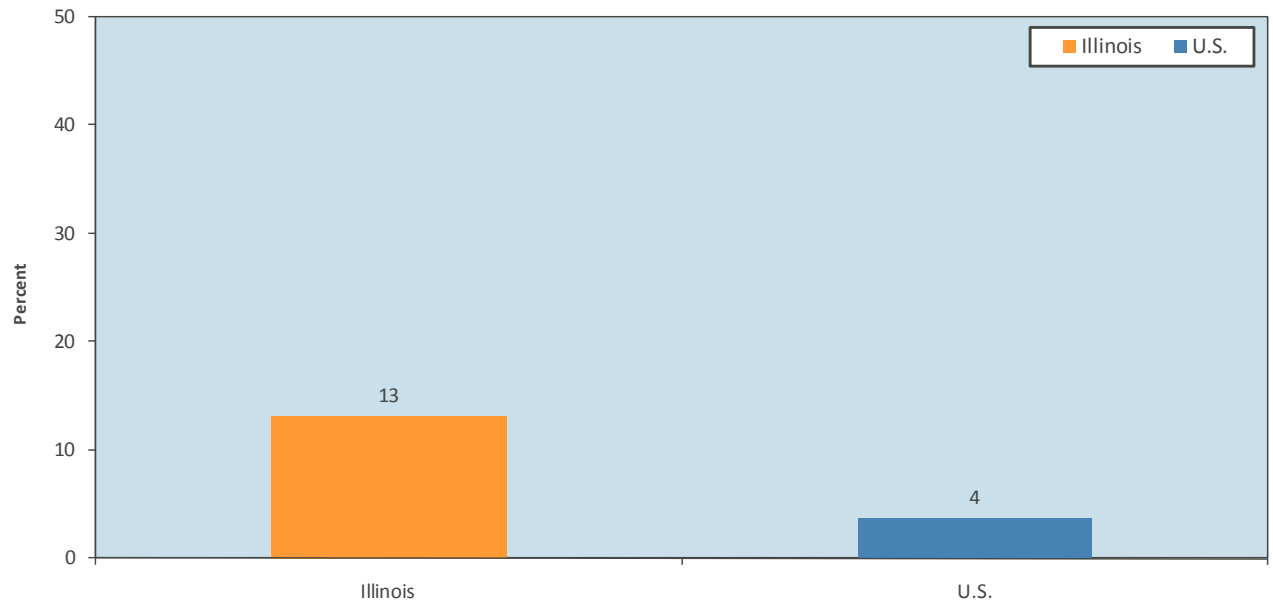
oral health

According to 2011/12 data from a representative survey, nearly nine in ten (87 percent) of Illinois infants and toddlers have teeth that are in "excellent" or "very good" condition, as reported by their parents. Nationally, a notably lower percentage of Latino children (73 percent) had teeth in "excellent" or "very good" condition, and this indicator also shows a strong relationship with family income. Children whose parents are foreign-born are also less likely to have healthy teeth.

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

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

Percentage of Children ages One Through Two Years Who Had Less Than "Very Good" Teeth: 2011/12



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

1 Ramos-Gomez,F., Crystal, Y. O., Ng, M. W., Tinanoff, N., & Featherstone, J. D. (2010). Caries risk assessment, prevention, and management in pediatric care. General Dentistry, November/December, 2010, 505-517.

2 Child Trends DataBank. (2012). Unmet dental needs. Retrieved from http://www.childtrends.org/?indicators=unmet-dental-needs

3 Ibid.

autism spectrum disorders

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

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

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

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates of ASD prevalence for this age group.

1 Centers for Disease Control and Prevention. (2012). Prevalence of autism spectrum disorders—Autism and Developmental Disabilities Monitoring Network, 14 sites, United States, 2008. MMWR Surveillance Summaries, 61(3).

2 Child Trends DataBank. (2012). Autism spectrum disorders. Retrieved from http://www.childtrends.org/?indicators=autism-spectrum-disorders

special health care needs

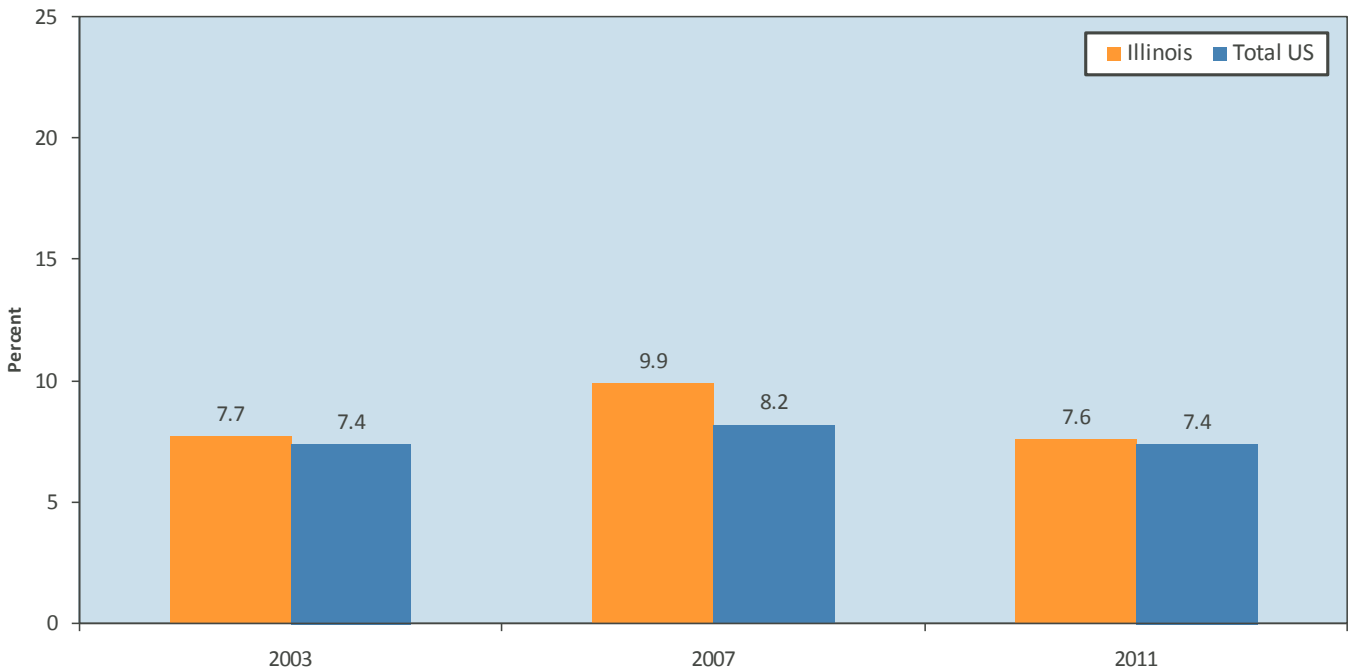
In 2011/12, about one in 14 Illinois children younger than three were reported by their parents to have a special health care need.

There is no consensus on how to define disabilities or "special health care needs" among children. Both terms encompass a broad range of chronic health conditions, from major physical or developmental disabilities to conditions that are often less limiting, such as autism spectrum disorder or asthma.

National data show a significantly higher percentage of black infants and toddlers had a special health care need (13 percent) compared with their white counterparts (eight percent).[1]

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

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



*Special health care needs include needing prescription medications, needing elevated services, being limited in activities, needing specialized therapies, or having an emotional/developmental/behavioral problem, when the need is expected to persist for at least a year.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

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

flourishing

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

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

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

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates of flourishing indicators for this age group.

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

Risk Factors:

smoking during pregnancy

Smoking during pregnancy (like cigarette smoking generally) is disproportionately associated with race/ethnicity and socioeconomic status. **In Illinois, American Indian/Alaska Native women have the highest rate among major race/ethnicity groups, at 22 percent. White women have the next highest risk, with 11 percent reporting smoking during pregnancy; black women are at nine percent. Pregnant Latina and Asian/Pacific Islander women have the lowest rates, at one percent each.**[1]

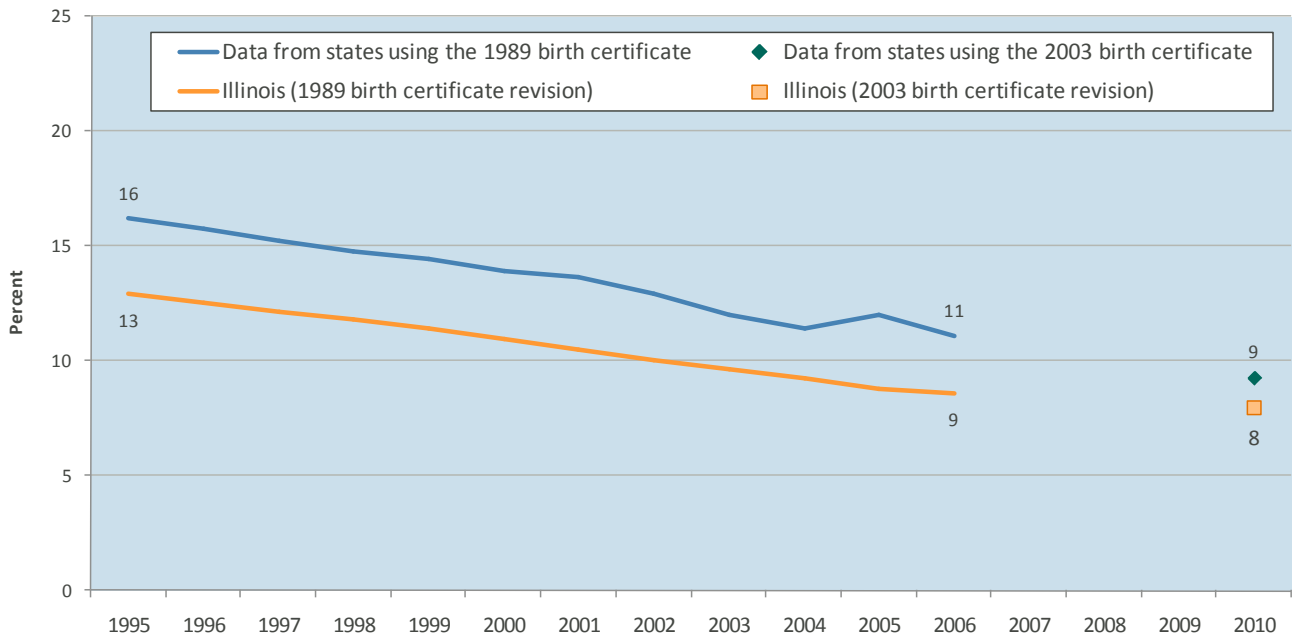
Differences by mother's level of education are still more striking. The highest rates of smoking during pregnancy are among women with less than a high school education; they are more than ten times more likely to smoke than are pregnant women who have completed four years of college. Younger women are also more likely than older women to smoke while pregnant.

If a pregnant women smokes, or even if she is exposed to "second-hand" (environmental) cigarette smoke, the harmful effects of smoking extend to the developing infant in utero. Infants born to mothers who smoke are more likely to be born with low weight, to develop asthma, and to become overweight in early childhood. They are three times more likely than infants whose mothers do not smoke during pregnancy to die from Sudden Infant Death Syndrome (SIDS).[2]

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

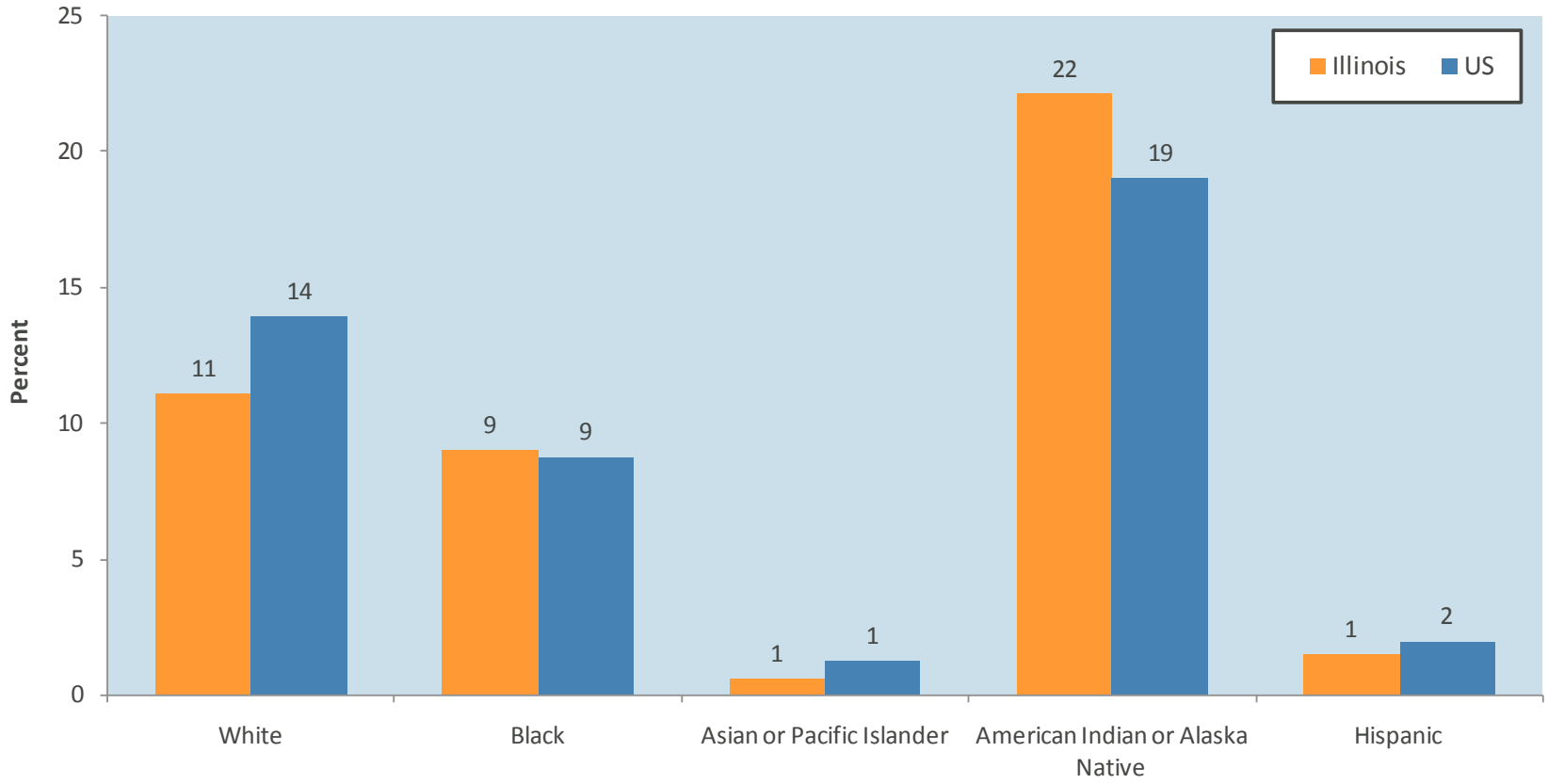
2 Child Trends DataBank. (2012). Mothers who smoke while pregnant. Retrieved from http://www.childtrends.

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



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

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

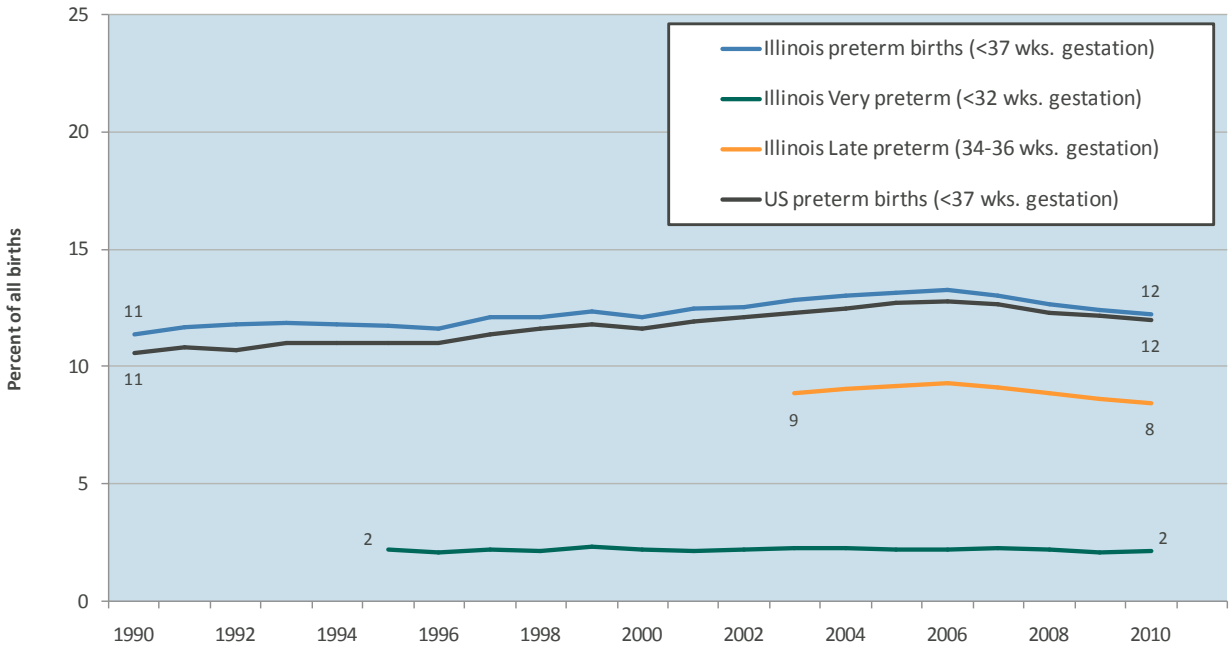


*US Data are based on the 34 States using the 2003 revision of the standard birth certificate, representing 76 percent of all births
Data Source: National Center for Health Statistics, CDC WONDER. Available at: http://wonder.cdc.gov.

Risk Factors:

preterm births

All Preterm, Very Preterm, and Late Preterm Births, as Percentages of All Births, 1990-2010



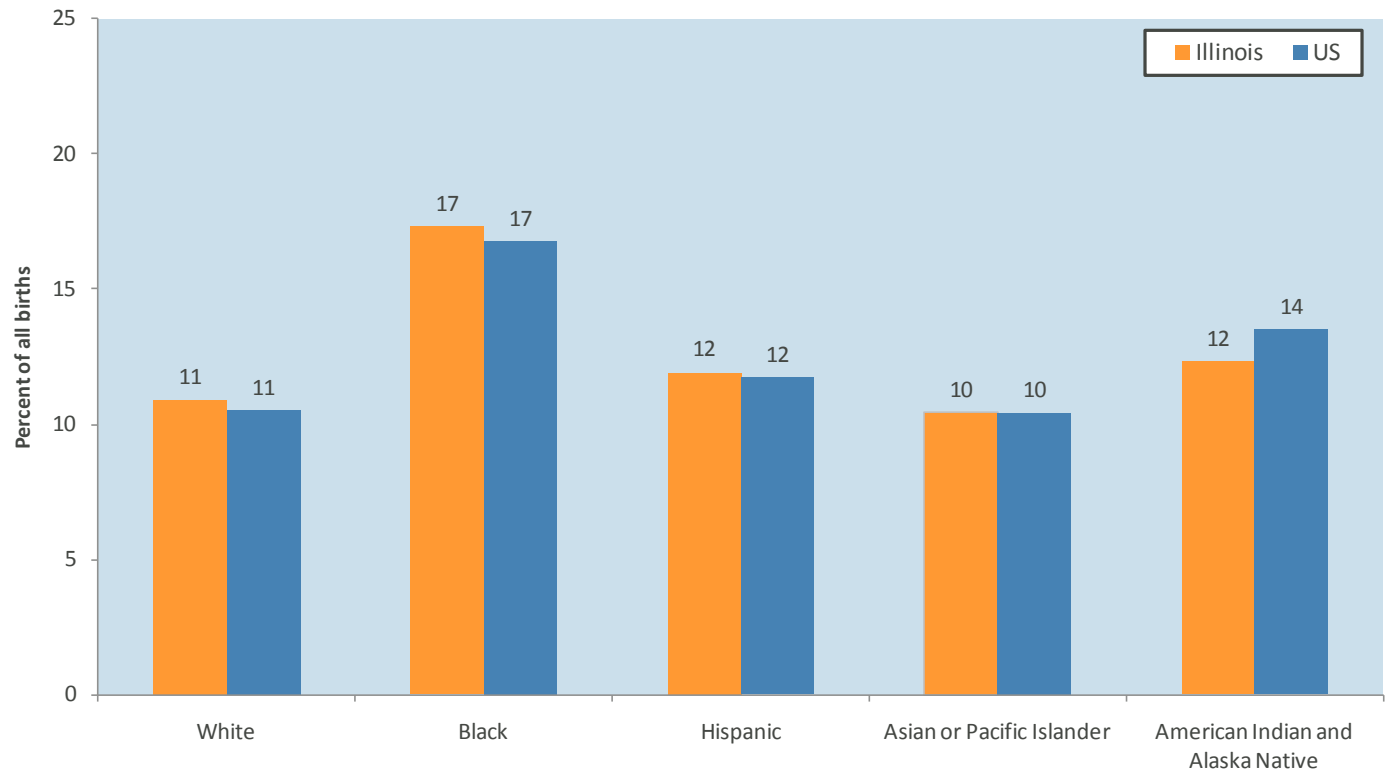
*Data for 2011 are preliminary
Note: Percentage calculations exclude records missing gestation period data.
Sources: Data for 1990-1994: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Available at http://www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm Data for 1995-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

Currently, about one in eight Illinois babies is born preterm. However, among black infants, the figure is closer to one in six, for Latino babies, about one in eight, and for white infants, closer to one in nine. These figures are comparable to U.S. averages. The causes of preterm birth are not all understood, but among the contributing factors are a multiple pregnancy (twins, triplets, etc.), mother's smoking or use of alcohol and other drugs during pregnancy, and high levels of maternal stress, including experiencing domestic violence. The Healthy People 2020 goal is 11.4 percent.[1]

Babies born preterm (before the 37th week of pregnancy) are at risk for a number of negative outcomes. Preterm birth is the leading cause of infant mortality. Infants born preterm have higher rates of health complications and lifelong disabilities, including mental retardation, learning and behavioral problems, cerebral palsy, lung problems, vision and hearing loss, diabetes, high blood pressure, and heart disease. Children born preterm may also have increasing difficulties with the more complex cognitive functioning called upon as they grow older, even before they enter school.[2]

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

Percentage of Births that are Preterm (Less Than 37 Weeks Gestation), by Race/Hispanic Origin, 2010

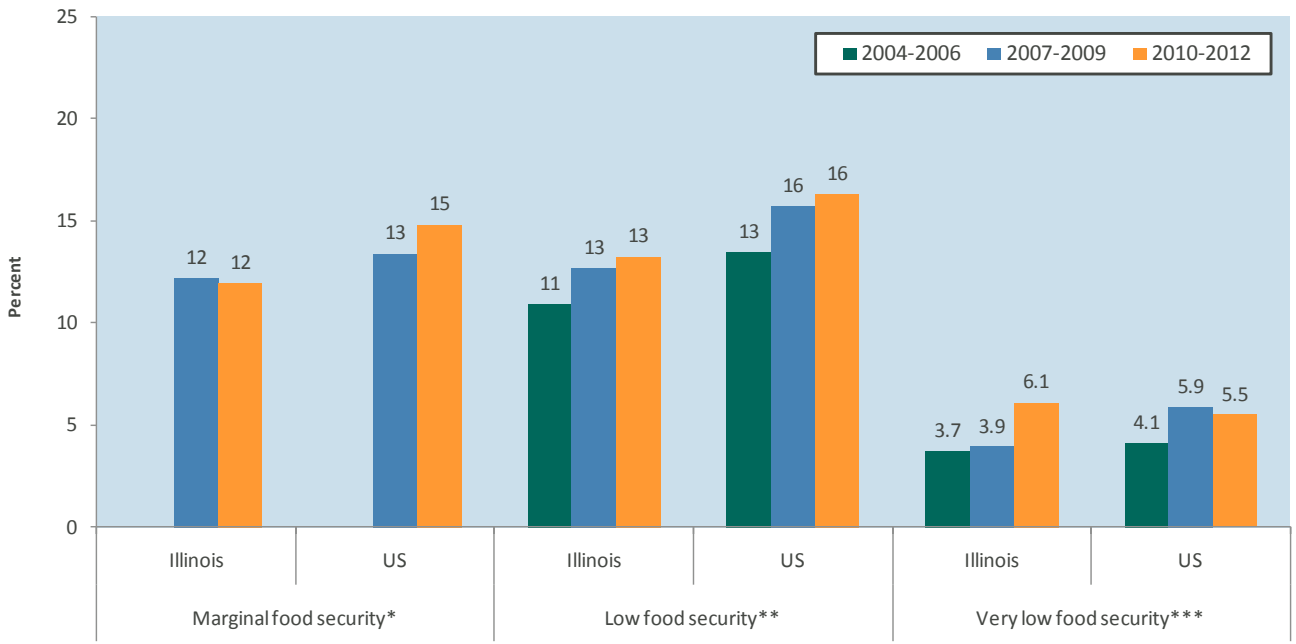


Note: Percentage calculations exclude records missing gestation period data.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

Risk Factors:

food insecurity

Percentage of Children, Ages Birth through Two, in Food-Insecure Households, 2004-2012



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

In 2010-2012, 12 percent of Illinois infants and toddlers lived in households with marginal food security, 13 percent lived with low food security, and six percent lived in a household with very low food security. That means that nearly a third lived in households that were not food-secure.

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

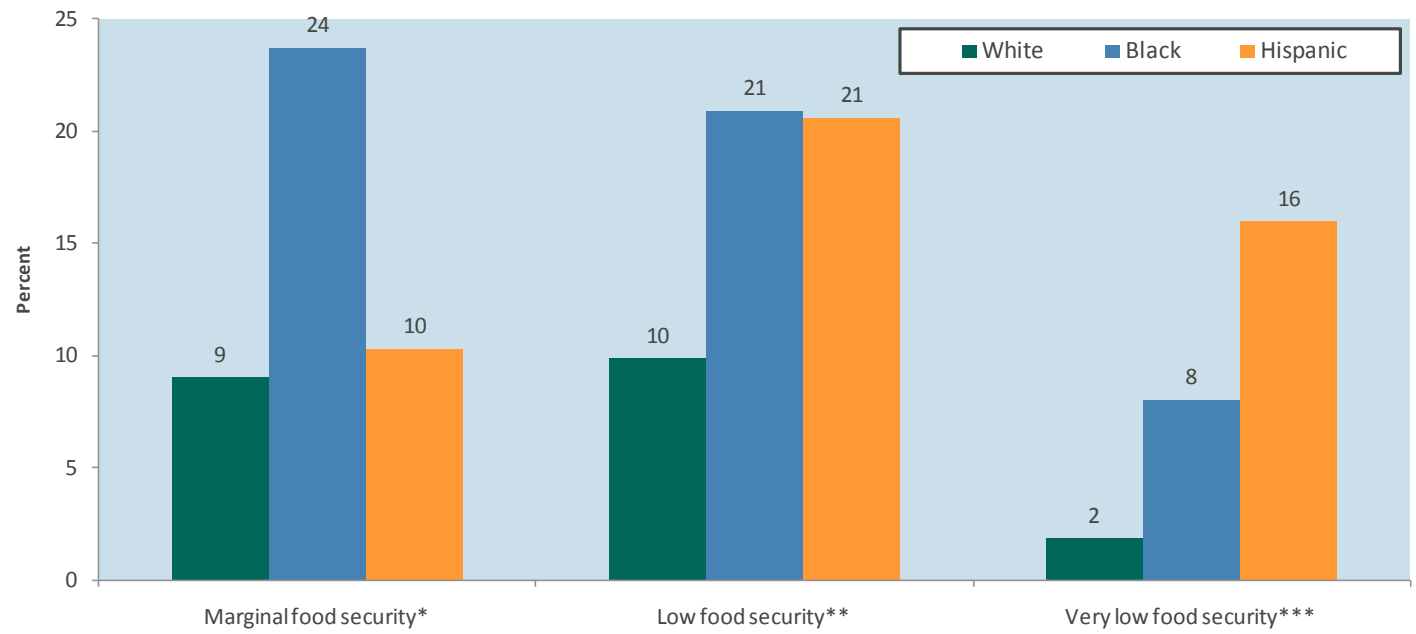
Studies also report that food insecurity is associated with higher rates of behavioral problems in three-year-olds. Food insecurity, particularly when experienced in the earliest primary grades, also has a significant detrimental effect on young children's interpersonal skills, self-control, and the

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

group of competencies (including attentiveness, persistence, and flexibility) termed "approaches to learning." Recent research shows that even "marginal" food insecurity can have negative effects on health.[2]

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

Percentage of Illinois Children, Ages Birth through Two, in Food-Insecure Households, by Race/Hispanic Origin, 2010-2012



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

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

Risk Factors:

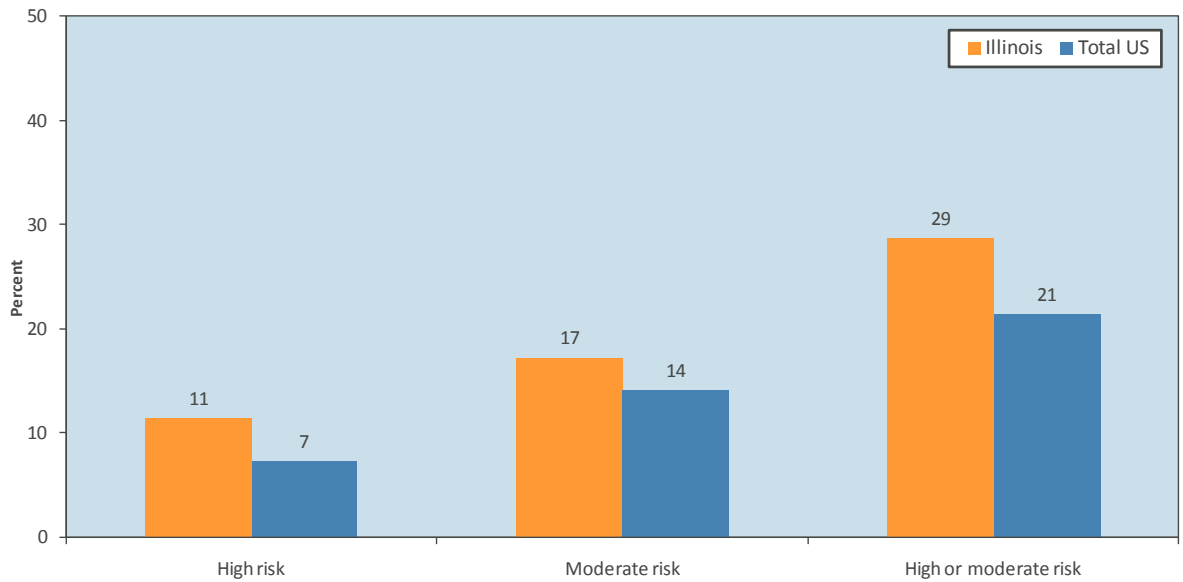
parental concerns about development

In 2011/12, nearly one in three Illinois infants and toddlers (29 percent) had parents who expressed concern about one or more items that are considered predictive of developmental delays. For children in this age group, these items included receptive and expressive language, and socio-emotional development. Research indicates that when parents express one or more concerns, their child's risk for disabilities is eight times as great as for those whose parents have no concerns; when parents express two or more concerns, the risk is twenty times as high.[1]

Developmental delays among young children can signal the presence of serious physical or psycho-social problems. Screenings—which may be conducted by pediatricians, or through parent questionnaires—can help identify children who are not meeting expected milestones of development.[2] Because development during infancy and toddlerhood is rapid and cumulative, the success of early intervention depends on early identification. Delayed development (sometimes termed "failure to thrive") can also indicate the presence of serious neglect or maltreatment.

Among all states, Illinois is 48th of 51 (where first is best) in the percentage of children younger than three who are at high risk for developmental delays, at 11 percent, versus seven percent nationally; 17 percent are at moderate risk, compared with 14 percent nationally.

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



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

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

Risk Factors:

adverse experiences

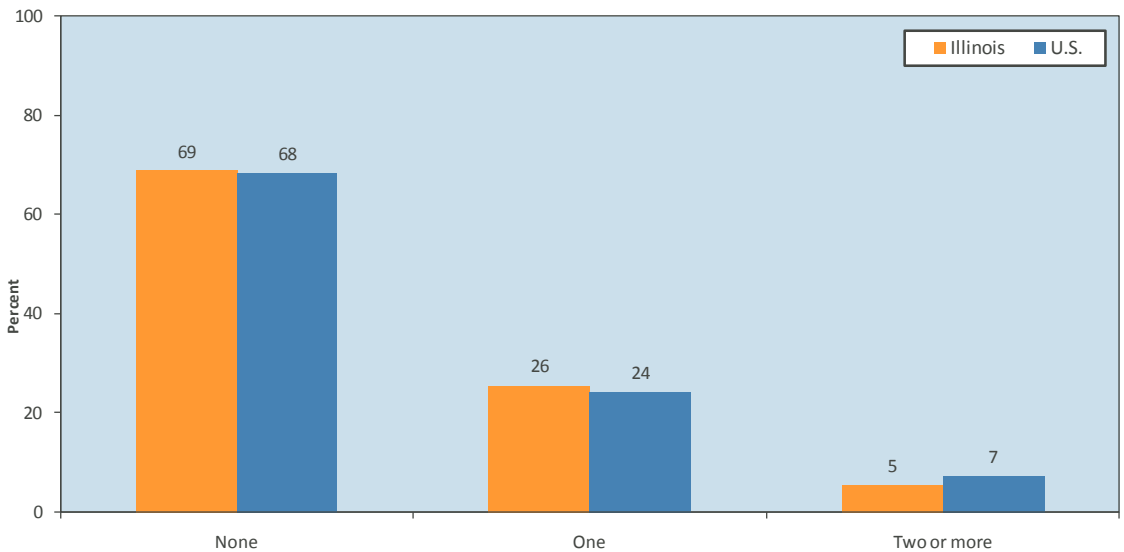
Evidence is accumulating that highlights the importance of cumulative stress in affecting a number of health and other life-course outcomes. While a degree of stress is unavoidable, when stress reaches "toxic" levels it interferes with the normal development of the body's neurological, endocrine, and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

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

Most Illinois infants and toddlers have experienced none of these adverse events. However, one in four has experienced at least one; the most prevalent is the experience of economic hardship "very" or "somewhat" frequently. About one in 18 has had two or more adverse experiences, which is significant because research shows that cumulative stressful experiences are particularly likely to be harmful.

National data show that the prevalence of two or more adverse experiences (excluding economic hardship) is more than four times as high among infants and toddlers living in poverty as it is among those in families with incomes at least twice the poverty level. Boys are less likely than girls to have had no adverse experiences, and are more likely to have a single such experience; boys and girls are equally likely to have had two or more. Children with special health care needs are more than twice as likely as those without such needs to have had two, and more than three times as likely to have had three or more, adverse experiences.

Adverse Experiences* Among Children Ages Birth Through Two: 2011/12



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

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

Risk Factors:

exposure to violence

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

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

One in six infants, and nearly half of two- to five-year-olds, were victims of violence within the past year, according to a 2008 nationally representative survey. The most common type of violence experienced was direct physical assault, followed by witnessing violence.

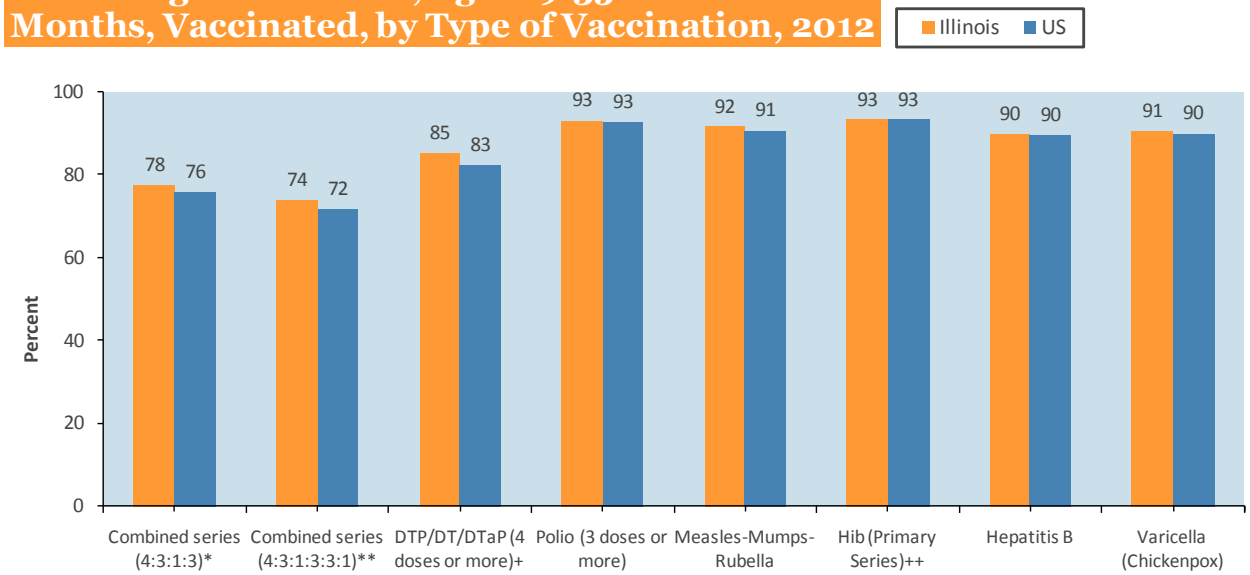
Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates for this age group.

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

Protective Factors:

immunizations

Percentage of Children, Ages 19-35 Months, Vaccinated, by Type of Vaccination, 2012



*The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib)

**The 4:3:1:3::3:1 combined series measures the number of children who have received 6 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine (DTP), 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, 3 or more doses of Haemophilus influenzae type b vaccine (Hib), three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella.

+ Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diptheria and tetanus toxoids and acellular pertussis vaccine.

++ Haemophilus influenzae type b vaccine (Hib).

Source: Centers for Disease Control and Prevention, National Immunization Program ,NIS data, tables, Jan-Dec. /www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

About one in five Illinois infants and toddlers lack one or more of the recommended vaccines. Young children in poor Illinois families are less likely than those in families living above the poverty level to receive all recommended immunizations.

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

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

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

Protective Factors:

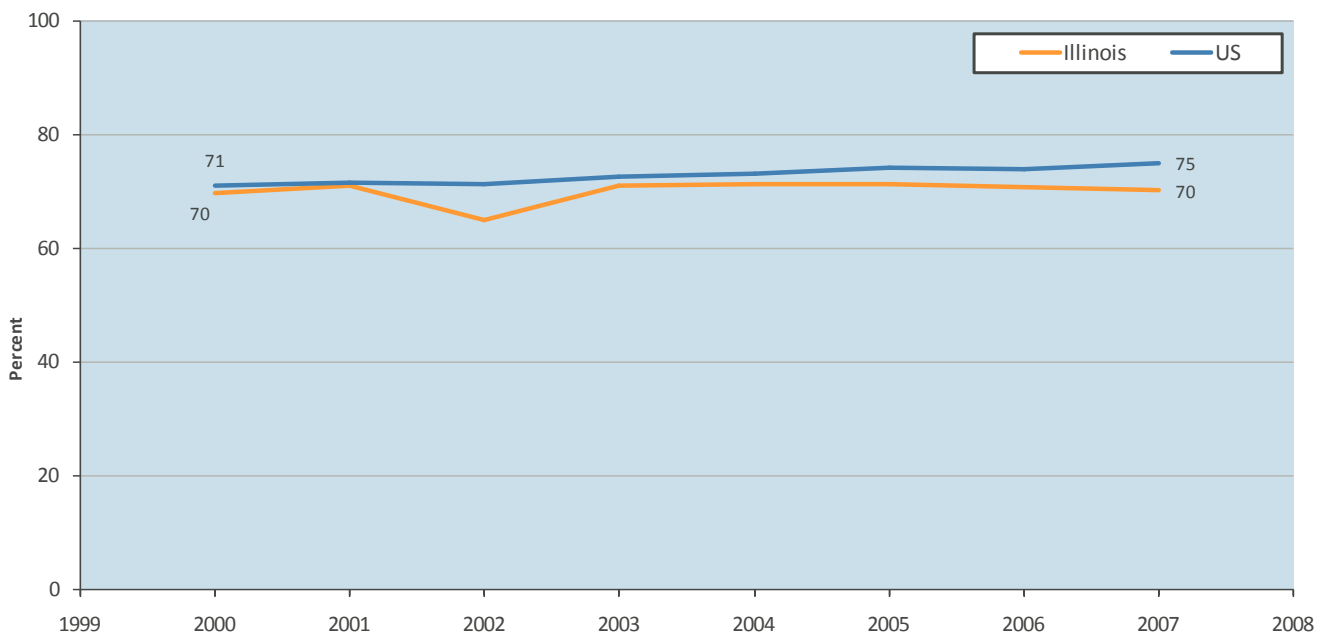
breastfeeding

Breastfeeding rates in Illinois lag behind those for the nation as a whole. For infants born in 2007 (the latest data available), 70 percent of mothers reported ever breastfeeding, 36 percent reported still breastfeeding at six months, and 16 percent reported breastfeeding at 12 months.

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

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

Percentage of Infants Whose Mothers Ever Breastfed, 2000-2007

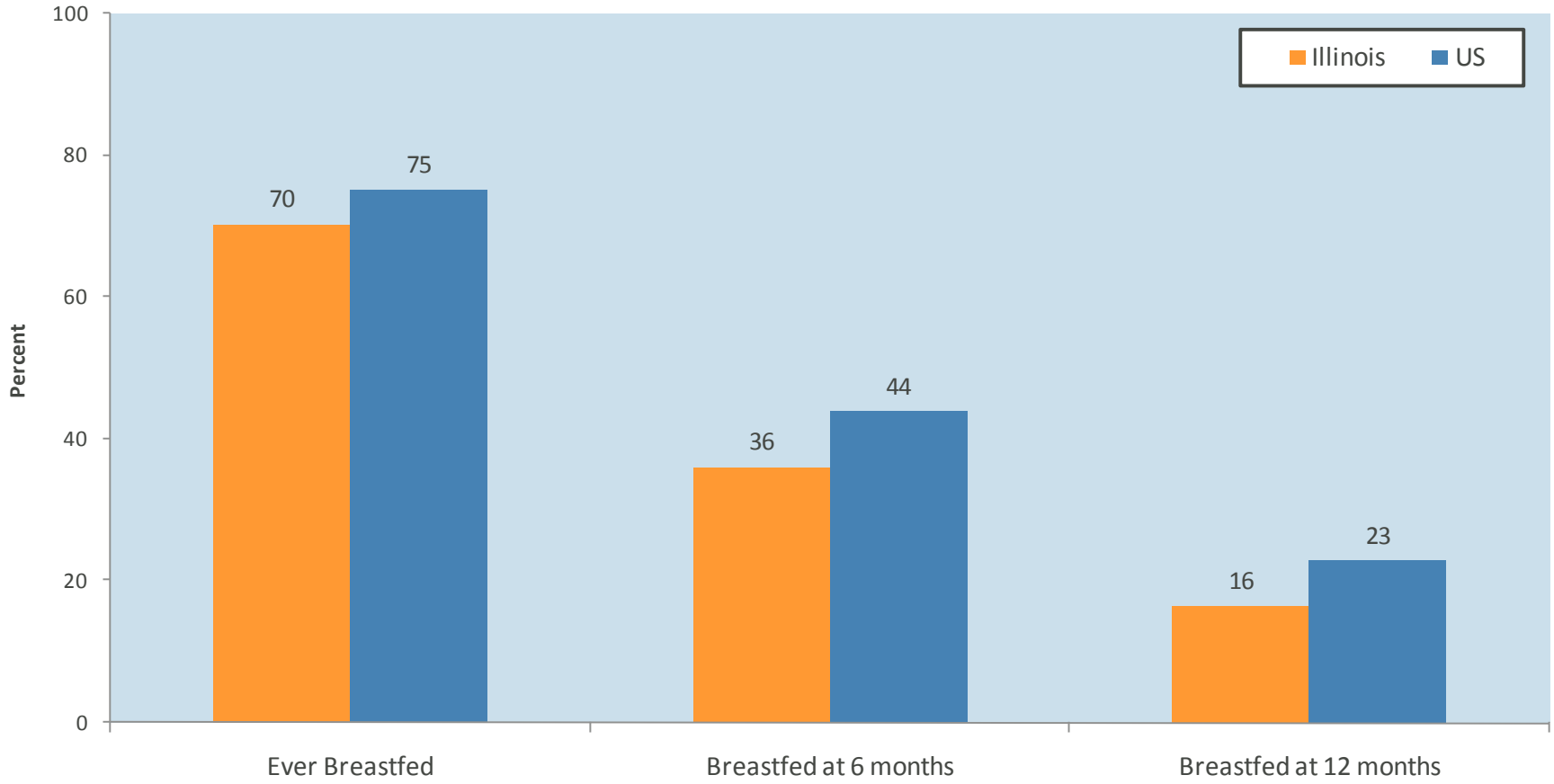


Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.

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

2 Ibid.

Percentage of Infants Whose Mothers Breastfeed, 2007

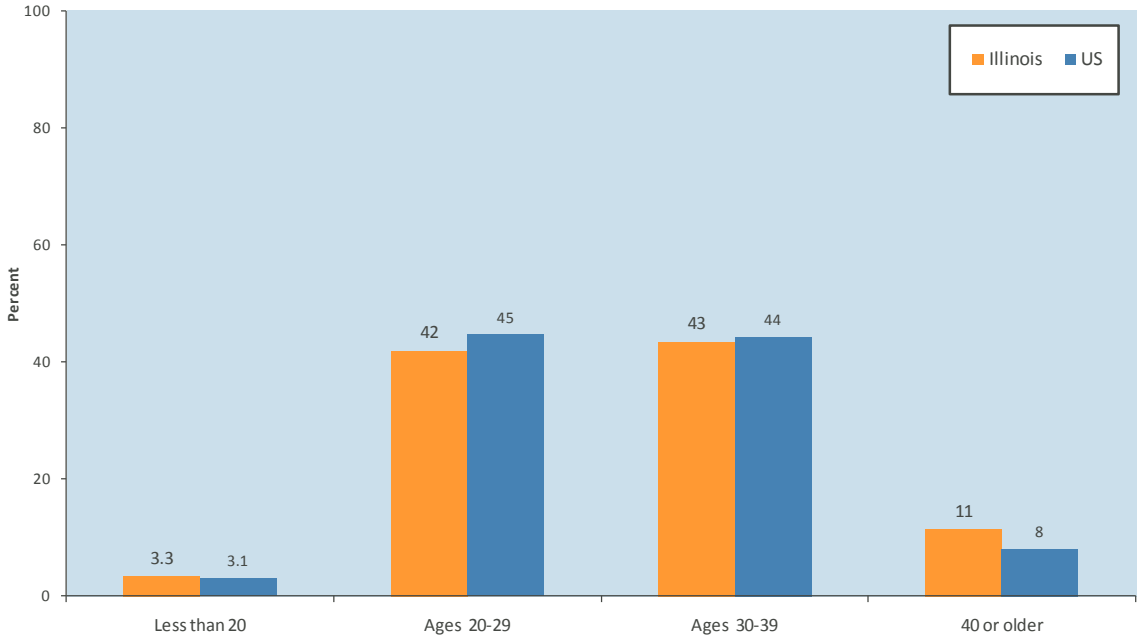


Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding among U.S. children born 2000–2009, CDC National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm

Parental Well-Being

parents' age

Population of Children Ages Birth through Two, Percentages by Mother's Age: 2011-2013



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

As of 2013, seven in ten Illinois infants and toddlers living with parents have at least one resident parent who is 30 or older. One in eight lives with a mother who is 40 or older, and more than one in five with a father of that age. Older mothers and fathers (30-plus) are a larger share among young white children than they are among their black peers. However, in 2011-2013, more than one in six young black children live with a mother who is 40 or older—compared with about one in nine for their white counterparts.

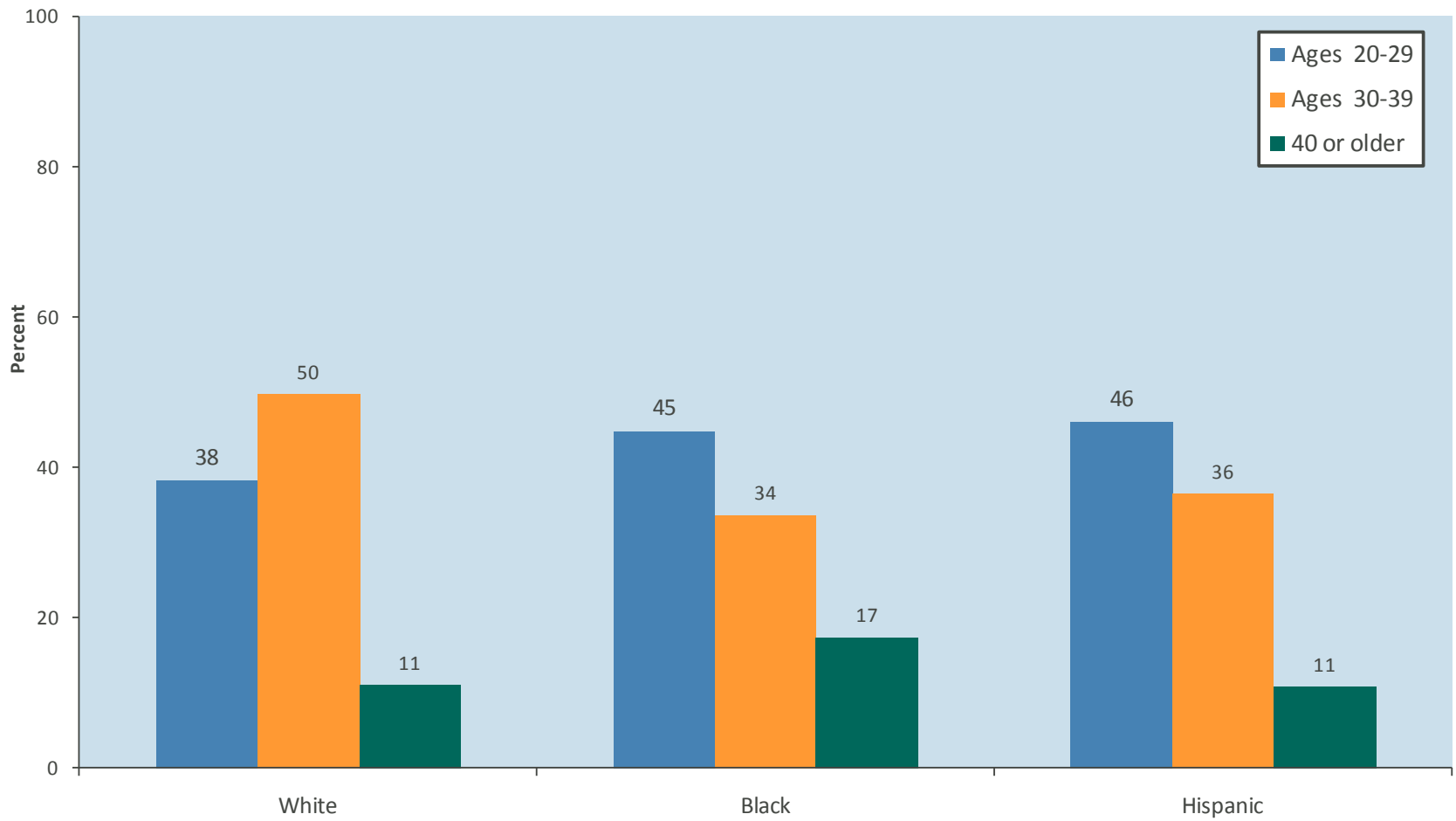
Men and women are starting families at increasingly older ages. Advancing age is associated with declining fertility and increased risk of genetic mutations in sperm and egg cells. Use of fertility-enhancing treatments increased in recent years, particularly among older women. These developments, which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

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

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

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

Population of Illinois Children, Ages Birth through Two, Percentage by Mother's Age and Child's Race/Hispanic Origin: 2011-2013



Note: Sample sizes were too small to include data by race for mothers under age 20.
Source: Child Trends' calculations using U.S. Census Bureau March Current Population Survey

parents' education

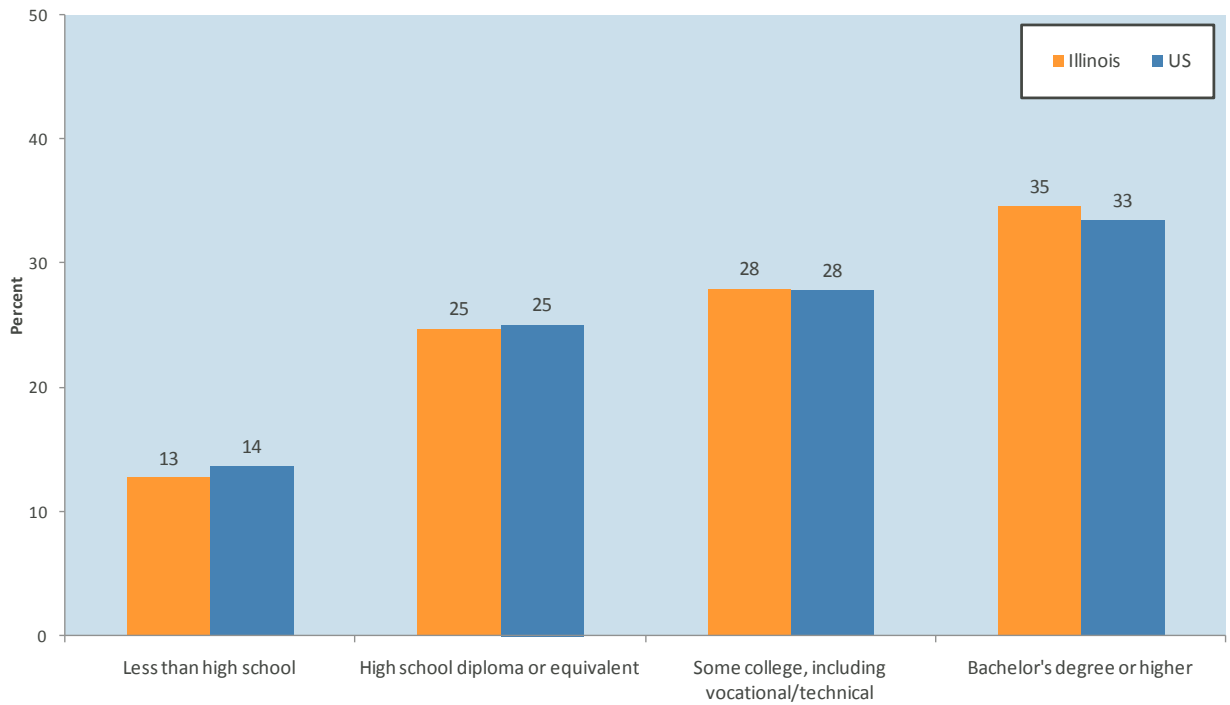
As a group, today's parents are more educated than they were in the past. More than one in three resident parents of Illinois children younger than three has a bachelor's degree or higher (35 percent of mothers, 42 percent of fathers), and nearly two-thirds have at least some years of college or other post-secondary training (63 percent of mothers, 66 percent of fathers). However, about one in eight (15 and 12 percent, respectively) has less than a high school education.

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

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

In Illinois, the proportion of infants and toddlers whose resident mothers who have at least a bachelor's degree is more than three times as high among whites as Hispanics (49 and 15 percent, respectively). Sixty-three percent of Hispanic infants and toddlers in Illinois have a mother with no schooling beyond high school.

Mother's Education, Among Children Ages Birth through Two: 2011-2013

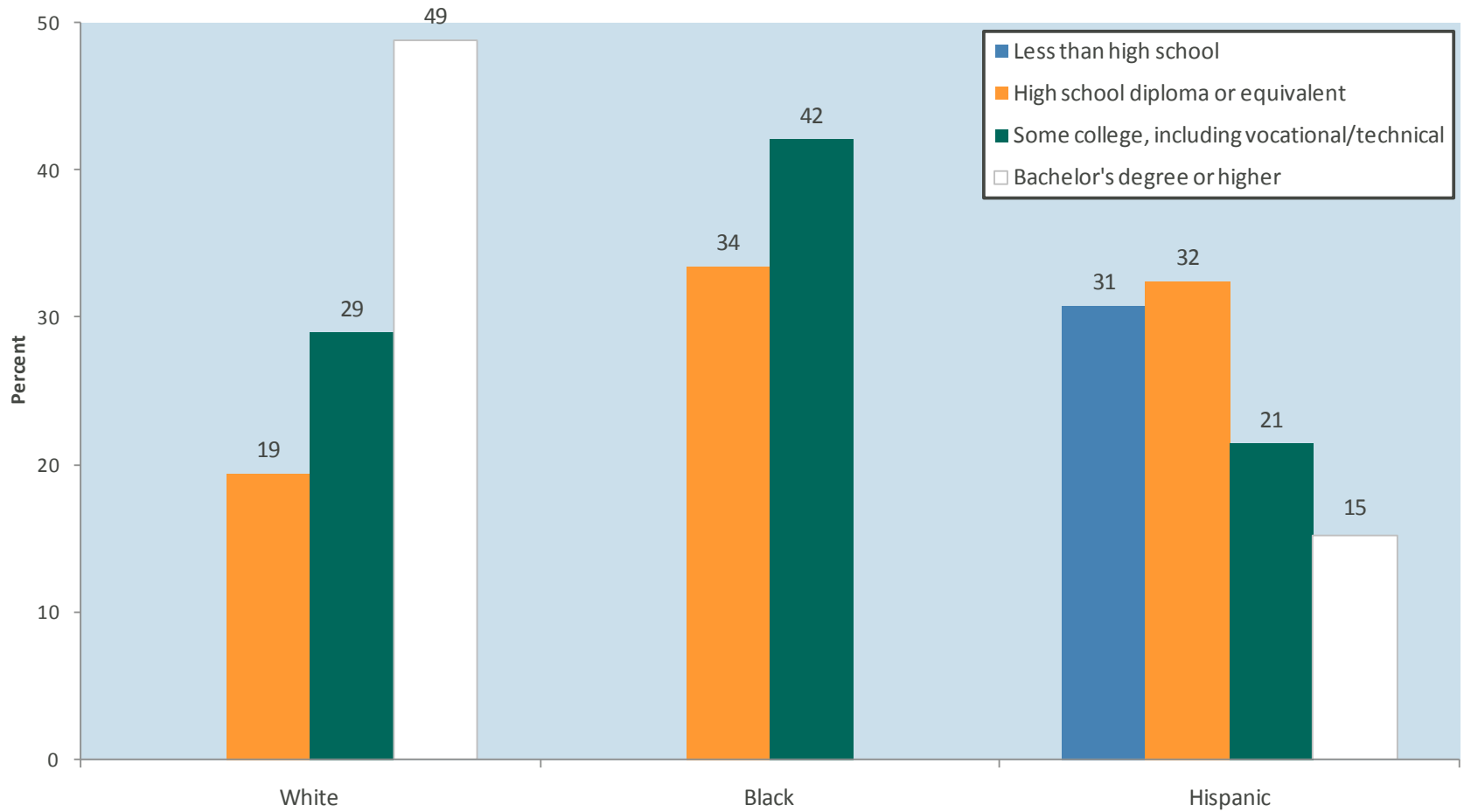


Source: Child Trends analysis of the March Current Population Survey.

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

2 Ibid.

Population of Illinois Children, Ages Birth through Two: Percentages by Mother's Education and Child's Race/Hispanic Origin: 2011-2013



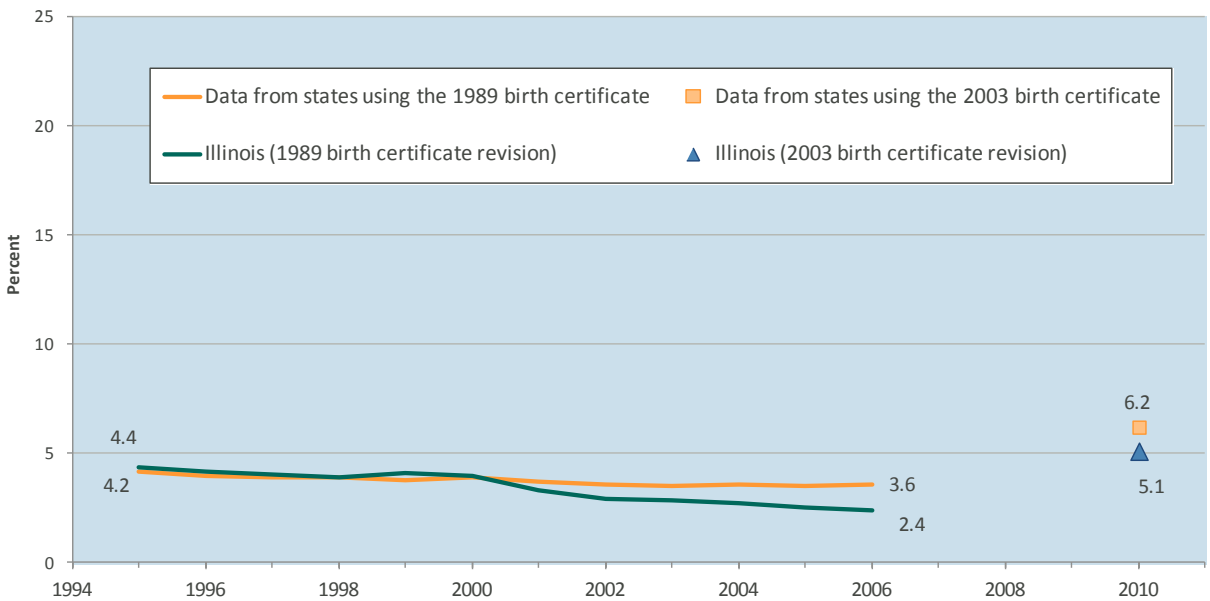
Source: Source: Child Trends' analysis of the March Current Population Survey.

prenatal care

In recent years, Illinois' record on prenatal care has been better than the nation's, and improving. For the most recent year available (2010), 5.1 percent of pregnant Illinois women received late or no prenatal care, compared with 6.2 percent of women nationally. However, black Illinois women have a rate that is three times that of their white counterparts, and the rate for American Indian/ Alaska Native women is more than four times higher than for whites.

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

Percentage of Births to Mothers Receiving Late* or No Prenatal Care, Selected Years, 1995-2010**

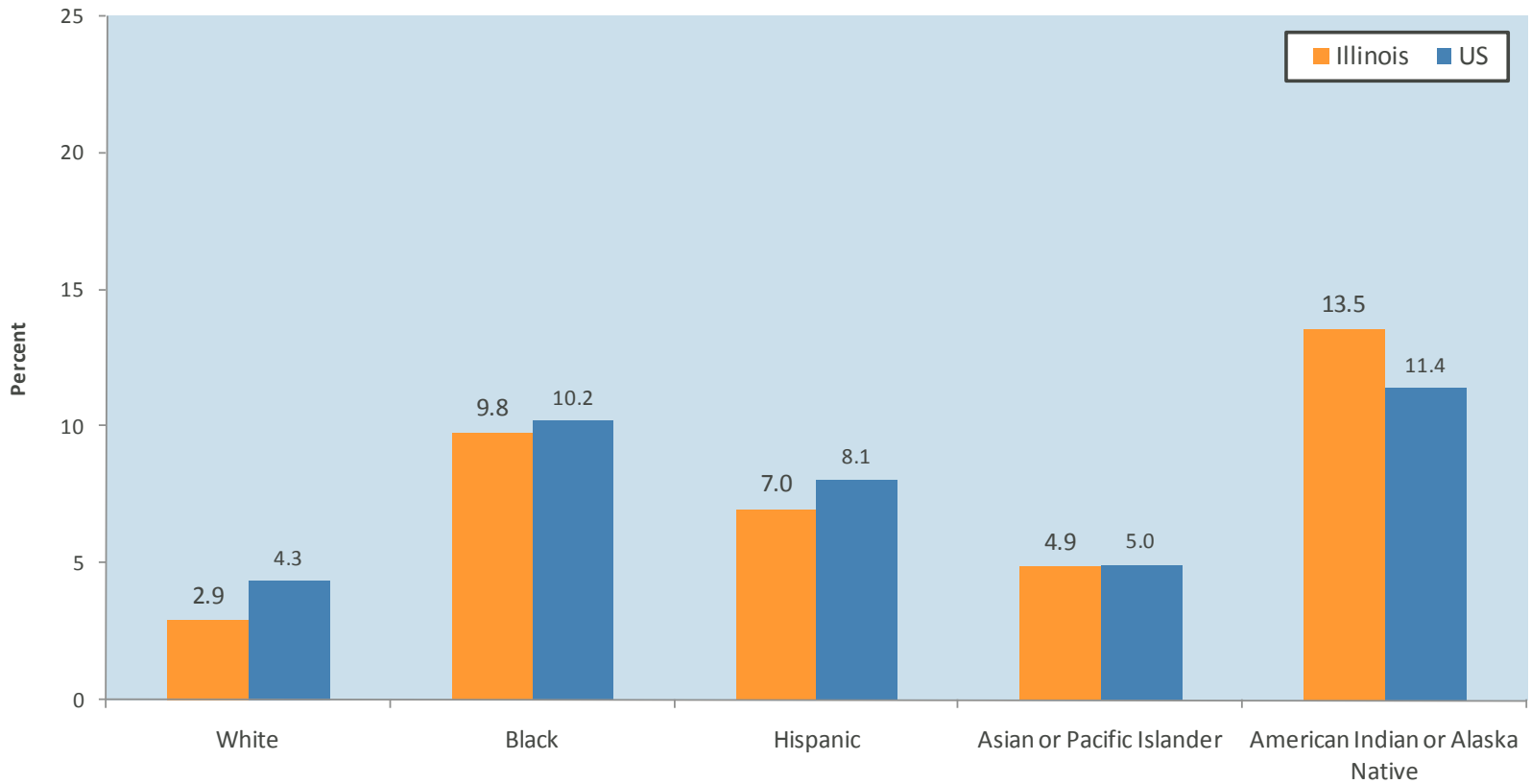


* Late care means that the mother received care only in the third trimester.
**In 2010, Illinois switched to the new birth certificate, so the data is not comparable to previous years. Differences are due to a change in question wording, from asking the month of pregnancy of first prenatal visit, to asking the date of first prenatal visit.

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

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

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



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

**US Data are based on the 34 states using the 2003 revision of the standard birth certificate, representing 76 percent of all births.

maternal mortality

Maternal mortality in Illinois is substantially lower than in the U.S. as a whole, and disparities across race/ethnicity groups are smaller, although overall patterns are similar. Maternal mortality among white mothers is slightly higher in Illinois than the national average, while black maternal mortality is 44 percent lower in Illinois than it is among all U.S. black mothers, and Latino maternal mortality is 73 percent lower in Illinois than it is among Latino mothers nationally. As of 2010, Illinois maternal mortality is about two-and-a-half times greater among black mothers than among whites, and about one-fourth as high among Latina mothers as among whites.

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

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

1 World Health Organization. (2012). Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and the World Bank estimates. Retrieved from http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

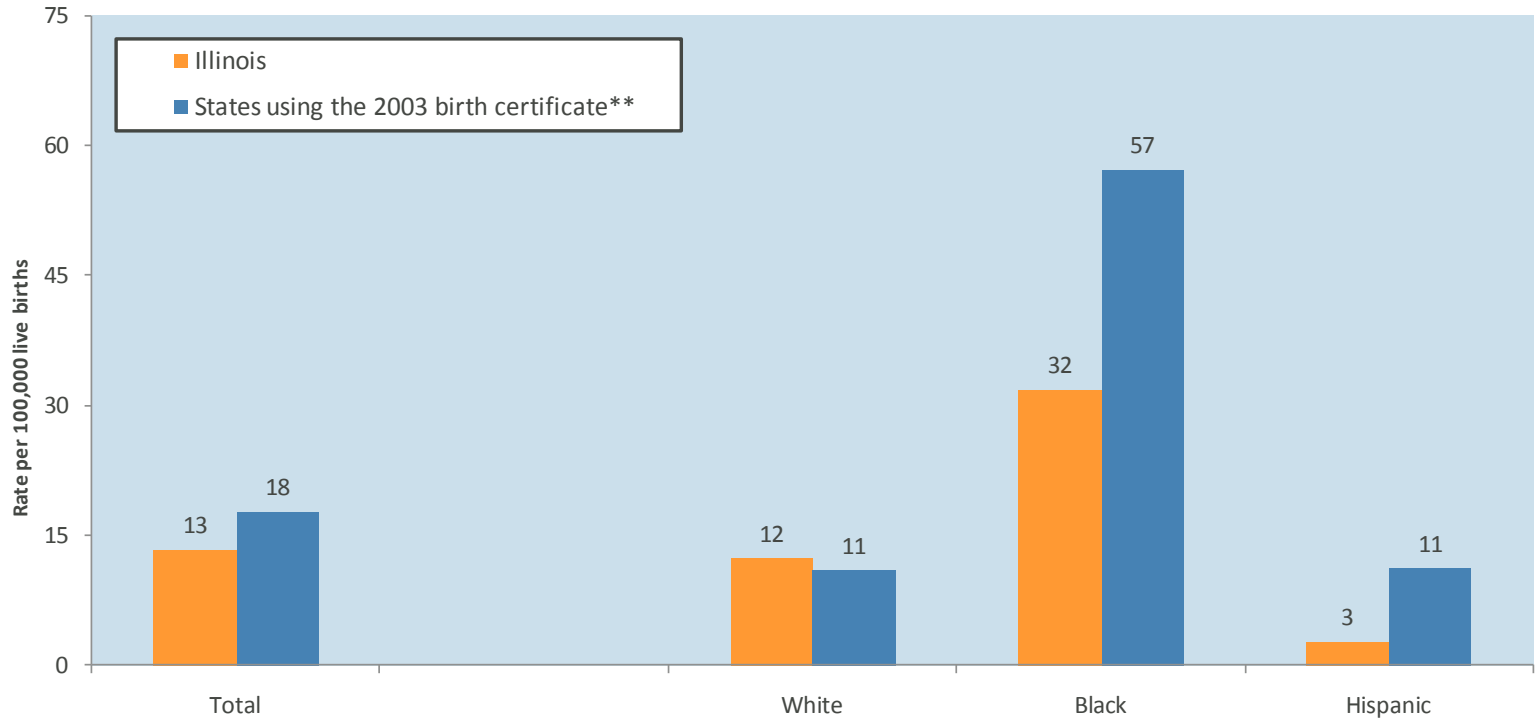
2 Amnesty International. (2010). Deadly delivery: The maternal health care crisis in the USA. Retrieved from http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf

3 Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. Retrieved from http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html

4 U.S. Department of Health and Human Services. (2013). Healthy People 2020. Objective MICH-5. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26

5 Bacak, S. J., Berg, C. J., Desmarais, J., Hutchins, E., & Locke, E. (Eds.) (2006). State mortality review: Accomplishments of Nine States. Centers for Disease Control and Prevention. Retrieved from http://www.cdph.ca.gov/data/statistics/Documents/MO-CDC-ReportAccomplishments9States.pdf

Maternal Mortality Rate* (per 100,000 live births), 2010

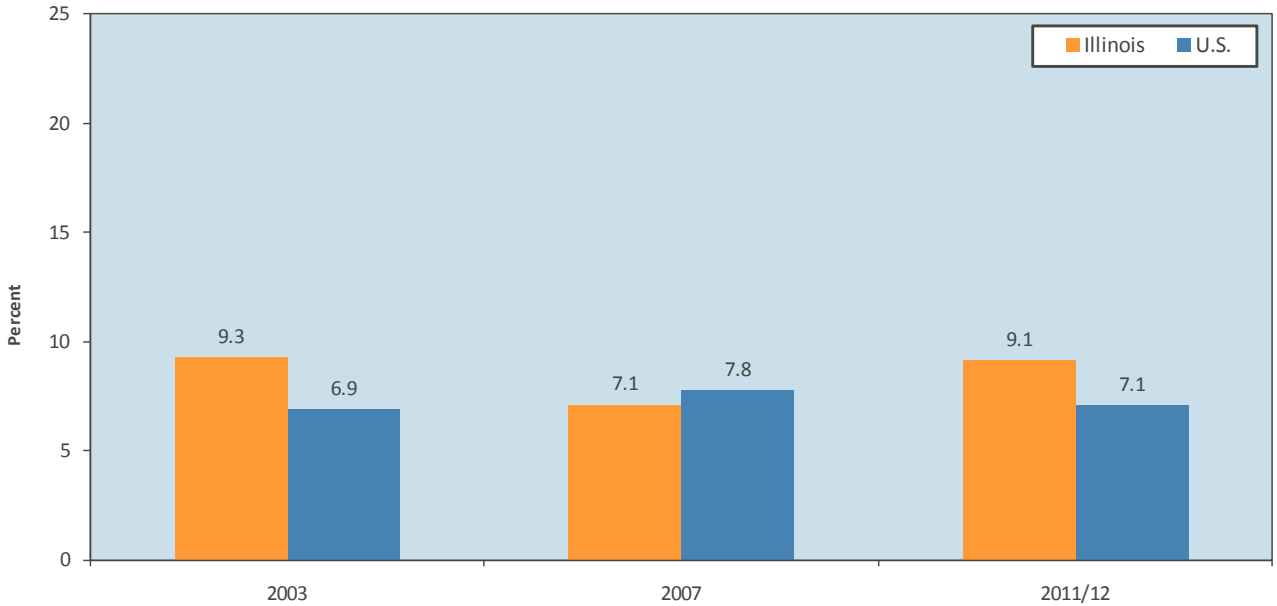


*The maternal mortality rate indicates the likelihood of a pregnant woman dying of maternal causes. The number of live births used in the denominator is an approximation of the population of pregnant women who are at risk of a maternal death. "Maternal deaths" are defined by the World Health Organization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

**States that used the 1989 version of the birth certificate are not comparable. In 2010, 34 states, representing 76 percent of births in the US, were using the 2003 revision.

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

Percentage of Children, Ages Birth through Two, Whose Parents Report Frequent Stress from Parenting,* 2003, 2007, 2011/12



*Children qualify as having stressed parents if their parents responded "Usually" or "Always" to one or more of the following statements about their feelings during the past 30 days: "child was much harder to care for than other children"; "often bothered a lot by their child's behavior"; and/or "angry with child"
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

Nine percent of parents of Illinois infants and toddlers reported parental stress in 2011/12, compared with seven percent nationally.

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

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

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

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

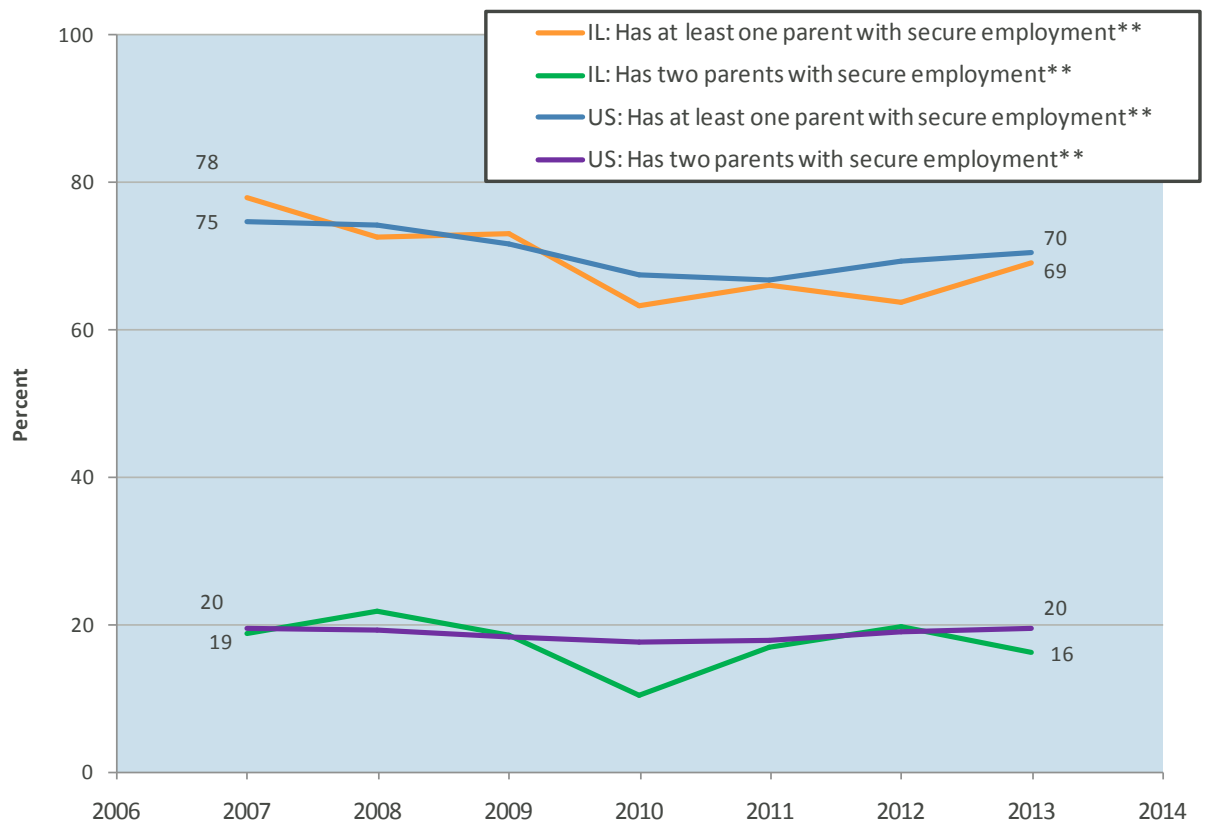
secure parental employment

As of 2013, just over two-thirds (69 percent) of Illinois infants and toddlers lived with at least one parent who was employed full-time, year-round. This is up from 2010's figure of 63 percent, a recent low reflecting the impact of the Great Recession. In 2011-2013, 79 percent of children in two -parent families, and 25 percent of children living with a single mother, had secure parental employment.

For nearly all families with young children, parental employment is a necessity for meeting basic needs. For low-income families, it is not a guarantee of escape from poverty, but it is associated with higher family income and greater access to private health insurance. In some cases, long hours of employment among mothers with very young children have been associated with modestly negative child outcomes.[1]

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

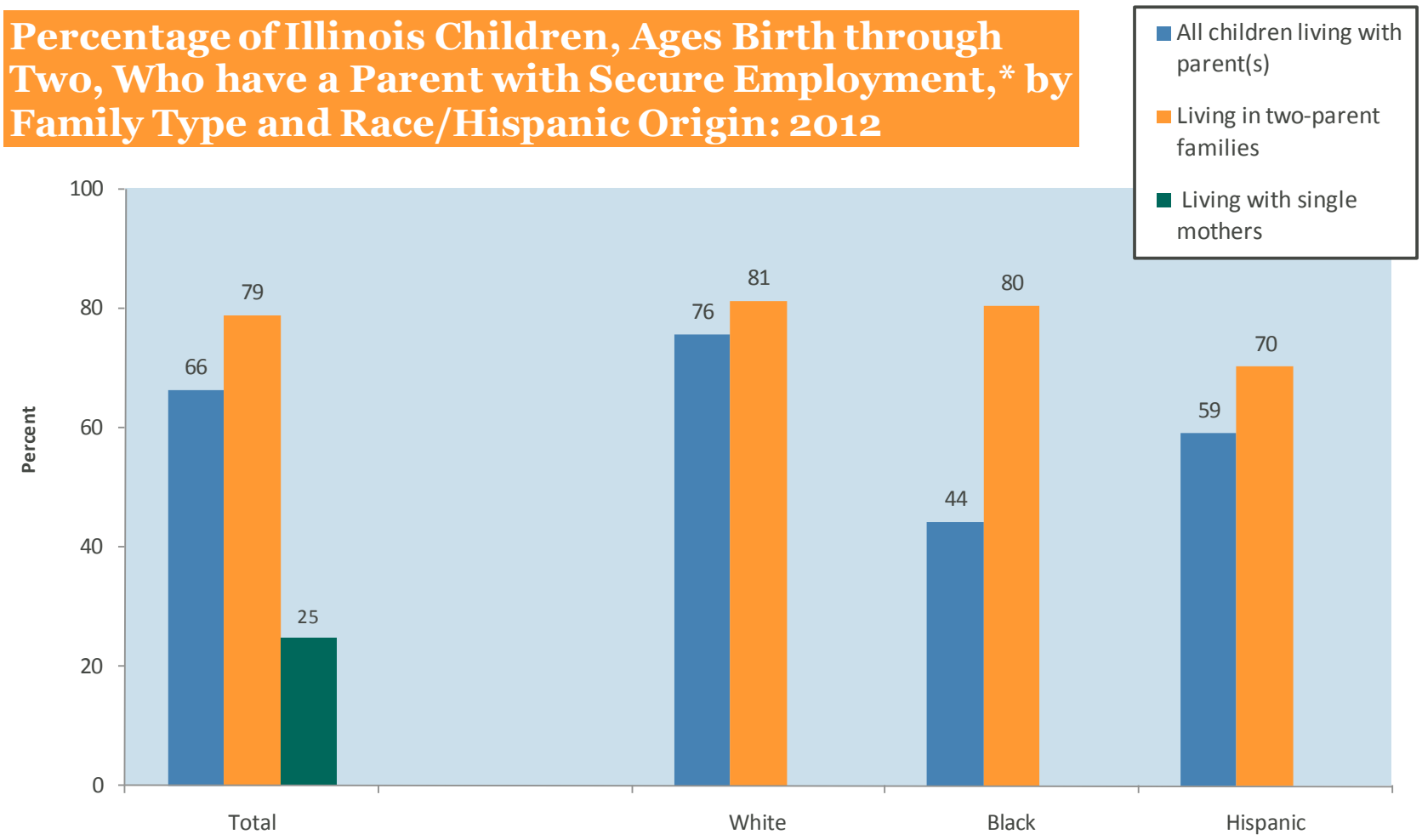
Percentage of Children, Ages Birth through Two, Who have a Parent with Secure Employment*: 2007-2013



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

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

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

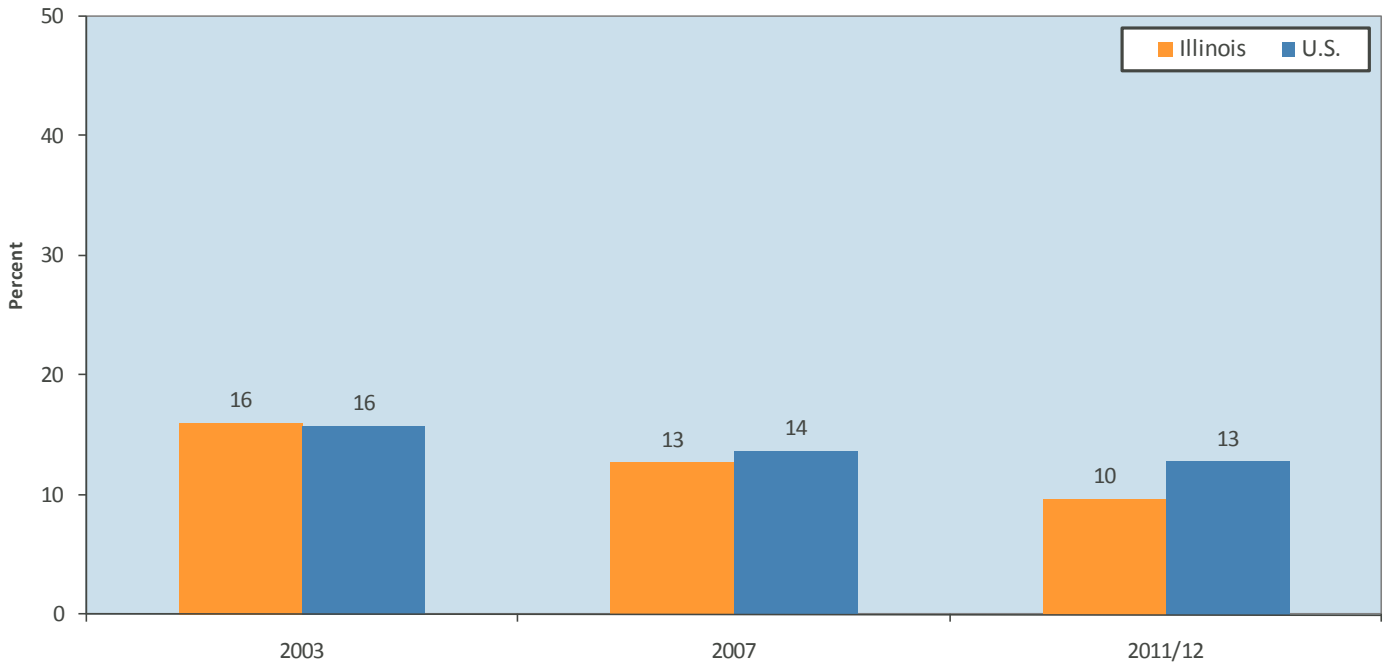


*Secure employment is defined as having worked full time for 50 to 52 weeks in the past year.
Source: Child Trends' analysis of Current Population Survey, March Supplement.

Neighborhood and Family Context

neighborhood safety

Parent Report of Unsafe Neighborhoods*, Among Children Ages Birth Through Age Two: 2003, 2007 and 2011/12



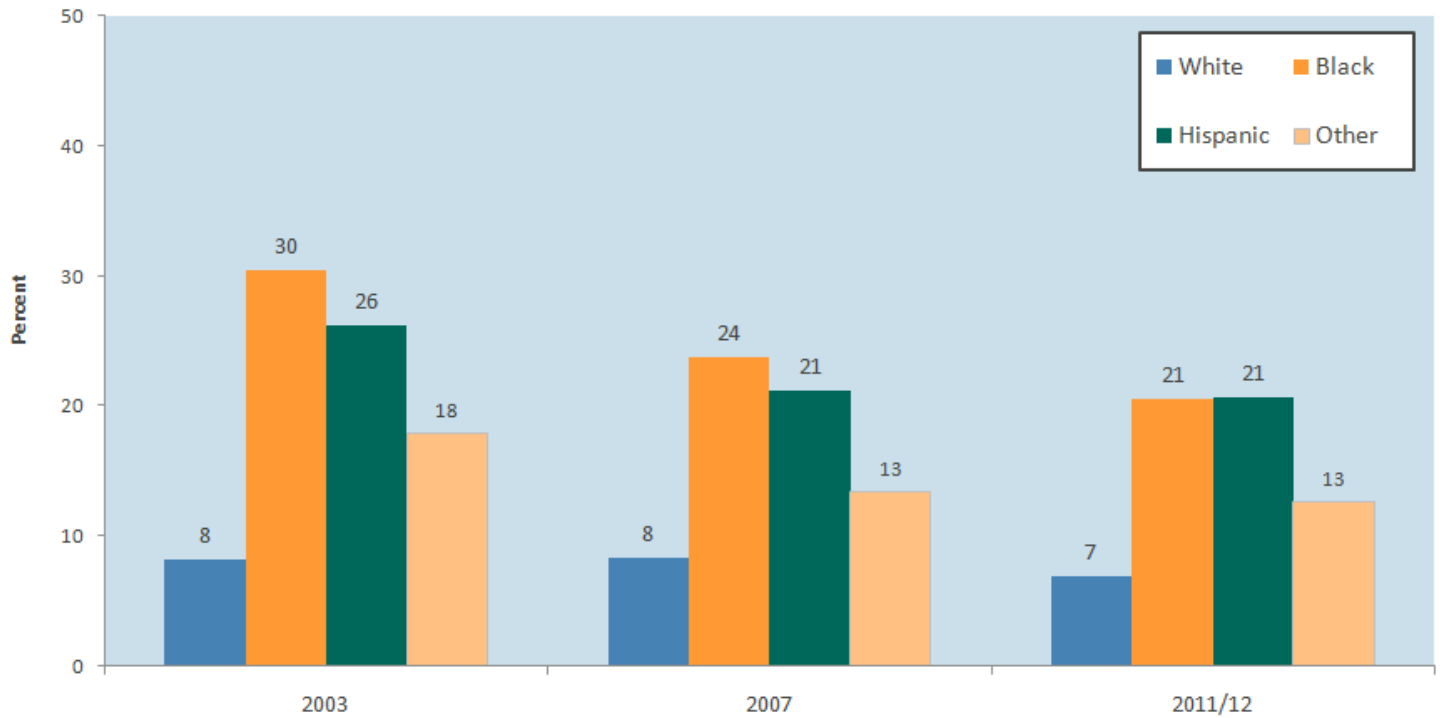
*Children in unsafe neighborhoods refers to children whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

In 2011/12, about one in ten Illinois infants and toddlers lived in neighborhoods their parents considered to be never or only sometimes safe. This percentage is down from one in seven in 2003. National data show young Latino and black children, and all children living in poverty, were more than two-and-a-half times as likely to live in unsafe neighborhoods as were their white, or their more economically secure, counterparts.

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

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

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



*Children in unsafe neighborhoods refers to children whose parents responded "never" or "sometimes safe" when asked "How often do you feel the child is safe in your community or neighborhood?"

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

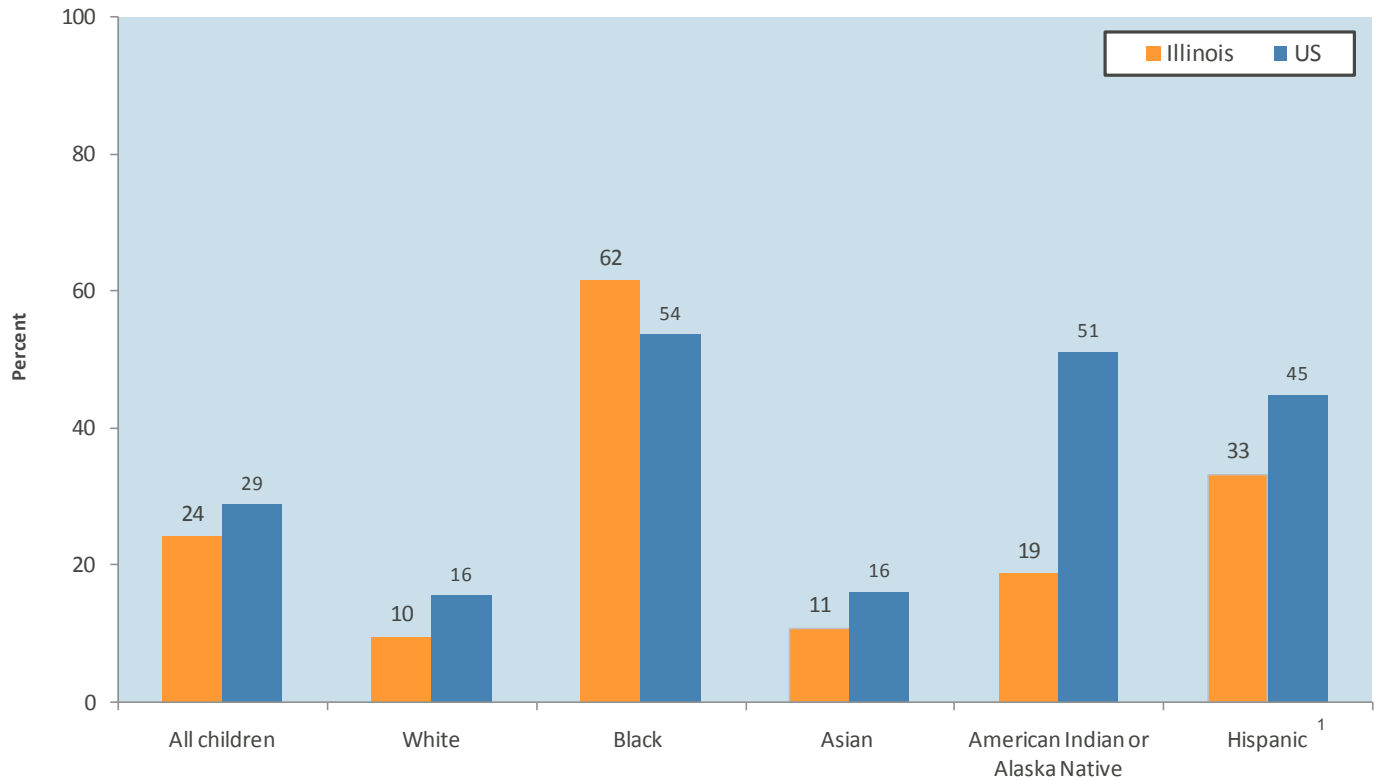
concentrated poverty

Nearly one in four (24 percent) Illinois under the age of 5 live in areas of concentrated poverty, and one in 20 (five percent) live in areas with poverty rates of 40 percent or more. Young Hispanic Illinoisans are more than three times as likely as their white counterparts to live in concentrated poverty, and young black Illinoisans more than six times as likely.

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

Here, areas with concentrated poverty are defined as census tracts where 20 percent or more of residents are poor.

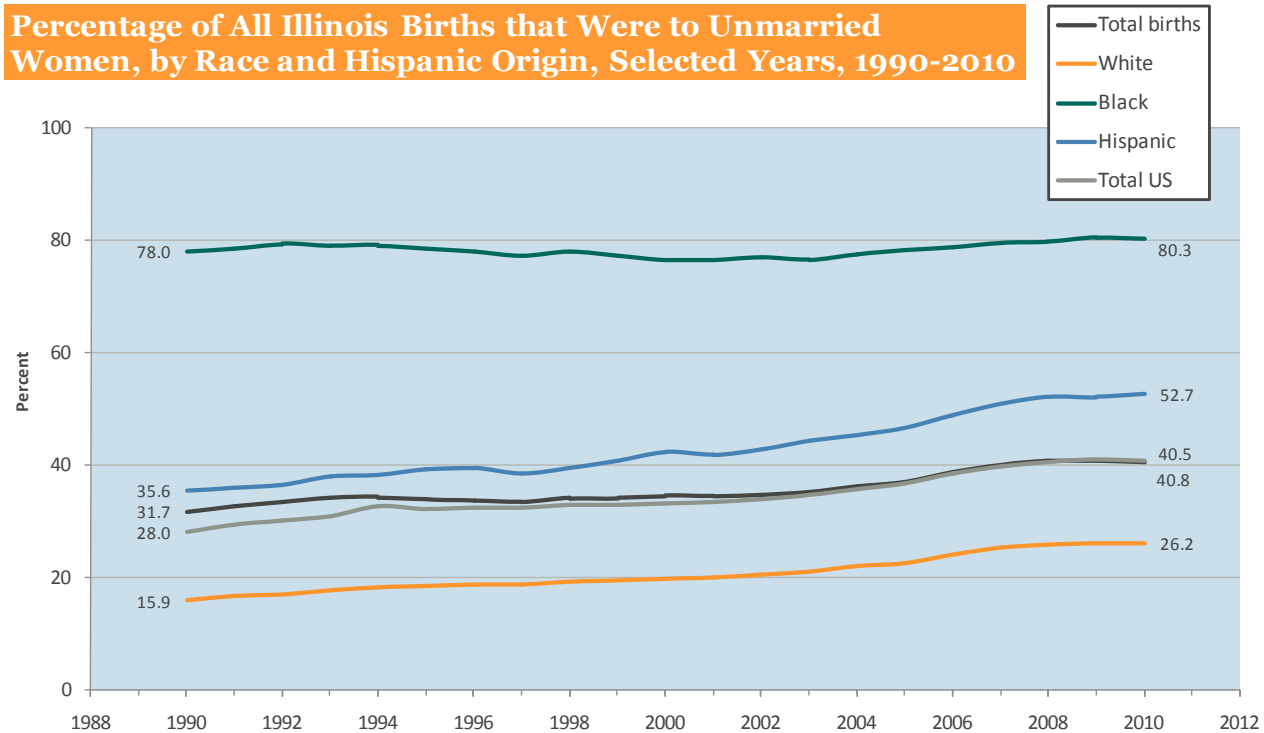
Percentage of Children, Birth through Four, Living in Concentrated Poverty,* Total, and by Race/Hispanic Origin: 2007-2011



* Concentrated poverty is defined as a census tract where 20 percent or more of the population has incomes below the poverty line.
[1] Hispanics may be any race
Source: Child Trends' analysis of the American Community Survey.

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

Percentage of All Illinois Births that Were to Unmarried Women, by Race and Hispanic Origin, Selected Years, 1990-2010



births to unmarried women

Sources: Data for 1990-2002: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2003-2010: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

There are marked disparities by race/ethnicity in the percentage of Illinois births that are to unmarried women. Among black women, the proportion is eight in ten; among Latinas it is a bit more than half; among white women, it is about one in four.

More than ever before, women are having births outside of marriage. Infants born to unmarried mothers are statistically at greater risk for economic hardship and other related poor outcomes.[1]

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

More so than age, mothers' education is strongly associated with the probability that a birth will occur outside marriage. Nationally, for women with less than a high school education, 83 percent of first births occur in the absence of marriage; for women with a high school diploma or some college that drops to 58 percent; and for college graduates, it drops further, to 12 percent.[3]

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

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

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

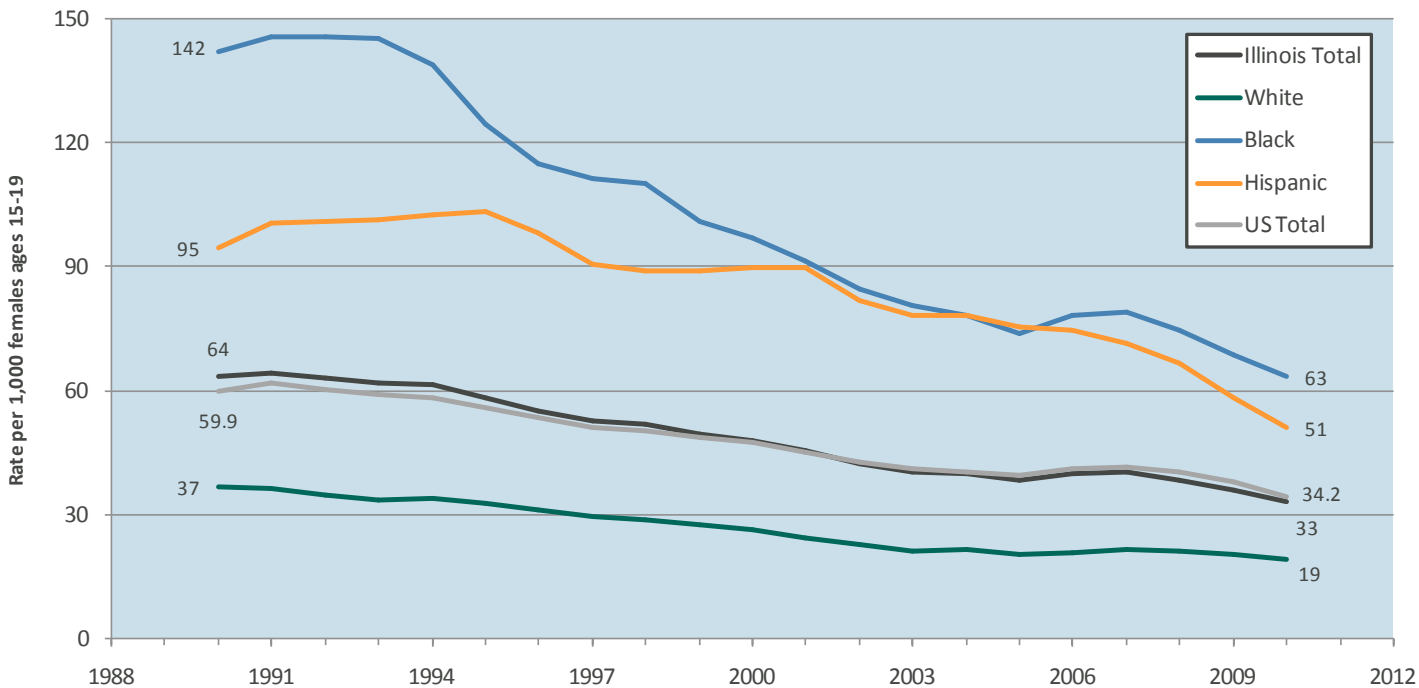
births to teens

In recent years, birth rates have fallen among white, black, and (especially) Latina teens in Illinois. However, rates among Hispanics are more than twice as high as they are among white teens, and rates among blacks are more than three times as high. Compared to national data, Illinois birth rates are higher among black teens, and lower among Hispanic, American Indian, and Asian teens.

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

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

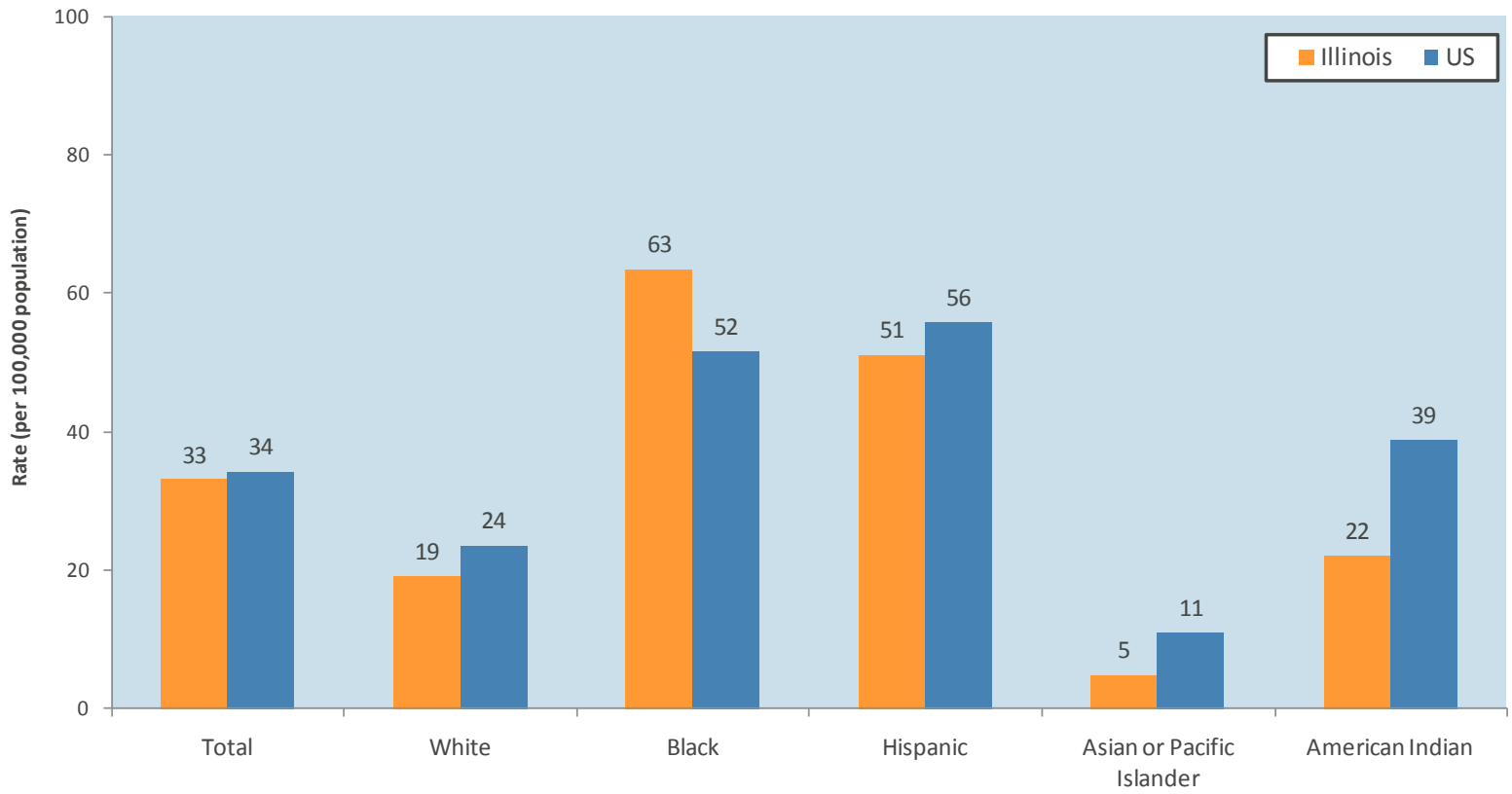
Birth Rates (per 1,000) for Illinois Females Ages 15 to 19, by Race and Hispanic Origin, Selected Years, 1960-2011*



Sources: Number of births 1990-1995: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Number of births 1995-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Population estimates 2000-2010: U. S. Census Bureau. (2012). Intercensal estimtes (2000-2010): State. Available at: http://www.census.gov/popest/data/intercensal/state/state2010.html. Population estimates 1990-1999: U. S. Census Bureau. (2003). State and county intercensal estimates by demographic characteristics (1990-1999) . Available at: http://www.census.gov/popest/data/intercensal/st-co/characteristics.html.

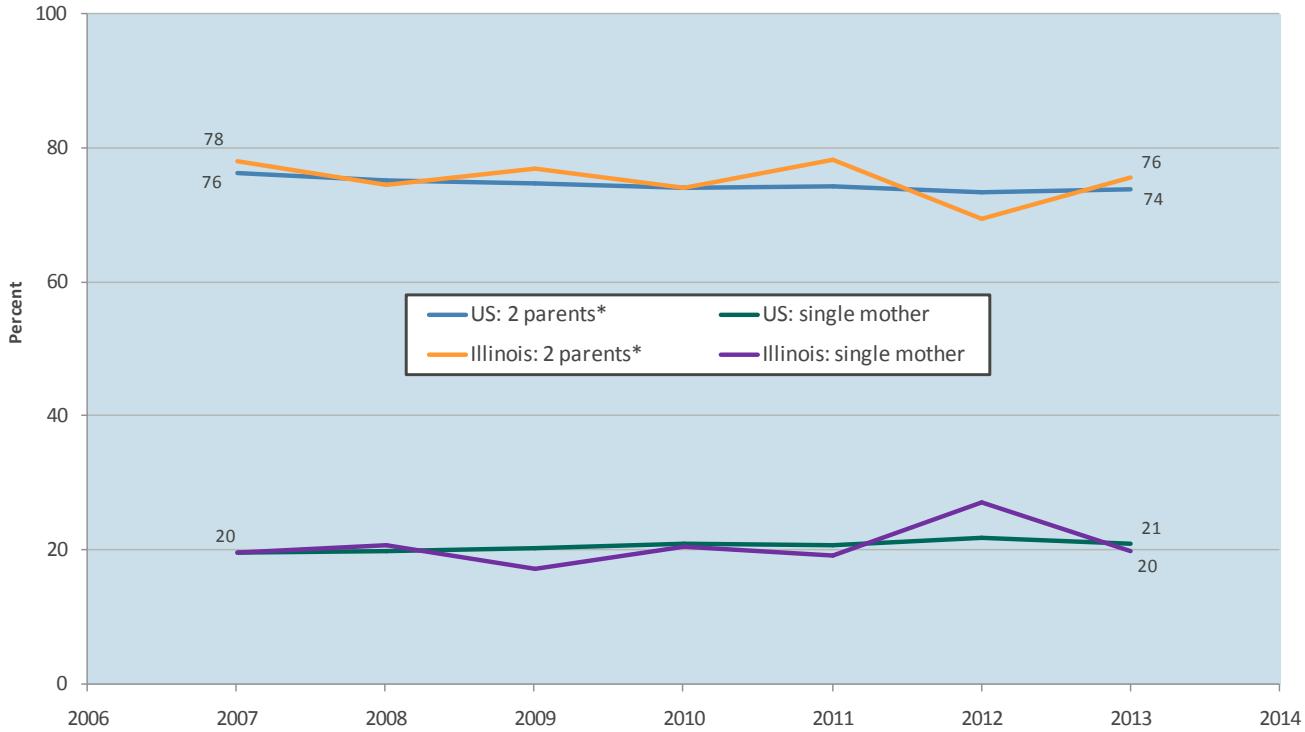
1 Child Trends DataBank. (2012). Teen births. Retrieved from http://www.childtrends.org/?indicators=teen-births

Birth Rates (per 1,000) for Females Ages 15 to 19, by Race and Hispanic Origin, 2010



Sources: Number of births: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Population estimates: U. S. Census Bureau. (2012). Intercensal estimtes (2000-2010): State. Available at: http://www.census.gov/popest/data/intercensal/state/state2010.html.

Family Structure among Children Ages Birth through Two, 2007-2013



*Includes biological, step-, or adoptive parents
Source: Child Trends' calculations from the Current Population Survey: March Supplement

With minor exceptions, trends in family structure among Illinois families closely parallel the national data.

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

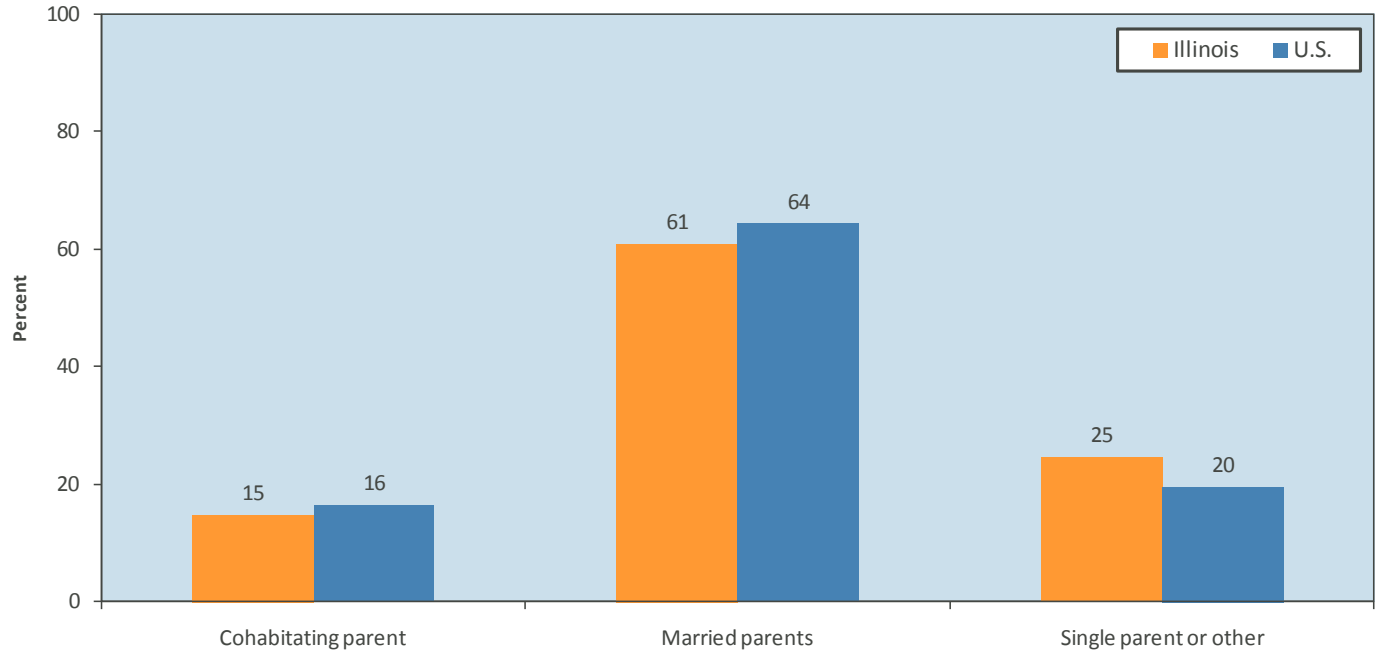
Young children who live with no biological parents, or in single-parent households, are less likely to exhibit behavioral self-control and more likely to be exposed to high levels of aggravated parenting than are children living with two biological parents. Single-parent families have much lower incomes, on average, than do two-parent families, while families headed by cohabiting partners fall in-between. Research finds, however, that the income differential only partially accounts for the negative effects in many areas of child and youth well-being (including health, educational attainment and assessments, behavior problems, and psychological well-being) associated with living outside of a married, two-parent family.[1]

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

As of 2013, three-quarters of Illinois infants and toddlers reside with two parents; about one in five lives with their mother only, and small percentages with their father only, or with no parent. For today's young adults, marriage is increasingly separated from parenthood.[2] As noted previously, family structure and family income are strongly associated. Low-income mothers in Illinois with an infant or toddler are four times as likely to be single, compared with their counterparts in more affluent families. Illinois infants or toddlers with single mothers are also disproportionately black (nearly six times more prevalent than among whites) and Latino (more than three times as prevalent).

Although six in ten Illinois infants and toddlers are in households headed by two married adults, one in seven lives with parents who are cohabiting rather than married. Nationally, nearly half of young children living with cohabiting parents are in poverty; a third have parents who have not finished high school, while the parents of another third have only a high school education.

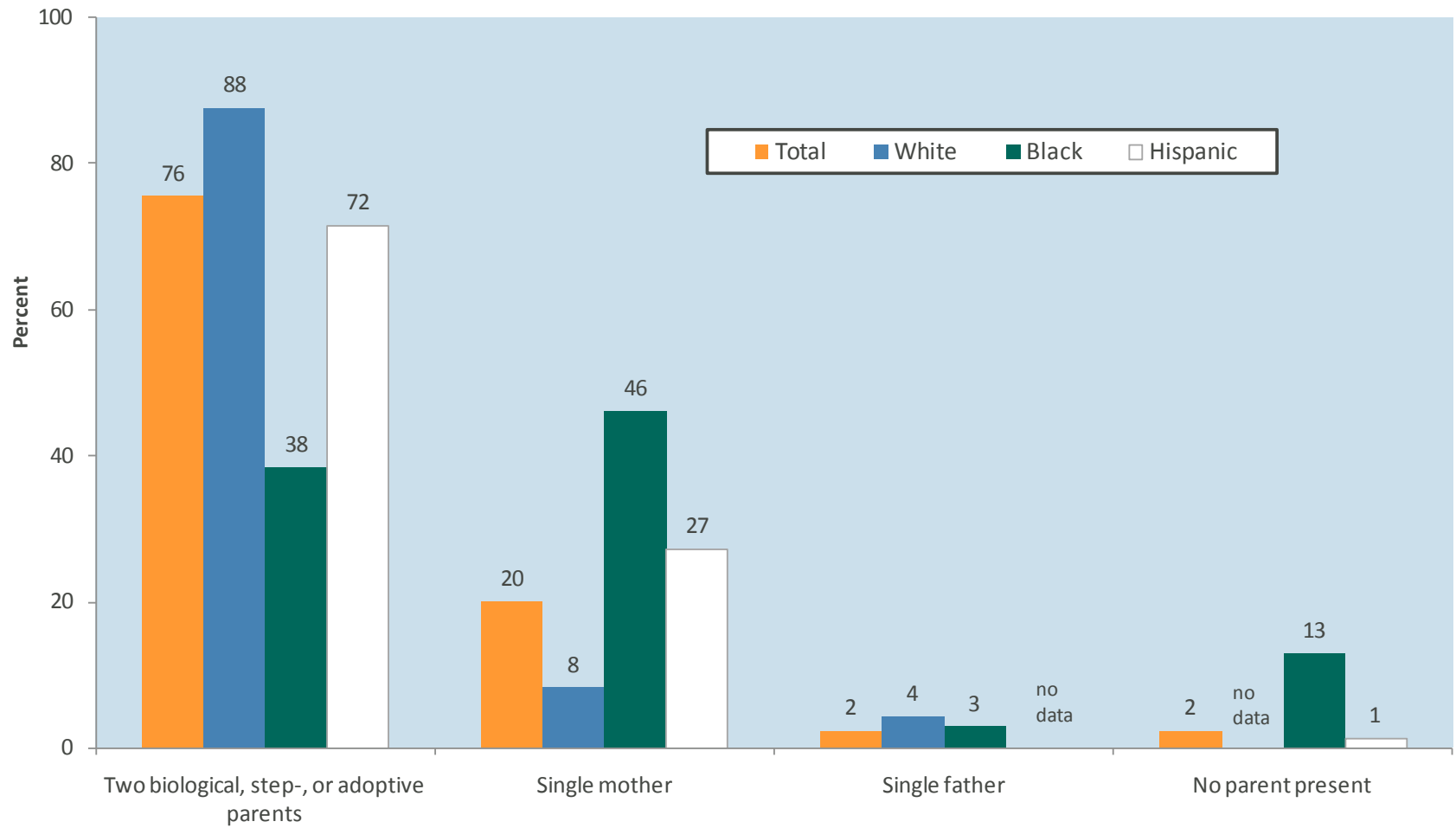
Percentage of Children, Ages Birth Through Two, by Family Structure, 2011/2012



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

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

Family Structure Among Illinois Children Ages Birth Through Two, Percentages by Race and Hispanic Origin, 2013



Source: Child Trends' calculations from the Current Population Survey: March Supplement

grandparent-headed households

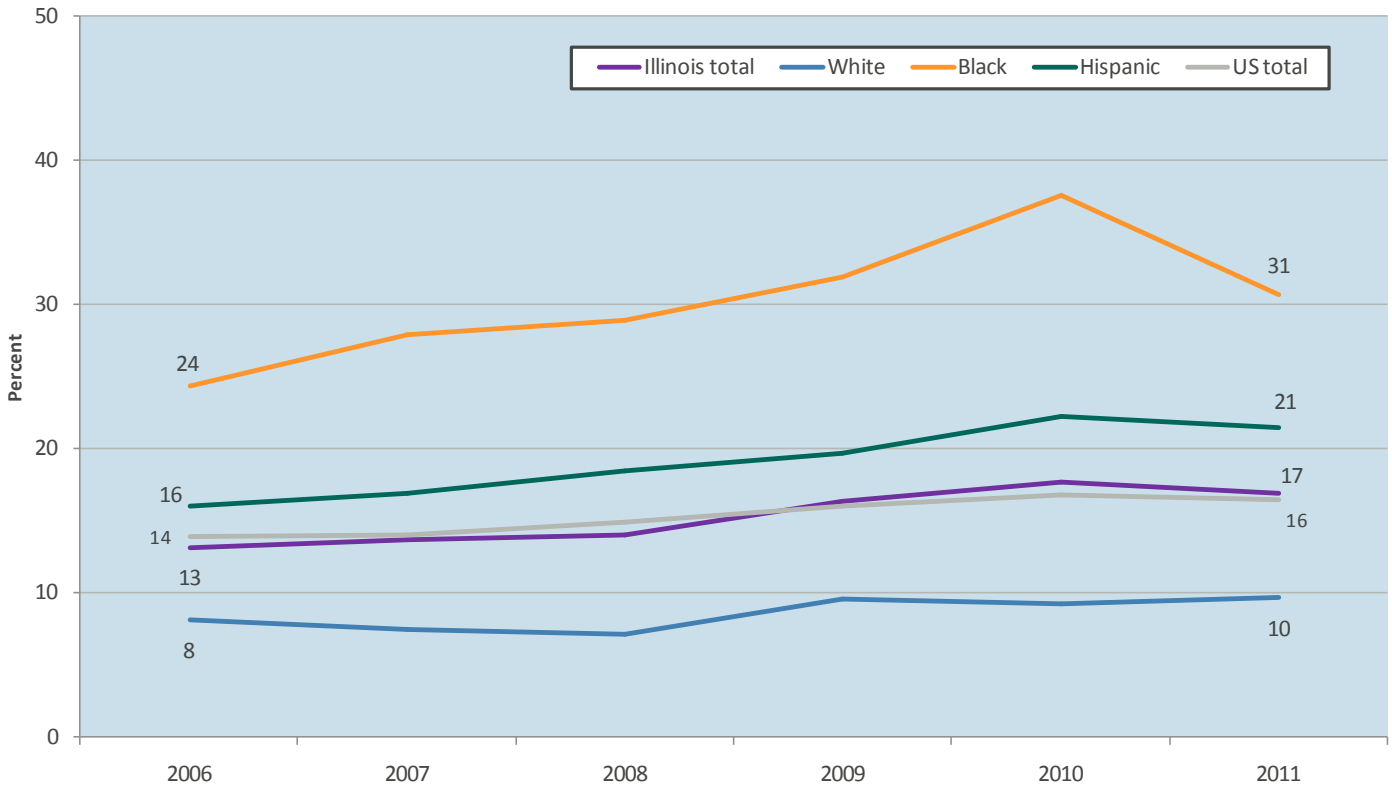
As of 2011, about one in six Illinois infants and toddlers lived in households headed by grandparents. This is an increase of 27 percent since 2006. Black and Hispanic infants and toddlers are more likely than their white peers to live in a grandparent-headed household.

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

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

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

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



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

infants and toddlers in foster care

Infants are more likely than children in any other age group to be placed in foster care. About one in four of children admitted to foster care for the first time are infants. On average, these will spend more of their childhood years in foster care than will older children who enter care. However, infants are adopted at higher rates than are older children.[1]

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

Because infancy is the period in which attachment relationships—which have long-term implications for social-emotional well-being—are established, foster care poses an exceptional risk for babies. Thus, almost by definition, infants in foster care have experienced multiple traumas.[2]

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates for infants and toddlers specifically.

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

2 Child Trends DataBank. (2012) Foster care. Retrieved from http://www.childtrends.org/?indicators=foster-care

English proficiency

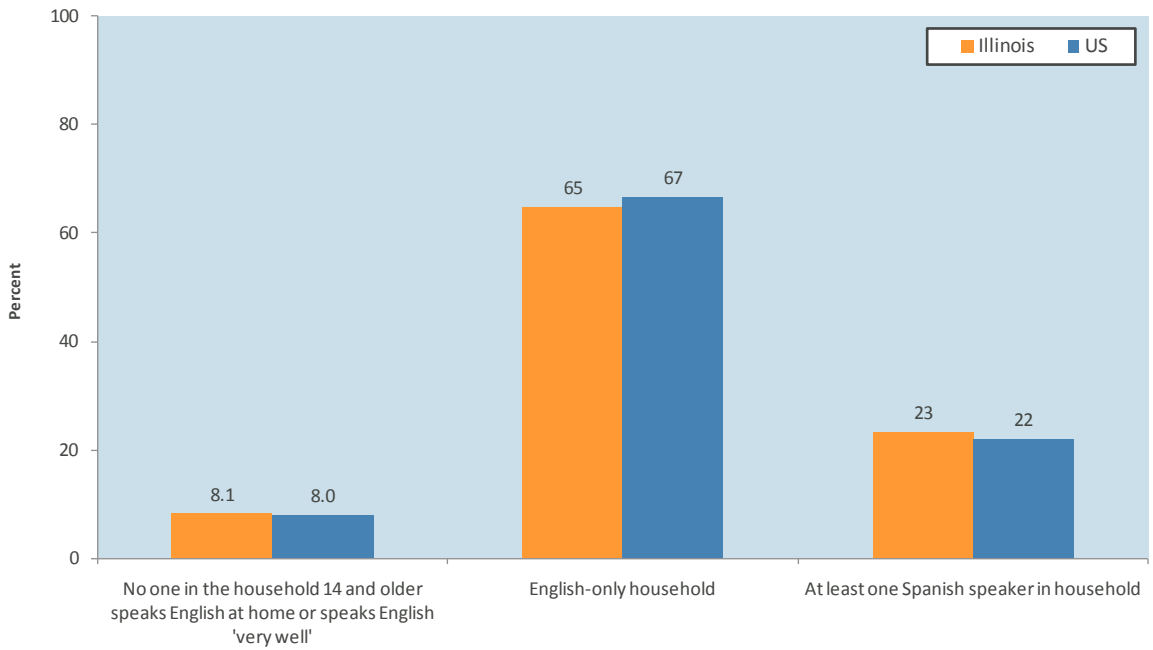
Illinois has the ninth-highest rate of infants and toddlers living in a household where no one over the age of 14 speaks English only or very well (8.1 percent in 2011). Sixty-five percent of Illinois households with an infant or toddler were ones where only English was spoken, compared with 67 percent nationally.[1]

Perhaps nowhere is the growing diversity of American culture more apparent than in the language environment of infants and toddlers. Research supports the cognitive and other benefits for children of growing up in a multi-lingual milieu.[2] However, young children's parents who have limited English proficiency may face difficulty in navigating the various service systems associated with meeting their own, and their children's, needs. For example, families with one or more parents who have limited English proficiency are less likely to receive a child care subsidy.[3]

Learning language is one of most important accomplishments of the infant-toddler period. Young children who are exposed to a language-rich environment reap advantages in later cognitive and social development. For children who are not English language speakers, research supports the effectiveness of direct dual-language instruction.[4]

Nationally, about one in thirteen infants and toddlers lives in a household where no adult speaks English at home, and all adults speak English less than "very well." One in five (22 percent) lives in a household where someone speaks Spanish. Just two-thirds of infants and toddlers live in households where English is the only language spoken.[5]

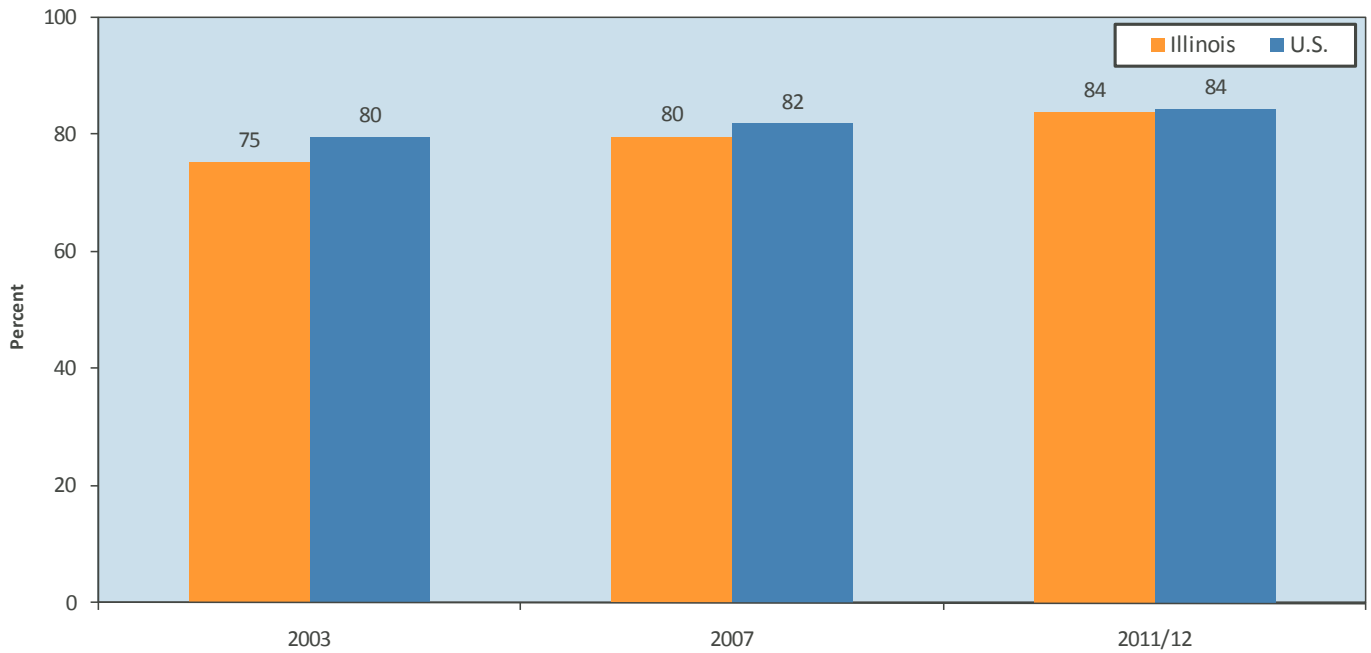
Children Ages Birth through Two, in Limited-English, Spanish-Speaking, and English-Only Households, 2011



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

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

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



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

Data from 2011 show that more than eight in ten (84 percent) Illinois babies and toddlers ate meals with their families at least four days per week. Nationally, young children in families who are in poverty are slightly less likely to share family meals than children in families with higher incomes. Regardless of race/Hispanic origin, large majorities of children frequently eat meals with family, though black children are slightly less likely to do so than are white or Latino children.

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

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

use of television and hand-held electronics

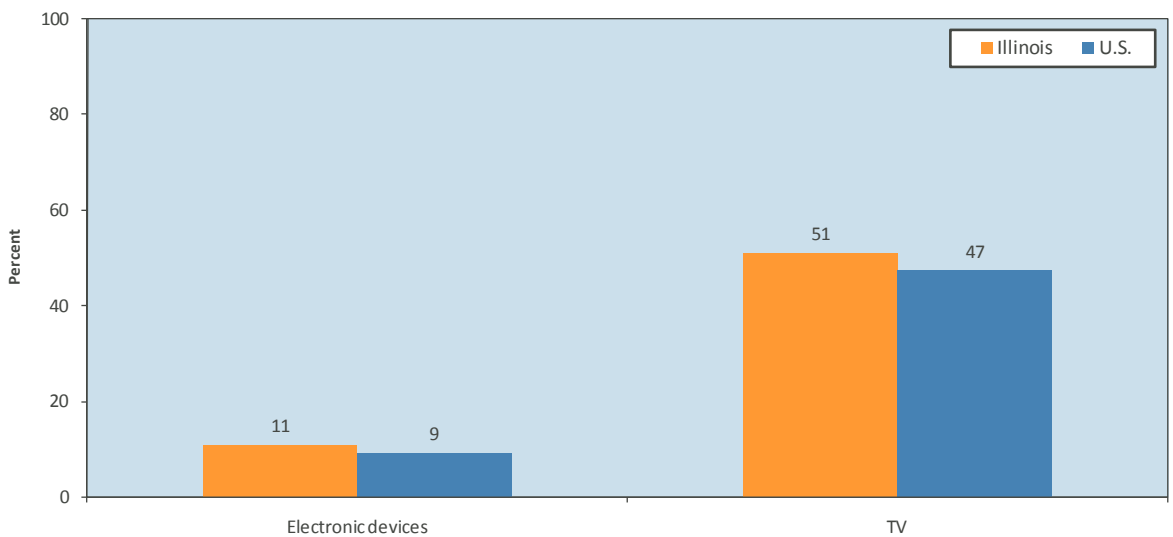
More than half of Illinois infants and toddlers (according to parents' report) spend an hour or more per weekday in front of a television, either watching programs or playing video games. Less than one-third are reported to watch "none" on a typical weekday. According to national data, black infants and toddlers and those living in poverty are more likely than their counterparts to watch an hour or more.

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

Other 2011/12 data supplement these by reporting on use of computers, cell phones, video games, and "other handheld electronic devices." More than one in five Illinois infants and toddlers use these for some amount of time on an average weekday, while one in nine are in front of them for an hour our more daily.

National data show that young black children are more than three times as likely as their white counterparts to be "heavy" users of these media (an hour or more on a typical weekday). Young children in poverty are about half again as likely to be "heavy" users as those in families with incomes at least twice the poverty level.

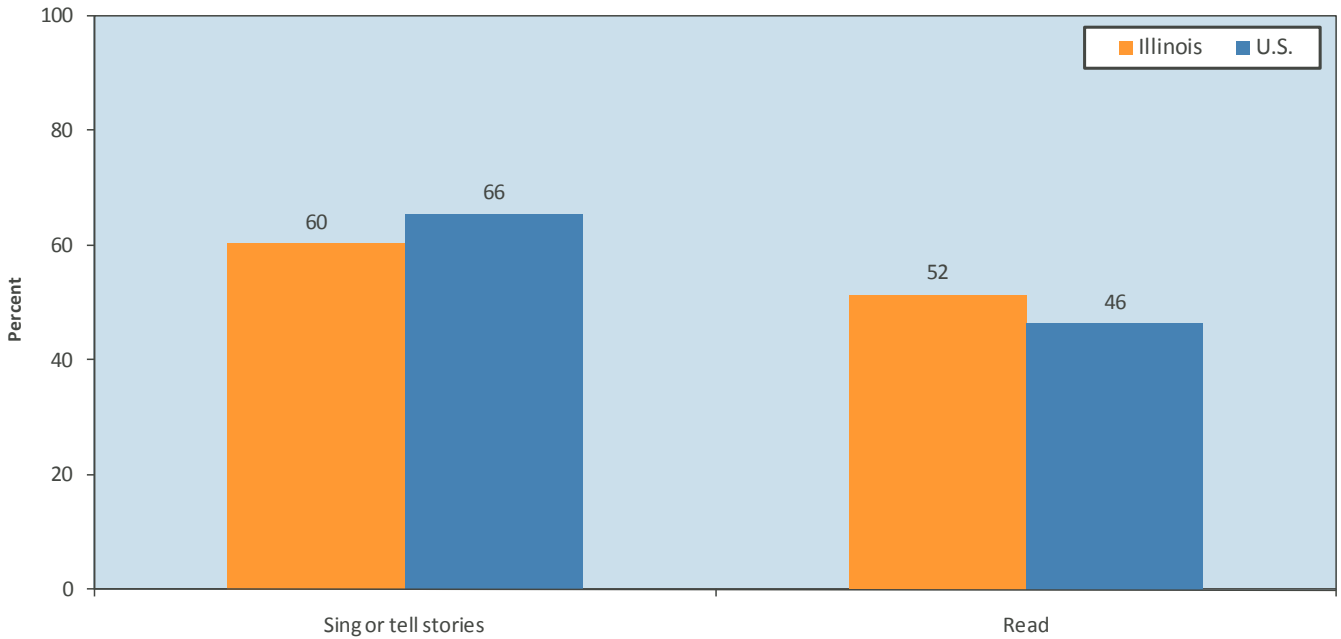
Percentage of Children, Ages Birth through Two, Who Spent and Hour or More In Front of the Television* and Using Electronic Devices on an Average Weekday: 2011/12**



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

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

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



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

reading, telling stories, and singing songs to young children

Just over half of Illinois children ages birth through two (52 percent) were read to by a family member every day during the past week. Children in families with higher levels of income are more likely to be read to regularly: about three in ten young children living in poverty are read to every day, compared with six in ten who live in families with the highest incomes (two or more times greater than the poverty level). Nationally, white children are about twice as likely as Latinos to have family members read to them frequently; black children fall in between.[1]

Children develop literacy skills and an awareness of language long before they are able to read. Since language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school.[2]

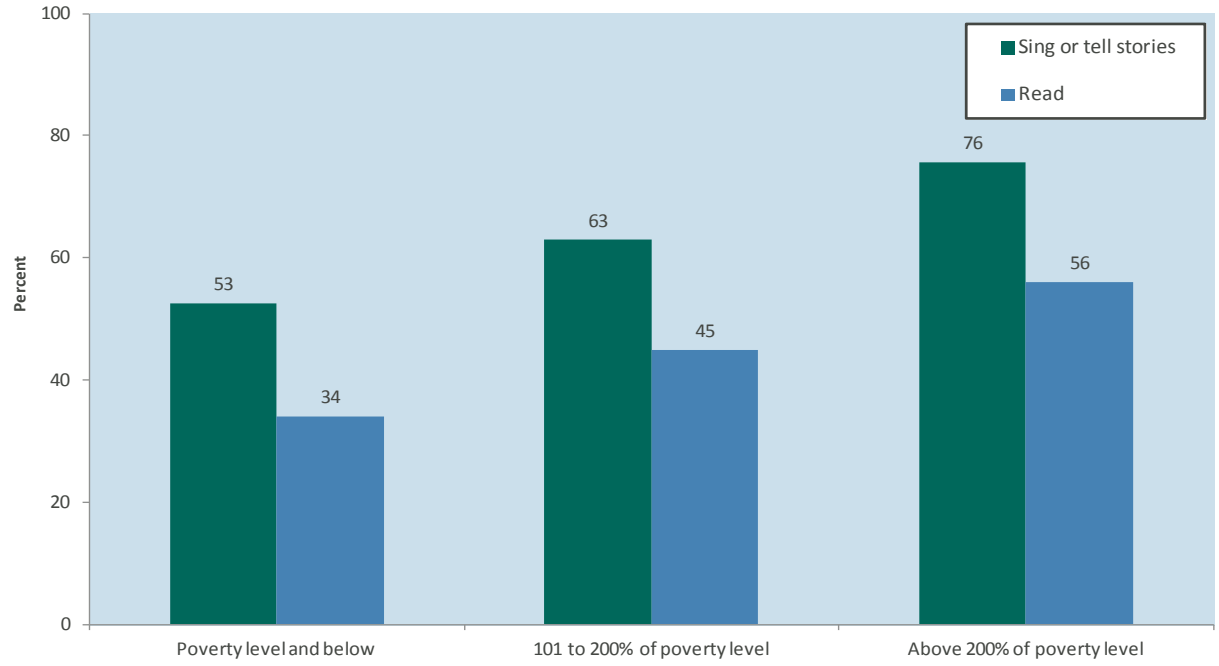
Young children who are regularly read to have a larger vocabulary, higher levels of phonological, letter name, and sound awareness, and better success at decoding words. The number of words in a child's vocabulary can be an important indicator of later academic success. Children's vocabulary use at age three is a strong predictor of language skill and reading comprehension at ages 9-10.[3]

1 Child Trends' analysis of the National Survey of Children's Health.
2 Child Trends DataBank. (2012). Reading to young children. Retrieved from http://www.childtrends.org/?indicators=reading-to-young-children
3 ibid.

Another shared activity that promotes early literacy skills and provides opportunities for closeness between young children and other family members is singing songs or telling stories together.

In 2011/12, 60 percent of Illinois infants and toddlers were sung to or told stories every day—lower than the national average of 66 percent. Illinois has some of the greatest disparities by income in children who were sung to or told stories every day. For children in poverty, Illinois has the lowest ("worst") rate among all the states, but for children in families with incomes four or more times higher than the poverty level, Illinois is ranked eighth best. Similar disparities exist for being read to every day.[4]

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



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

4 Child Trends' analysis of the National Survey of Children's Health taken from the Data Resource Center for Child and Adolescent Health at childhealthdata.org

Public/Private Supports

parental leave

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

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

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

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

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

Survey data do not include sufficient numbers of cases to provide reliable Illinois-specific estimates for this indicator.

1 Employees must be part of a firm with at least 50 workers within 75 miles of the worksite; must have worked at least twelve months with the firm, and have worked 1,250 hours during the past year.

2 Matos, K. & Galinsky, E. (2012). 2012 National Study of Employers. Families and Work Institute. Retrieved from http://familiesandwork.org/site/research/reports/NSE_2012.pdf

3 National Partnership for Women & Families. (2012). Dads expect better: Top states for new dads. Retrieved from http://www.nationalpartnership.org/site/DocServer/Dads_Expect_Better_June_2012.pdf?docID=10581

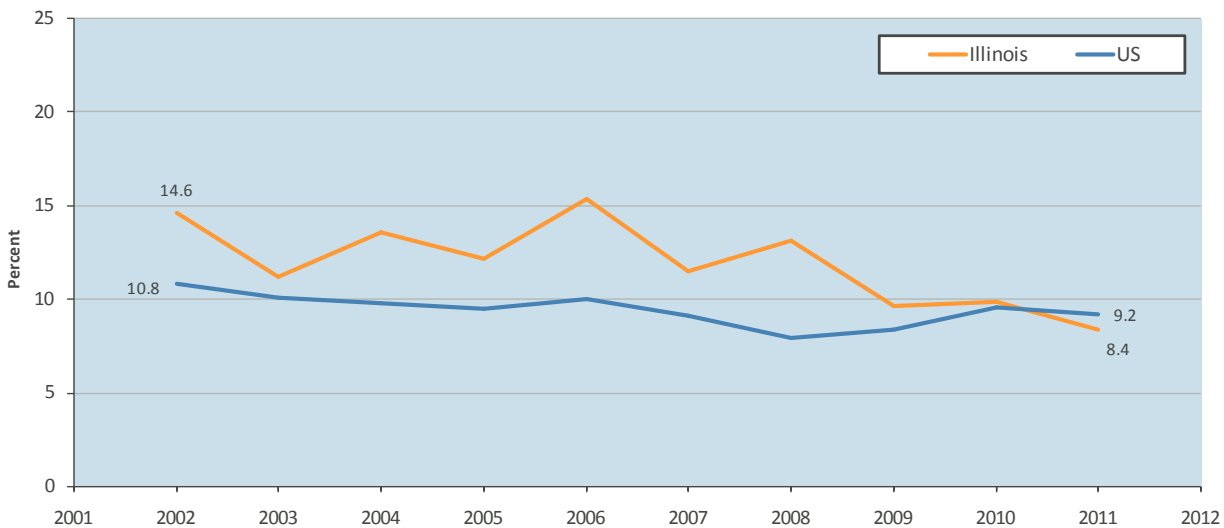
child care: enrollment, quality, cost, subsidy

Like other states, Illinois has a patchwork of insufficiently coordinated child care options, the quality of which is uncertain. The types of care employed mothers predominantly use for their children (ages birth through four) have changed only slightly in the past 25 years. Between 1985 and 2011, the percent of these children whose primary caregiver during working hours was a parent has fluctuated between 22 and 29 percent. The proportion in center-based programs increased from 23 to 26 percent between 1997 and 2011. The percentage of children who were cared for by a relative has remained fairly steady for the past decade, between 25 and 27 percent. The strongest trend has been a consistent decrease in the percentage of children who are cared for by a non-relative at home, which declined from 28 to 14 percent between 1985 and 2011.[1]

Numerous studies have documented an association between high-quality care and children's positive development. The strongest evidence of positive long-term outcomes associated with early childhood programs comes from studies of intensive and comprehensive programs targeting the most vulnerable children.[2] Recent research has suggested that a relatively high level of quality is needed in order to affect child outcomes.[3]

States use multiple ways to invest in the quality of child care. First, their licensing systems are designed to ensure the health and safety of children. Second, states invest in the quality of child care settings with monies received from the Child Care and Development Fund, which includes a specific set-aside for improving the quality and availability of programs serving infants. Finally, states invest in professional development systems and services

Percentage of Eligible* Infants and Toddlers Served by a Child Care Subsidy Program: 2002-2011**



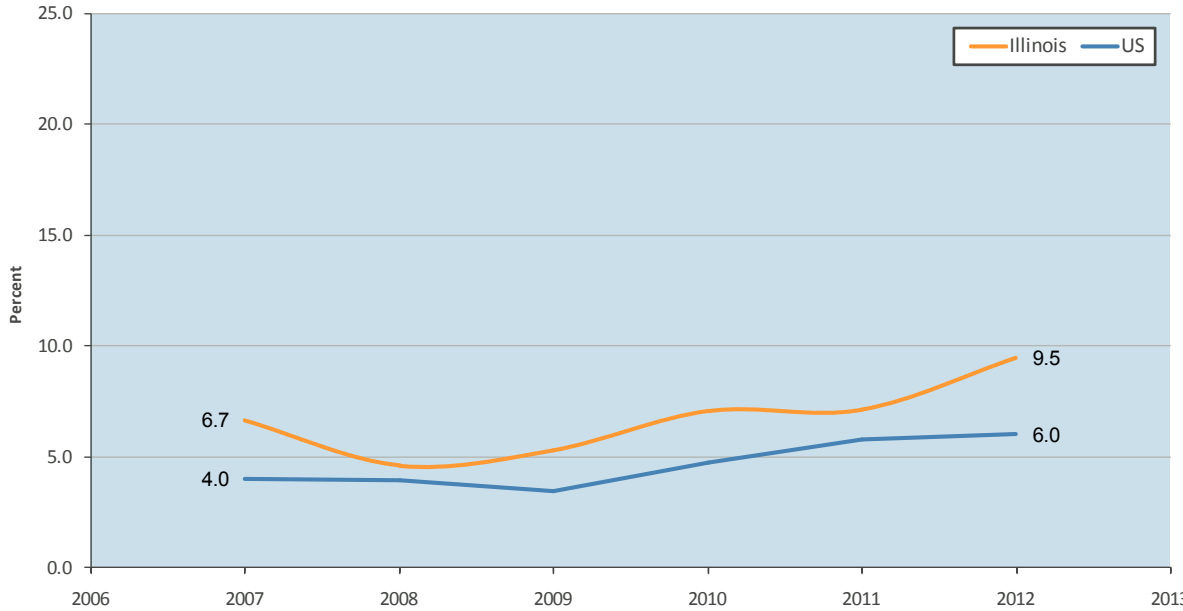
*Eligibility for subsidy in Illinois is based on a number of factors, including income, savings, and employment status. The estimate here is based on all infants and toddlers living in households with incomes of less than 185% of the federal poverty level.
** Data for 2011 is preliminary and may be modified at a later date.
Sources: Data for child care subsidies: ACF 801 administrative data (total number of children served multiplied by the % in each age range). Office of Child Care, Administration for Children and Families, Department of Health and Human Services. *Child care and development fund* statistics. Available at: http://www.acf.hhs.gov/programs/occ/resource/ccdf-statistics. Eligibility data: Child Trends analysis of the Current Population Survey, December Food Security Supplement.

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

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

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

Percent of Eligible* Infants and Toddlers Served by Head Start Programs, School Years 2007-2012



*Head Start guidelines require that at least 90% of children enrolled live at or below 100% FPL. The other 10% do not have income restrictions. The figures here are based on the number of infants and toddlers living below 100%FPL.
Sources: Head Start Data: HHS/ACF/OHS. (2013). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Eligiblity data: Child Trends' analysis of the Current Population Survey, March Supplement. Downloaded from: http://www.census.gov/cps/data/cpstablecreator.html.

that articulate standards for high quality care, provide supports for providers and programs to achieve those standards, and provide parents access to ratings of program quality.

The largest federal child care subsidy program is the Child Care and Development Fund (CCDF), serving nearly 17,000 Illinois infants and toddlers in 2011, representing eight percent of infants and toddlers with family incomes less than 185% of the federal poverty level in the state.[4] The stated goals of the Child Care and Development Fund subsidies are to promote promote parental employment, and the quality and accessibility of child care.[5] Child care subsidies are administered via vouchers to parents, or slots with contracted providers, and cover a portion of parents' child care expenses.

In 2012, Early Head Start in Illinois served more than 9,000 infants and toddlers, about one in ten of those who were eligible.[6] Early Head Start (EHS) is a comprehensive child development and family support program for infants, toddlers, and pregnant women in low-income families. Apart from family income, each EHS program sets its own eligibility criteria, targeting their services to best meet the needs of families and children in their community. Services may be delivered in centers, family child care homes, or individual family homes. In addition, EHS programs must allocate at least 10% of their enrollment slots to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act.[7]

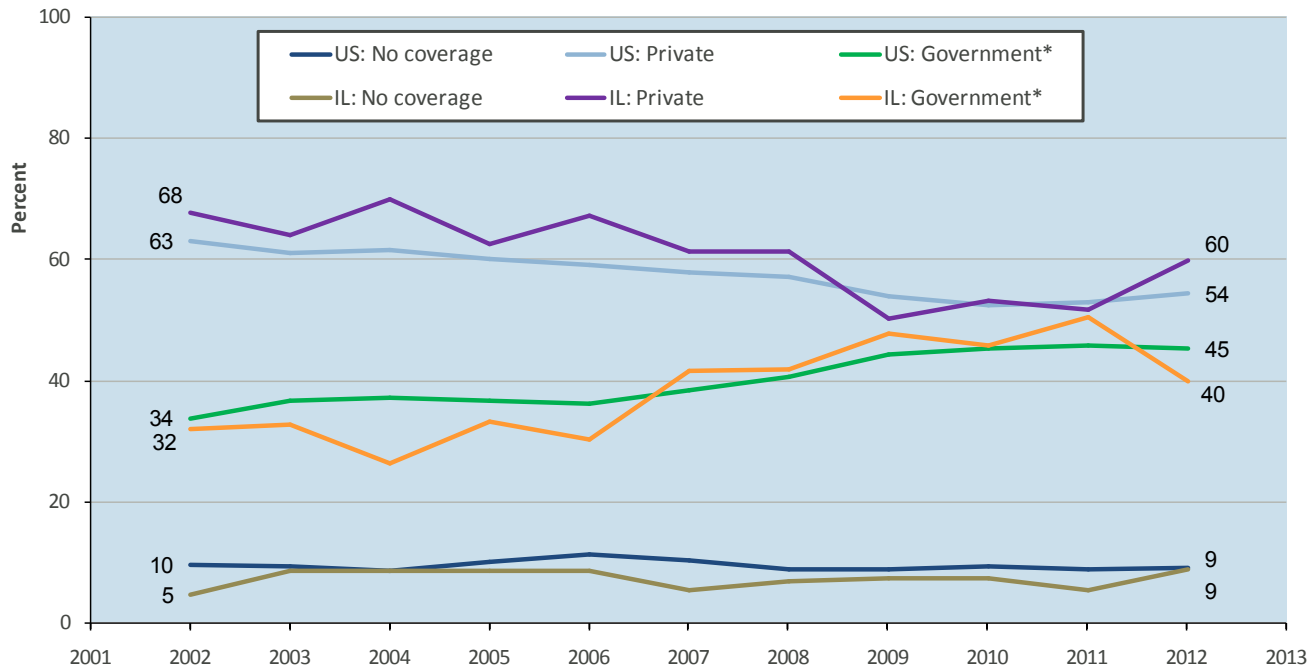
4 http://www.acf.hhs.gov/programs/occ/resource/child-care-and-development-fund
5 http://www.acf.hhs.gov/sites/default/files/occ/ccdf_factsheet.pdf
6 HHS/ACF/OHS. (2012). Program Information Reports. Available at: http://eclkc.ohs.acf.hhs.gov/hslc/mr/pir. Includes those enrolled in Migrant Early Head Start.
7 Early Head Start National Resource Center. http://www.ehsnrc.org/ChildEligible.htm

health insurance

In Illinois, infants and toddlers are much less likely than the national average to lack health insurance. Illinois had the fifth lowest rate of infants and toddlers without health insurance in 2011: two percent, compared with the national rate of six percent.[1] Lower-than-average rates of uninsurance were the case across white, black, and Hispanic sub-groups. A greater percentage of Illinois infants and toddlers are covered by public health insurance (among all these sub-groups) than is the case nationally. The proportion covered by private insurance is comparable to U.S. figures, except in the case of black infants and toddlers, who are considerably less likely than their counterparts nationally to have private insurance (22 and 31 percent, respectively).

Children not covered at all by health insurance, or who experience gaps in coverage, are less likely than those with continuous insurance coverage to have a regular source of health care, and are more likely than children continuously insured to have medical care delayed or unmet, and to have prescriptions unfilled. Gaps in coverage can be particularly detrimental for children with chronic health conditions, such as asthma, that require frequent, consistent preventive monitoring by health care providers.[2]

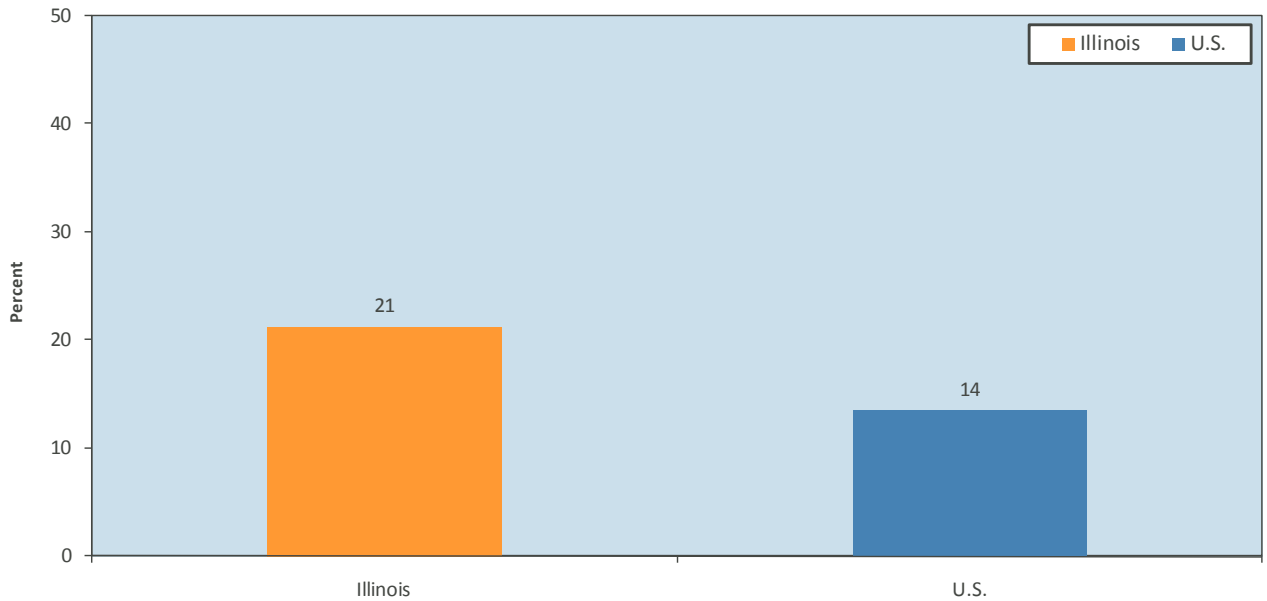
Children, Ages Birth through Two Years, Covered by Health Insurance at Any Point in the Past Year: Percentages by Type of Insurance, Selected Years, 2002-2012



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

1 Child Trends' analysis of the American Community Survey, Public Use Microdata Sample.
2 Child Trends DataBank. (2012). Health care coverage. Retrieved from http://www.childtrends.org/?indicators=health-care-coverage

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



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

More than one in five Illinois parents or children received one or more home visits between pregnancy and the child's third birthday, according to 2011/12 data.

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

Nationally, families living in poverty were about twice as likely to receive a home visit as were families with incomes at least double the poverty level. Black children were more likely to have gotten a home visit than were their white or Latino peers. Families with single mothers were more likely than two-parent families to have received a home visit.

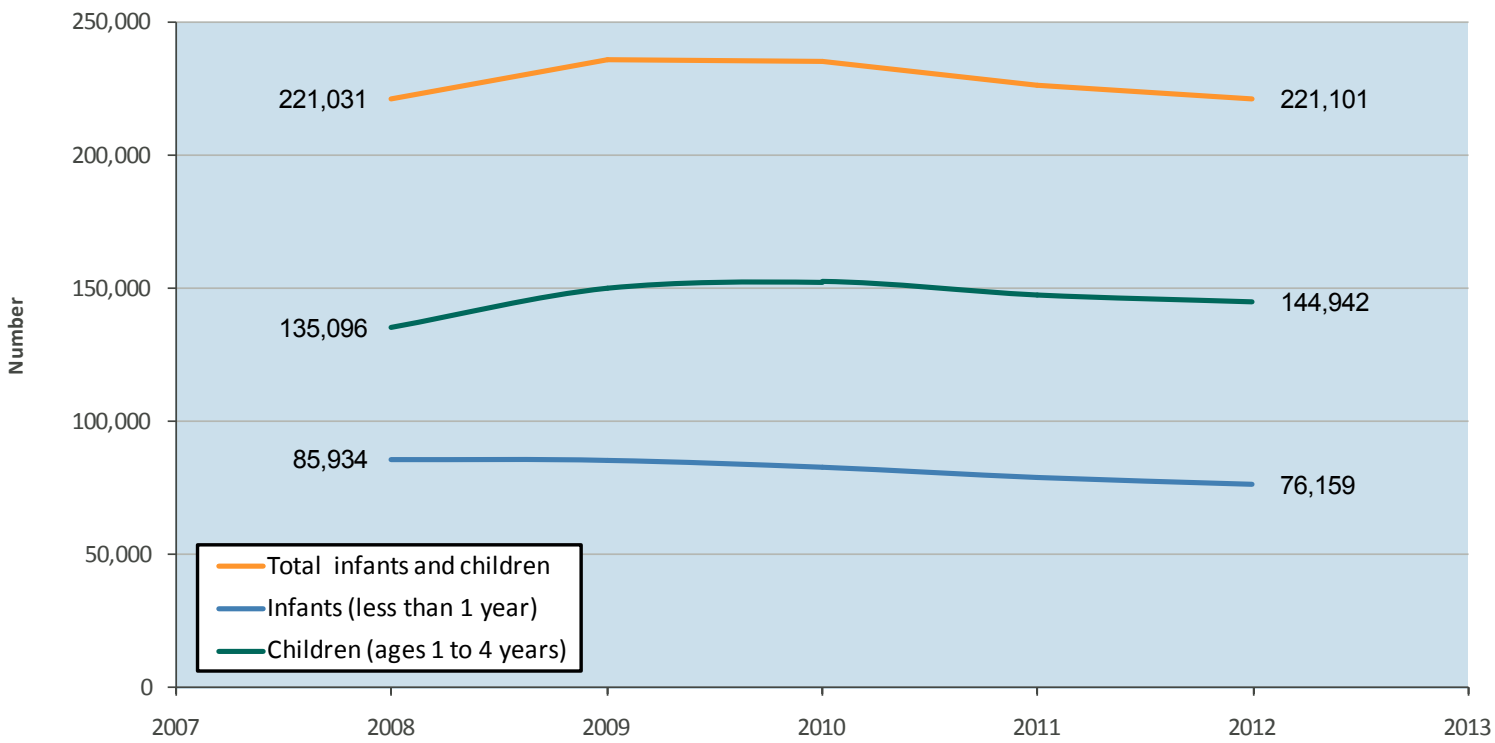
1 Kahn, J. & Moore, K. A. (2010). What works for home visiting programs: Lessons from experimental evaluations of programs and interventions. Child Trends Fact Sheet. Retrieved from http://www.childtrends.org/Files/Child_Trends-2010_7_1_FS_WWHomeVisitpdf.pdf

WIC

More than 220,000 Illinois infants and toddlers were served by WIC in 2012, about three-quarters of the estimated eligible population.[1]

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

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

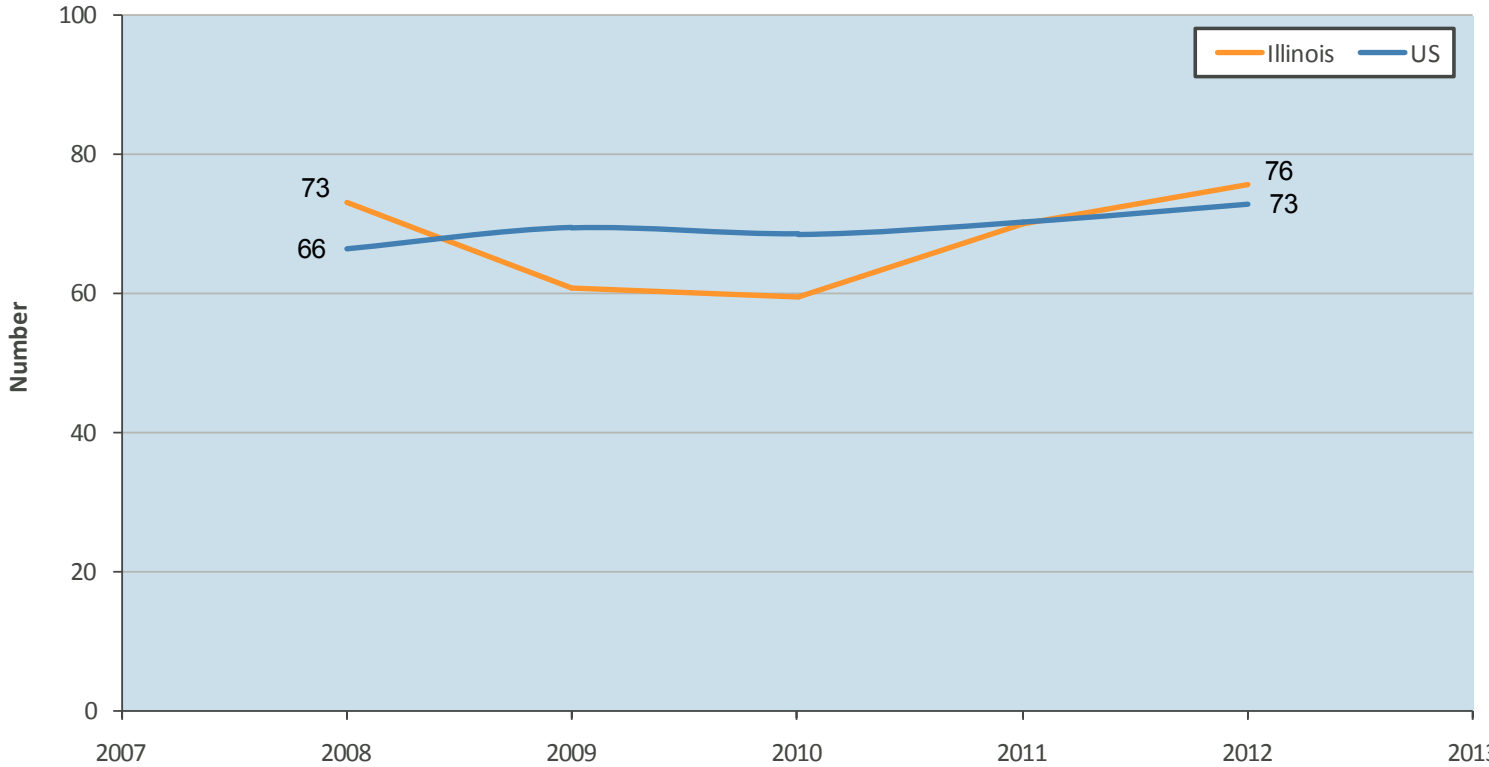


*2012 are preliminary data

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

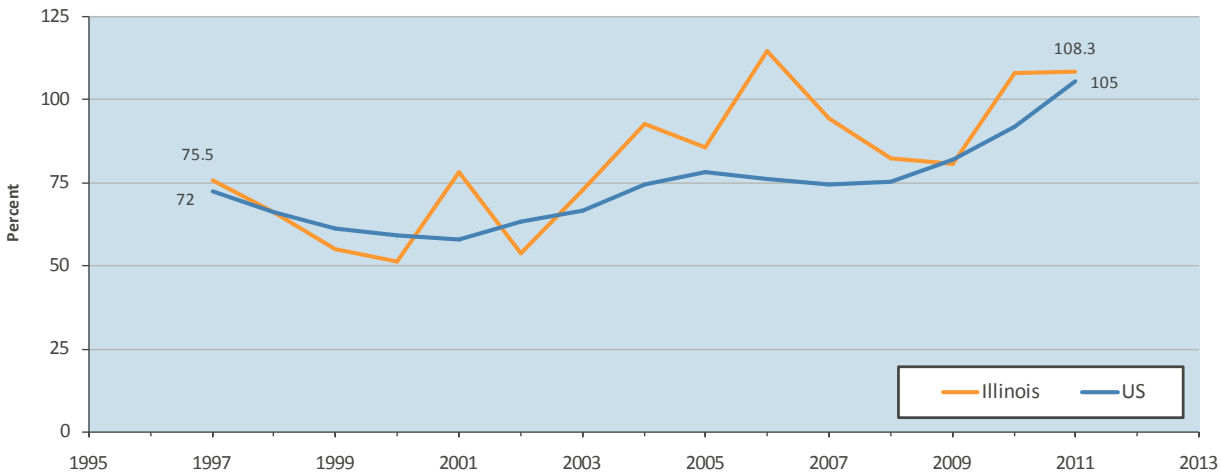
1 http://www.fns.usda.gov/pd/wisummary.htm
2 http://www.fns.usda.gov/wic/faqs/faq.htm
3 http://www.fns.usda.gov/wic/aboutwic/wicataglance.htm
4 Ibid.

Percentage of Eligible** Infants and Children, Ages Birth through Four, Served by the WIC Program, Fiscal Years, 2008-2012**



*Eligible children are estimated by all children less than five with family income less than 185% of the Federal Poverty Level.
**2012 are preliminary data
Source: USDA. (2013).Monthly Data: Agency Level, Participation and Program Costs by Category per person. Available at: http://www.fns.usda.gov/pd/wicmain.htm. Eligible participants estimated with Child Trends Analysis of the Current Population Survey, Food Security Supplement.

Children, Ages Birth Through Four, Who Received Food Stamps/SNAP, as a Percentage of Children at 125 percent of the Federal Poverty Level, Fiscal Years 1997-2011



Sources: Data for 1997-2007: U.S. Department of Agriculture, Food and Nutrition Service. www.fns.usda.gov/ora/MENU/Published/snap/SNAPPartNational.htm; Data for2008-2009: Letfin, J., Eslami, E., & Strayer, M. (2011). Trends in Supplemental Nutrition Assistance Program participation rates: 2002 to 2009. Department of Agriculture, Food and Nutrition Service. http://www.fns.usda.gov/ora/menu/Published/snap/FILES/Participation/Trends2002-09.pdf. Data for 2010: Eslami, E., Letfin, J. & Strayer, M. (2012). Supplemental Nutrition Assistance Program participation rates: Fiscal year 2010. Department of Agriculture, Food and Nutrition Service. Available at http://www.fns.usda.gov/ora/MENU/Published/snap/FILES/Participation/Trends2010.pdf. Data for 2011: Strayer, M., Eslami, E., & Letfin, J. (2012). Characteristics of Supplemental Nutrition Assistance Program households: Fiscal year 2011. Department of Agriculture, Food and Nutrition Service. Available at http://www.fns.usda.gov/ora/MENU/Published/snap/FILES/Participation/2011Characteristics.pdf

supplemental nutrition assistance program (SNAP)

In 2011, 273,000 Illinois children younger than five years received SNAP benefits. Using 125 percent of the federal poverty level as a conservative proxy for eligibility, these data suggest that the majority of this most-vulnerable group is receiving SNAP benefits.

Nationally, 96 percent of eligible poor households with children receive assistance from the Supplemental Nutrition Assistance Program (SNAP, formerly known as the food stamp program), a benefit designed to increase the food purchasing power of low-income households. Receiving SNAP benefits increases what households spend on food, and the availability of calories and protein.[1] Also, when controlling for other relevant factors, several studies suggest SNAP receipt increases food security,[2] defined by the U.S. Department of Agriculture as having "access at all times to enough food for an active, healthy life for all household members."[3]

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

1 Fox, M.K., Hamilton, W., Lin, B. (2004). Effects of food assistance and nutrition programs on nutrition and health: Volume 4, Executive summary of the literature review. Economic Research Service/USDA. p. 11. Available at: http://www.ers.usda.gov/publications/fanrr19-4/.

2 Ibid, p. 12.

3 Nord, M, Andrews, M, and Carlson, S. (2007). Household food security in the United States 2006. Economic Research Report No. ERR-49. Available at: http://www.ers.usda.gov/publications/ERR49

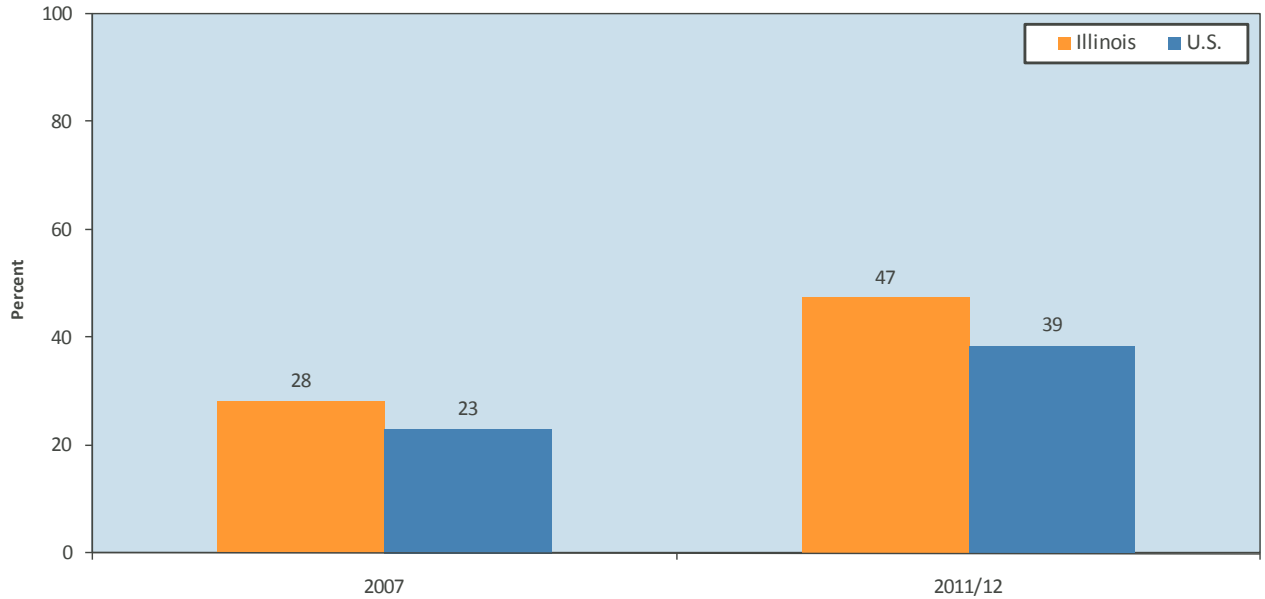
4 Tiehen, L, Joliffe, D., and Gundersen, C. (2012). Alleviating poverty in the United States: The critical role of SNAP benefits. U.S. Department of Agriculture, Economic Research Service. Retrieved from http://www.ers.usda.gov/publications/err132/

developmental screening

In 2011, just under half (47 percent) of Illinois infants and toddlers were screened, compared with 28 percent in 2007. Clear progress has been made in improving rates of developmental screening among the youngest children. This is higher than the national level of 39 percent. National-level data show inequities by race/Hispanic origin seen in earlier years are now non-significant. However, children identified as having a special health care need were more likely to receive a screening than were children without such need.

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

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



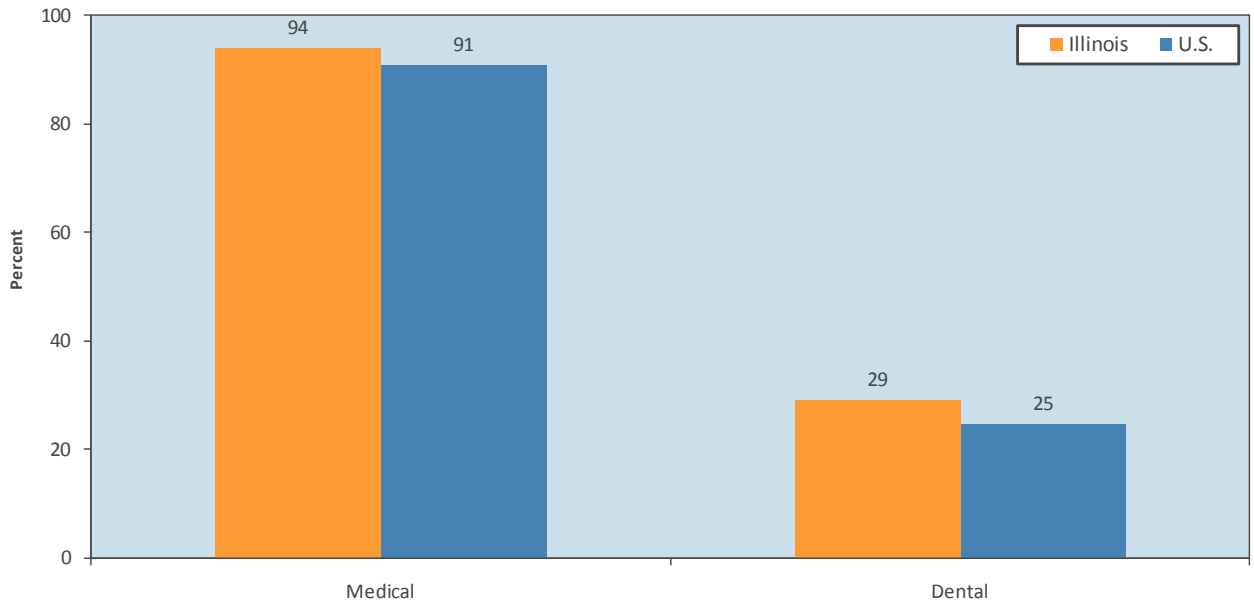
*Using a Standardized Developmental Screening tool.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

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

2 Guevara, J. P., Gerdes, M., Localio, R., Huang, Y. V., Pinto-Martin, J., Minkovitz, C. S., Hsu, D., Kyriakou, L, Baglivo, S., Kavanagh, J., & Pati, S. (2012). Effectiveness of developmental screening in an urban setting. Pediatrics, Published online December 17, 2012.

3 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening. Pediatrics, 118(1), 405-420.

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



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

In Illinois, infants and toddlers are more likely than the national average to have received preventive medical care. Illinois has the sixth lowest rate of infants and toddlers who had no preventive care in the past year—six percent, versus the national average of nine percent. With respect to preventive dental care, 29 percent of Illinois infants and toddlers, compared with a national average of 25 percent, had a visit within the past year.[1]

Preventive medical care (also known as "well-child care") is a critical opportunity to detect a possible developmental delay or disability, early treatment of which can lessen the future impact on both the child and family. In addition, well-child visits allow physicians to promote behaviors conducive to healthy development, and to give age–appropriate counseling or anticipatory guidance. For example, physician guidance has been found to increase the likelihood that parents will read to their child, or that a child will be breastfed.[2]

According to data from a 2011 national survey, more than nine in ten infants and toddlers had at least one preventive pediatric visit in the past 12 months. However, children in poor families, and black and Latino children, were less likely to get well-child care.[3]

1 Child Trends' analysis of the National Survey of Children's Health.
2 Child Trends DataBank. (2012). Well-child visits. Retrieved from http://www.childtrends.org/?indicators=well-child-visits
3 Child Trends' analysis of the National Survey of Children's Health.

early intervention services

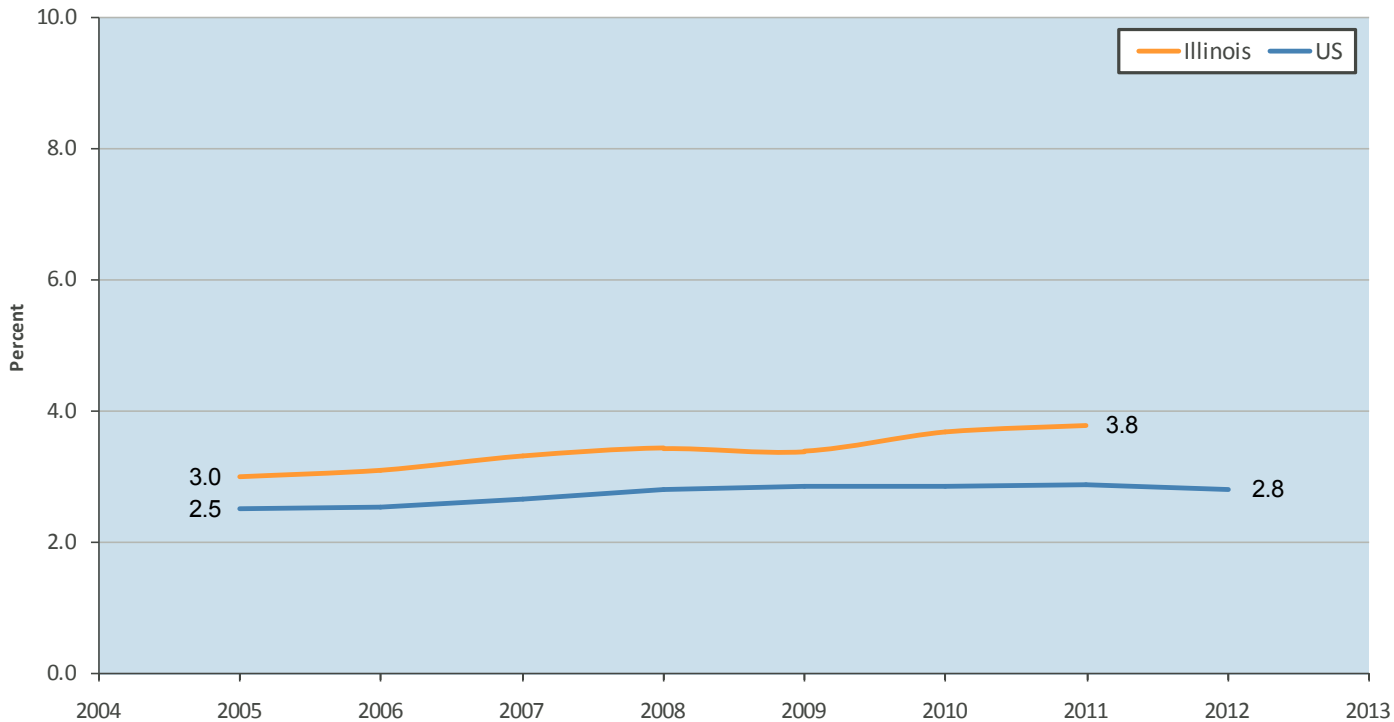
Early intervention services, also known as the Program for Infants and Toddlers with Disabilities, was established in 1986 as part of the Individuals with Disabilities Act.

In 2011, approximately 19,000 Illinois infants and toddlers were served by this program, which represents just under four percent of the total population.[1]

The purpose of the program is to improve outcomes for infants and toddlers with disabilities through provision of direct services to the child as well as services to the family.[2] Early intervention services are offered, through states and territories, to children with identified disabilities or, in some states, to those who are at risk for developing a disability, between the ages of birth and two years. States' eligibility criteria for early intervention services vary,[3] as do the services they offer.

Funding provided by the program varies from year to year, depending on Census-based estimates of the number of infants and toddlers in the general population.

Percentage of Infants and Toddlers Served by Early Intervention Services (Part C), 2005-2012



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

1 http://ectacenter.org/partc/partcdata.asp
2 http://ectacenter.org/partc/partc.asp#overview
3 http://ectacenter.org/~pdfs/topics/earlyid/partc_elig_table.pdf

Conclusion

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

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

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

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

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

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

Second, there are great disparities—primarily related to economic circumstances—in the well-being of Illinois infants and toddlers. The achievement gap, noted in the introduction to this report, we know begins during this period, and it is here where it can most readily be addressed. In a society where commentators have remarked for some time on the increasing polarization between "haves" and "have-nots," this bodes for a continuation, if not a deepening, of that trend. In turn, this has implications for the stability of the social contract, for the costs of providing for (or neglecting) those who fail to achieve self-sufficiency, for the competitiveness of the future workforce, and for the well-being of the generation of elders who will depend on today's youngest Illinoisans, collectively and individually, to sustain them in a stage of life that has its own set of developmental vulnerabilities.

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

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

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

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

Appendix

Demographics

Percentage of Illinois Children, Ages Birth Through Two, in Deep Poverty, Poverty, and Who are Low-Income, 2003-2013

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Deep poverty (<50% FPL)	13.0	12.3	6.9	11.3	8.5	9.0	10.6	12.7	11.9	14.5	11.7
Poverty	24.4	18.3	14.9	21.2	19.7	15.7	23.5	22.9	23.3	25.0	20.2
Low-income (<200% FPL)	40.6	44.1	34.2	43.4	37.1	39.6	41.1	47.9	51.6	49.5	45.4

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

Number of Illinois Children Ages Birth Through Two, and Percentage by Race and Hispanic Origin, 2000-2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	521,546	528,102	530,706	529,724	522,259	516,139	510,788	508,199	506,445	502,540	494,424	489,333	486,360
Percent													
White	-	-	-	-	-	-	-	-	-	-	50.3	50.5	50.7
Hispanic	-	-	-	-	-	-	-	-	-	-	25.5	25.5	25.5
Black	-	-	-	-	-	-	-	-	-	-	15.6	15.4	15.2
Asian	-	-	-	-	-	-	-	-	-	-	4.7	4.8	4.8
American Indian or Alaska Native	-	-	-	-	-	-	-	-	-	-	0.2	0.2	0.2
Pacific Islander	-	-	-	-	-	-	-	-	-	-	0.02	0.03	0.03
Two or more races	-	-	-	-	-	-	-	-	-	-	3.7	3.7	3.6

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

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

	2006	2007	2008	2009	2010	2011
Total	25.9	26.9	26.9	26.0	26.3	25.7
Two foreign-born parents	14.9	16.0	14.8	13.4	14.0	12.8
One foreign-born parent, one native-born parent	6.1	6.2	6.6	6.0	6.5	7.6
Single parent, foreign-born	4.9	4.7	5.5	6.6	5.8	5.3

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

Percentage of Illinois Children, Ages Birth Through Two, in Deep Poverty, Poverty, and Who are Low-Income, by Race and Hispanic Origin, 2013

	Deep poverty (<50% FPL)	Poverty	Low-income (<200% FPL)
Total	11.7	20.2	45.4
Race/ Hispanic origin			
White	8.0	14.2	30.8
Black	16.0	30.8	61.8
Hispanic	16.6	26.0	67.0

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

Fertility Rates[1] in Illinois (per 1,000 Women) by Race and Hispanic Origin, and Birth Rates[1] by Age: Selected Years, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	6735	67.3	66.4	67.5	67.3	67.0	67.9	68.1	66.8	64.8	62.8
Race/Hispanic origin											
White	58.1	57.9	57.5	58.6	58.5	58.0	58.6	59.2	58.6	58.1	57.6
Black	76.1	74.3	71.8	71.9	71.2	71.0	73.3	74.5	73.2	71.3	67.8
Hispanic	105.4	106.4	103.5	104.5	102.9	102.6	102.4	99.7	94.3	87.2	77.8
Asian or Pacific Islander	69.9	68.2	67.8	69.7	70.1	68.4	68.9	68.1	68.1	65.2	64.0
American Indian or Alaska Native	50.9	49.6	50.5	51.8	62.2	58.1	60.4	56.2	55.4	55.3	50.4
Age											
10-14	0.9	0.8	0.7	0.6	0.6	0.7	0.6	0.6	0.6	0.4	0.4
15-19	47.9	45.7	42.2	40.2	40.1	38.5	39.8	40.2	38.5	35.9	33.0
20-24	102.9	100.0	97.1	96.9	93.9	91.7	94.1	93.2	89.7	84.5	79.4
25-29	113.4	113.0	113.9	114.9	114.1	115.0	114.0	113.7	108.8	104.2	100.4
30-34	99.3	101.3	100.1	103.0	103.4	102.8	103.5	104.2	104.8	103.7	102.8
40-44	8.2	8.4	8.7	9.1	9.4	10	9.9	9.9	10.4	10.8	10.9
45-54[2]	0.4	0.5	0.5	0.5	0.6	0.5	0.6	0.6	0.7	0.7	0.7

*Data for 2011 are preliminary.

[1]The total number includes births to women of all ages, 15-44 years. The rate shown for all ages is the general fertility rate, which is defined as the total number of births per 1,000 women aged 15-44 years. Age-specific birth rates are defined as the total number of births per 1,000 women in a specific age group (between ages 15 and 44).

[2]Birth rates computed by relating births to women ages 45-54 years to women ages 45-49 years.

Sources: Number of births: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/. Population estimates: U. S. Census Bureau. (2012). Intercensal estimtes (2000-2010): State. Available at: http://www.census.gov/popest/data/intercensal/state/state2010.html.

Estimated Life Expectancy (in Years) of Newborns in Illinois, by Race and Gender, Selected Years 1939-2001

	1939-41	1949-51	1959-61	1969-71	1979-81	1989-91	1999-2001
All races	-	-	69.6	70.1	73.4	74.9	77.1
Male	-	-	-	66.5	69.6	71.3	73.9
Female	-	-	-	74.0	77.1	78.3	80.3
White[1]	-	-	-	71.2	74.3	76.2	78.1
Male	62.9	66.0	67.3	67.7	70.6	72.8	75.3
Female	67.5	71.6	73.8	75.0	78.0	79.3	80.8
Black[1]	-	-	-	63.7	67.6	67.5	70.6
Male	-	-	61.5	59.5	63.0	62.4	66.8
Female	-	-	66.2	68.0	72.1	72.4	74.2

[1]Data for whites and blacks include Hispanics.

[2]2011 data are preliminary.

Sources: Data for 1999-2001: Wei, R., Anderson, R. N., Curtin, L.R., Arias, E. (2012). U.S. decennial life tables for 1999–2001: State life tables. National vital statistics reports, 60 (9). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_09.pdf. Data for 1989-1991: National Center for Health Statistics. (1998). U.S. decennial life tables for 1989–91, vol II, State life tables no. 14, Illinois. Hyattsville, Maryland. Available at: http://www.cdc.gov/nchs/data/lifetables/life89il.pdf. Data for 1979-1981: National Center for Health Statistics. (1985). State life tables, Alabama-Wyoming. U.S. Decennial Life Tables for 1979-81, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/life-tables/life79ilacc.pdf. Data for 1969-1971: National Center for Health Statistics. (1975). Illinois: State life tables: 1969-71. U.S. Decennial Life Tables for 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life69_2_12-6.pdf. Data for 1959-1961: National Center for Health Statistics. (1966). Illinois: State life tables: 1959-61. Life Tables: 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life59_2_1-26.pdf. Data for 1949-1951: U. S. Department of Health, Education, and Welfare. (1956). State life tables: 1949-51. Vital Statistics-Special Reports 41(12). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life49-51_41supp.pdf. Data for 1939-1941: U. S. Public Health Service. (1948). State and regional life tables: 1939-41. Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life39-41.pdf.

Percent of Illinois Infants Born in the indicated Year Expected to Die Before Reaching Age 3, by Race and Gender, Selected Years 1939-2001

	1939-41	1949-51	1959-61	1969-71	1979-81	1989-91	1999-2001
All races	-	-	2.7	2.4	1.6	1.2	0.8
Male	-	-	-	2.6	1.8	1.4	1.0
Female	-	-	-	2.1	1.4	1.1	0.6
White[1]	-	-	-	2.0	1.3	0.9	0.7
Male	4.6	3.1	2.8	2.3	1.5	1.0	0.8
Female	3.5	2.4	2.1	1.8	1.1	0.8	0.6
Black[1]	-	-	-	3.8	2.8	2.4	1.8
Male	-	-	4.7	4.1	3.1	2.6	2.0
Female	-	-	4.0	3.4	2.6	2.2	1.7

[1]Data for whites and blacks include Hispanics. Prior to 1979, "blacks" include all non-whites.

Sources: Data for 1999-2001: Wei, R., Anderson, R. N., Curtin, L.R., Arias, E. (2012). U.S. decennial life tables for 1999–2001: State life tables. National vital statistics reports, 60 (9). Hyattsville, MD: National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_09.pdf. Data for 1989-1991: National Center for Health Statistics. (1998). U.S. decennial life tables for 1989–91, vol II, State life tables no. 14, Illinois. Hyattsville, Maryland. Available at: http://www.cdc.gov/nchs/data/lifetables/life89il.pdf. Data for 1979-1981: National Center for Health Statistics. (1985). State life tables, Alabama-Wyoming. U.S. Decennial Life Tables for 1979-81, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/life-tables/life79ilacc.pdf. Data for 1969-1971: National Center for Health Statistics. (1975). Illinois: State life tables: 1969-71. U.S. Decennial Life Tables for 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life69_2_12-6.pdf. Data for 1959-1961: National Center for Health Statistics. (1966). Illinois: State life tables: 1959-61. Life Tables: 1969-11, 2(14). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life59_2_1-26.pdf. Data for 1949-1951: U. S. Department of Health, Education, and Welfare. (1956). State life tables: 1949-51. Vital Statistics-Special Reports 41(12). Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/lifetables/life49-51_41supp.pdf. Data for 1939-1941: U. S. Public Health Service. (1948). State and regional life tables: 1939-41. Washington: U.S. Government Printing Office. Available at: http://www.cdc.gov/nchs/data/dvs/lewk4_illinois.pdf.

Percentage of Illinois Infants Born at a Low and Very Low Birthweight,[1] By Mother's Race and Hispanic Origin, Selected Years 1990-2010

	1990	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010[1]
Low birthweight (less than 2,500 grams)	7.6	7.9	8.0	7.9	8.0	8.0	7.9	8.0	8.2	8.3	8.4	8.5	8.6	8.5	8.4	8.4	8.3
Race/Hispanic origin																	
White[2]	5.5	6.2	6.4	6.4	6.5	6.5	6.5	6.7	7.0	7.1	7.3	7.3	7.4	7.3	7.3	7.1	7.0
Black[2]	14.4	14.5	14.5	14.0	14.2	14.2	14.1	13.8	14.3	14.4	14.6	15.1	14.3	14.6	13.8	14.1	13.8
Hispanic[2]	5.7	6.0	5.8	6.2	6.3	6.4	6.2	6.6	6.2	6.4	6.7	6.7	7.2	6.8	6.6	6.8	6.8
Asian or Pacific Islander[3]	7.0	8.2	8.1	7.8	8.2	8.1	8.6	8.4	8.4	8.2	8.1	8.6	9.0	8.2	9.0	9.2	9.2
American Indian or Alaska Native[3]	4.4	8.0	9.6	5.7	8.2	11.0	8.0	9.6	7.9	10.5	6.7	11.3	9.4	6.8	8.3	12.4	6.5
Plurality of birth																	
Singleton	-	6.5	6.5	6.3	6.3	6.3	6.2	6.2	6.3	6.3	6.4	6.6	6.7	6.5	6.4	6.5	6.4
Twin or more	-	55.9	57.1	55.2	56.3	57.4	56.5	56.0	57.4	57.6	57.8	58.1	60.1	59.7	57.8	56.2	56.3
Very low birthweight (less than 1,500 grams)	1.4	1.5	1.5	1.6	1.6	1.7	1.6	1.5	1.6	1.6	1.7	1.6	1.6	1.6	1.5	1.5	1.5
Race/Hispanic origin																	
White[2]	0.9	1.1	1.1	1.2	1.2	1.1	1.2	1.2	1.3	1.3	1.4	1.2	1.3	1.3	1.3	1.2	1.2
Black[2]	3.1	3.1	3.2	3.1	3.2	3.5	3.5	3.1	3.5	3.4	3.3	3.4	3.2	3.3	3.1	3.2	3.1
Hispanic[2]	1.1	1.2	1.0	1.2	1.2	1.4	1.2	1.1	1.2	1.1	1.2	1.2	1.3	1.2	1.2	1.1	1.3
Asian or Pacific Islander[3]	0.9	1.1	1.1	1.2	1.2	1.4	1.2	1.1	1.4	1.2	1.2	1.3	1.3	1.0	1.2	1.3	1.4
Plurality of birth																	
Singleton	-	1.2	1.2	1.2	1.2	1.2	1.2	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.1	1.2	1.2
Some college or Associate's degree	-	12.9	12.5	13.0	12.1	13.5	13.0	12.1	13.5	12.5	13.1	12.3	11.9	12.8	111.8	11.1	10.8

"-" Indicates data not available.

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

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

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

Sources: Data for 1990: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Available at http://www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm Data for 1995-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html

Illinois Infant and Preschooler Death Rates (per 100,000), by Sex and Race/Hispanic Origin for Selected Years, 1990-2010

	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Under 1 year[1]	1138.2	970.4	899.8	776.3	758.2	806.5	769.0	778.7	774.4	710.5	747.8	714.9	688.0
Sex													
Male	1252.3	1025.5	955.6	849.2	835.6	835.8	852.0	879.2	865.7	779.7	815.9	799.4	761.5
Female	1019.6	913.1	841.7	700.3	677.6	775.7	681.9	672.6	679.7	638.9	677.2	626.7	611.0
Race/Hispanic origin													
White	-	-	649.5	610.9	557.3	632.4	611.2	596.6	622.2	542.1	587.4	550.7	516.1
Black	-	-	1815.3	1505.8	1574.9	1661.0	1509.2	1652.4	1431.2	1410.6	1275.2	1347.7	1382.5
Hispanic	-	-	773.9	566.9	579.5	647.7	610.5	605.2	675.7	555.6	583.2	598.8	557.6
Asian or Pacific Islander	-	-	619.9	511.9	464.4	270.7	-	329.1	401.5	390.8	456.7	355.6	511.2
Ages 1-4	46.7	45.1	30.7	33.0	29.9	29.0	29.4	26.8	25.7	27.6	25.6	27.8	26.4
Sex													
Male	51.8	51.5	28.2	30.4	26.4	24.0	26.4	22.6	22.4	21.7	17.1	26.3	25.4
Female	41.4	38.4	33.1	35.4	33.2	33.8	32.4	30.7	28.8	33.4	33.7	29.3	27.4
Race/Hispanic origin[2]													
White	-	-	25.2	24.4	21.7	25.3	19.8	21.6	21.0	22.5	17.7	26.2	23.9
Black	-	-	52.8	64.0	57.7	53.1	66.7	53.1	47.7	54.5	56.1	49.8	52.0
Hispanic[3]	-	-	26.6	29.2	27.3	17.9	27.9	23.1	22.5	19.8	21.2	18.1	18.0
Asian or Pacific Islander	-	-	-	-	-	-	-	-	-	-	-	-	-

*Data based on preliminary estimates and may be revised.
1 Death rates for "Under 1 year" (based on population estimates) differ from infant mortality rates (based on live births)
Sources: Number of deaths for 1990-1995 and all data for 2000-2010: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Population estimates for 1990-1995: U. S. Census Bureau. (2003). State and county intercensal estimates by demographic characteristics (1990-1999) . Available at: http://www.census.gov/popest/data/intercensal/st-co/characteristics.html.

Illinois Substantiated Victims of Child Maltreatment, Ages Birth Through Two: 2009-2011

	2009	2010	2011
Number of Unique Victims	8,371	8,030	7,562
Unique Victims per 1,000 population	15.5	14.9	15.4

Sources: Data for 2009: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2010) Child Maltreatment 2009. Washington, DC: U.S. Government Printing Office. Table 3-10. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2009.Data for 2010: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2011) Child Maltreatment 2010. Washington, DC: U.S. Government Printing Office. Table 3-11. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2010. Data for 2011: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2012) Child Maltreatment 2011. Washington, DC: U.S. Government Printing Office. Table 3-4. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011

Illinois Infant and Toddler Homicide (Ages Birth Through Two) Rate per 100,000: 1999-2010

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	6.5	6.5	7.0	5.3	4.0	7.5	4.8	4.9	5.3	5.9	6.8	5.3
Sex												
Male	5.6*	6.4*	8.2	4.8*	4.4*	9.7	6.8*	6.1*	6.6*	7.4*	7.8*	5.5*
Female												
Race/Hispanic origin												
White	4.7*	-	4.1*	-	3.8*	4.2*	3.6*	-	-	3.8*	4.6*	-
Black	18.8*	21.9	19.0*	19.3*	-	20.2*	12.6*	13.9*	18.5*	16.1*	15.1*	20.2*
Hispanic	-	-	-	-	-	-	-	-	-	-	-	-

*Estimate is based on fewer than 20 deaths.
- Not reported because there were fewer than 10 deaths in that year.
Source: Centers for Disease Control and Prevention. (2013). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Available at: http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html

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

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total fatal injuries	106	78	95	72	89	75	104	81	95	78	75
Fatal injuries (rate per 100,000 population)	20.4	14.8	17.9	13.6	17.0	14.5	20.4	15.9	18.8	15.5	15.1
Sex											
Male	19.9	17.1	23.3	12.9	19.5	17.8	23.0	18.1	22.9	14.9	19.4
Female	20.8	12.4	12.3	14.3	14.5	11.1	17.6	13.7	14.5	16.2	10.7
Race/Hispanic origin											
White	14.8	9.5	12.3	9.0	14.4	12.2	14.3	15.3	17.4	14.2	12.4
Black	39.7	33.8	51.4	41.3	37.0	31.0	57.9	28.9	39.1	32.5	33.3
Hispanic[1]	17.7*	12.1*	8.3*	-	12.1*	11.2*	9.6*	7.9*	11.0*	7.8*	10.3*
Mechanism											
Suffocation	9.8	6.6	9.4	7.6	7.3	8.5	11.6	9.3	11.9	10.2	11.3
Other causes	10.6	8.1	8.5	6.0	9.8	6.0	8.8	6.7	6.9	5.4	3.8
Age group											
Less than 1 year	35.2	26.4	34.0	25.7	30.2	32.3	38.5	29.2	41.7	30.4	33.8
1 to 2 years	13.0	8.7	9.9	7.6	10.4	5.8	11.4	9.2	7.4	8.3	6.0

*Based on fewer than 20 deaths.
1 Hispanics may be of any race
Source: National Center for Injury Protection and Control. (2013). WISQARS online, fatal injury reports. Available at: http://www.cdc.gov/injury/wisqars/fatal.html

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

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Illinois	17.5	14.6	11.3	9.4	7.9	6.4	7.7	6.3	5.0	3.6	3.2	2.2	1.8	1.5	1.3
US	7.6	6.5	5.0	4.0	3.0	2.6	2.3	1.8	1.5	1.2	0.9	0.7	0.6	0.6	0.6

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

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

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

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

Percent of New Mothers in Illinois Who Smoked During Pregnancy: 1995-2010[1]

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2010[1]
Total	12.9	12.5	12.1	11.8	11.4	10.9	10.5	10.1	9.6	9.3	8.7	8.6	7.9
Race/Hispanic origin													
White	15.9	15.4	15.0	14.8	14.7	14.2	13.9	13.4	13.1	12.8	12.2	12.2	11.1
Black	15.0	15.2	14.7	14.0	13.6	13.8	13.3	12.7	12.3	11.5	10.8	10.2	9.0
Hispanic	2.5	2.5	2.4	2.4	2.2	2.0	1.8	1.7	1.5	1.4	1.1	1.4	1.5
Asian or Pacific Islander	1.5	1.1	1.4	1.2	1.0	0.7	1.2	0.9	0.9	0.9	0.5	0.8	0.6
American Indian or Alaska Native	21.5	17.9	24.7	18.7	23.4	23.9	22.4	23.9	20.6	22.2	20.2	23.3	22.1
Age													
Under 15 years	5.0	4.8	4.5	5.9	5.9	5.9	7.0	5.0	6.1	3.4	5.6	4.0	4.2
15-19 years	13.9	14.9	15.6	16.0	16.0	15.6	15.0	14.3	13.4	12.8	12.0	11.6	10.6
20-24 years	16.0	15.3	15.4	15.3	15.2	15.5	15.4	15.4	15.3	15.0	14.2	13.8	13.8
25-29 years	11.9	11.6	10.7	10.5	10.0	9.4	9.2	8.8	8.6	8.5	8.5	8.6	8.4
30-34 years	11.2	10.4	9.5	8.6	8.1	7.2	6.7	6.2	5.8	5.5	5.0	5.0	4.5
35-39 years	12.2	11.8	11.4	10.7	9.8	8.8	8.2	7.4	6.7	6.2	5.3	4.7	3.8
40 years and over	11.5	10.8	11.1	10.3	9.5	10.5	10.2	8.4	8.1	6.9	6.4	5.6	4.2
Education of mother[1]													
0-8 years	4.2	4.0	4.2	4.0	4.0	3.4	3.2	3.3	3.0	3.1	3.3	3.4	-
Eight grades or less	-	-	-	-	-	-	-	-	-	-	-	-	4.0
9-11 years	29.5	28.9	27.9	27.3	25.8	25.5	24.7	24.0	22.6	22.3	21.0	20.4	-
Ninth through 12th grade, no diploma	-	-	-	-	-	-	-	-	-	-	-	-	17.9
12 years	19.5	18.9	18.4	17.8	17.8	17.2	16.4	15.9	15.8	15.2	14.3	14.2	-
High School Diploma or GED	-	-	-	-	-	-	-	-	-	-	-	-	13.8
13-15 years	11.1	11.0	10.2	10.0	9.7	9.4	9.7	9.3	9.3	9.1	8.8	8.5	-
Some college or Associate's degree	-	-	-	-	-	-	-	-	-	-	-	-	8.9
16 years	2.5	2.2	2.2	1.9	1.9	1.6	1.5	1.5	1.4	1.3	1.2	1.2	-
BA or more	-	-	-	-	-	-	-	-	-	-	-	-	1.0

"-": Data not available..

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

[2]Data are based on the 2003 Revision of the U.S. Standard Certificate of Live Birth for smoking status, and data is not comparable to earlier years.

[3] Includes only mothers of age 20 or older.

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

Vaccinations of Illinois Children 19-35 Months of Age: 2012 (Percentage)

	2012
Combined series (4:3:1:3)[1]	78
Race/Hispanic origin[2]	
White	84
Black	-
Hispanic	75
Asian or Pacific Islander	-
Asian	96
American Indian or Alaska Native	
Poverty status	
Below poverty	71
At or above poverty	83
Location of residence	
Central city	73
Remaining areas inside metropolitan statistical area	79
Outside metropolitan statistical area	-

"-" Indicates no data available

1 The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib).

2 Persons of Hispanic origin may be of any race.

3 The 4:3:1:3::3:1 combined series measures the number of children who have received 6 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine (DTP), 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, 3 or more doses of Haemophilus influenzae type b vaccine (Hib), three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella.

4 Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diptheria and tetanus toxoids and acellular pertussis vaccine.

5 Haemophilus influenzae type b vaccine (Hib).

Notes: Final estimates of data from the National Immunization Survey include an adjustment for children with missing immunization provider data. Poverty status is based on family income and family size using Bureau of the Census poverty thresholds. Children missing information about poverty status were omitted from analysis by poverty level.

Source: Centers for Disease Control and Prevention, National Immunization Program ,NIS data, tables, Jan-Dec . /www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis

	2012
Combined series (4:3:1:3:3:1)[3]	74
Race/Hispanic origin 2	
White	80
Black	-
Hispanic	73
Asian	-
American Indian or Alaska Native	-
Poverty status	
Below poverty	68
At or above poverty	80
Location of residence	
Central city	69
Remaining areas inside metropolitan statistical area	76
Outside metropolitan statistical area	-
Individual vaccines	
DTP/DT/DTaP (4 doses or more)4	85
Polio (3 doses or more)	93
Measles-Mumps-Rubella	92
Hib (Primary Series)[5]	93
Hepatitis B	90
Varicella (Chickenpox)	91

Percentage of Illinois Infants Whose Mothers Breastfeed: 2007

Illinois infants who were:	2000	2001	2002	2003	2004	2005	2006	2007
Ever breastfed	69.8	71.1	65.0	71.0	71.2	71.3	70.7	70.2
Breastfed at 6 months	29.4	34.0	34.8	39.5	41.3	39.2	41.2	36.0
Breastfed at 12 months	13.4	17.3	15.2	19.9	17.6	17.0	18.2	16.4

Source: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Breastfeeding Practices: Results from the National Immunization Survey. Available online at http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm.

Percentage of Illinois Children Ages Birth Through Two in Food-Insecure and Marginally Food-Secure Households, 2002-2012

	2004-2006	2007-2009	2010-2012
Marginal food security[1]	-	12.2	12.0
Poverty			
Below 185% poverty	-	21.4	22.0
Above 185% poverty or income not reported	-	6.2	6.3
SNAP receipt			
Family received SNAP in past 12 months	-	26.3	26.3
Family did not receive SNAP in past 12 months	-	18.2	17.6
WIC receipt			
Family received WIC in past 30 days	-	19.4	29.8
Family did not receive WIC in past 30 days	-	22.3	17.4
Race/Hispanic origin			
Hispanic	-	10.5	10.3
White	-	12.4	9.0
Black	-	13.4	23.7
Family structure			
Two biological/adoptive parents	-	9.9	8.8
Single parent	-	19.5	21.7
Other	-	15.7	16.5
Low food security[2]	10.9	12.7	13.3
Poverty			
Below 185% poverty	22.7	22.6	21.2
Above 185% poverty or income not reported	5.5	6.3	8.8
SNAP receipt			
Family received SNAP in past 12 months	36.5	36.2	27.5
Family did not receive SNAP in past 12 months	19.9	15.6	24.6
WIC receipt			
Family received WIC in past 30 days	30.1	32.0	23.0
Family did not receive WIC in past 30 days	20.4	17.0	26.4
Race/Hispanic origin			
Hispanic	13.3	24.8	20.6
White	7.4	5.3	9.9
Black	28.1	23.3	20.9
Family structure			
Two biological/adoptive parents	-	11.5	11.5
Single parent	-	16.2	17.7
Other	-	16.3	26.4

	2004-2006	2007-2009	2010-2012
Very low food security3	3.7	3.9	6.1
Poverty			
Below 185% poverty	10.1	9.4	10.4
Above 185% poverty or income not reported	0.8	0.4	3.7
SNAP receipt			
Family received SNAP in past 12 months	21.0	6.6	24.1
Family did not receive SNAP in past 12 months	4.5	8.3	3.4
WIC receipt			
Family received WIC in past 30 days	10.2	12.6	21.7
Family did not receive WIC in past 30 days	7.6	3.9	6.8
Race/Hispanic origin			
Hispanic	2.4	5.2	15.9
White	1.3	3.9	1.8
Black	15.6	2.9	8.1
Family structure			
Two biological/adoptive parents	-	3.9	3.4
Single parent	-	3.7	15.1
Other	-	6.1	-

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

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

	2003	2007	2011
Illinois	7.7	9.9	7.6
Total U.S.	7.4	8.2	7.4

Note: Special health care needs include needing prescription medications, needing elevated services, being limited in activities, needing specialized therapies, or having an emotional/developmental/behavioral problem, when the need is expected to persist for at least a year.
Source: Child Trends' analysis of National Survey of Children's Health.

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

	None	One	Two or more
Illinois	68.9	25.6	5.5
U.S.	68.4	24.3	7.3

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

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

	High risk	Moderate risk	High or moderate risk
Illinois	11.4	17.2	28.7
Total U.S.	7.3	14.1	21.4

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

Percentage of Children ages One Through Two Years Who Had Less Than Very Good Teeth: 2011/12

	2011/12
Illinois	13.1
U.S.	3.7

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

Parental Well-Being

Percentage of Children, Ages Birth through Two, Whose Parents Report Frequent Stress from Parenting,[1] 2003, 2007, 2011/12

	2003	2007	2011/12
Illinois	9.3	7.1	9.1
U.S.	6.9	7.8	7.1

[1]Children qualify as having stressed parents if their parents responded "Usually" or "Always" to one or more of the following statements about their feelings during the past 30 days: "child was much harder to care for than other children"; "often bothered a lot by their child's behavior"; and/or "angry with child"
Source: Child Trends Analysis of National Survey of Children's Health

Percentage Distribution of Illinois Children Ages Birth through 2, by Resident Parents' Age, and by Child's Race and Hispanic Origin, Selected Years, 2007-2013

	2007	2008	2009	2010	2011	2012	2013
Mother's age							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	41.3	43.2	40.9	45.4	40.9	46.4	38.1
Ages 30-39	47.1	48.0	46.5	41.6	46.3	38.4	45.5
Ages 40 or older	9.1	-	11.7	10.3	11.9	10.0	12.4
White							
Less than 20	-	-	-	-	-		-
Ages 20-29	39.4	33.7	33.2	42.6	36.7	45.8	31.5
Ages 30-39	50.4	57.8	52.8	45.7	46.6	43.5	60.7
Ages 40 or older	-	-	14.1	-	15.5	-	-
Black							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	-	-	-	-	-	-	-
Ages 30-39	-	-	-	-	-	-	-
Ages 40 or older	-	-	-	-	-	-	-
Hispanic							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	45.4	60.5	49.8	51.2	43.5	47.4	46.5
Ages 30-39	42.6	33.8	34.7	29.4	45.6	35.1	30.9
Ages 40 or older	-	-	-	-	-	-	-
Father's age							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	26.4	27.8	30.5	31.3	23.5	24.9	21.2
Ages 30-39	54.4	54.5	49.7	42.3	47.8	57.4	56.2
Ages 40 or older	19.2	17.4	19.5	25.2	28.1	16.2	21.6
White							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	27.0	24.2	26.0	29.7	21.1	29.6	-
Ages 30-39	52.0	57.9	51.1	45.2	52.0	53.7	66.0
Ages 40 or older	21.0	17.4	22.3	23.0	25.6	-	-
Black							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	-	-	-	-	-	-	-
Ages 30-39	-	-	-	-	-	-	-
Ages 40 or older	-	-	-	-	-	-	-
Hispanic							
Less than 20	-	-	-	-	-	-	-
Ages 20-29	-	37.0	39.7	39.0	-	-	-
Ages 30-39	47.1	48.2	49.2	36.5	46.3	54.6	42.1
Ages 40 or older	-	-	-	-	-	-	-

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

Illinois Maternal Mortality Rate[1] (per 100,000 live births), 1999-2004, 2005-09, and 2010[2]

	1999-2004	2005-2009	2010
Total	9.1	9.2	13.3
Race/Hispanic origin			
White	4.6	6.4	12.3
Black	25.7	27.9	31.8
Hispanic	7.4	4.2	2.7
Age of mother			
Younger than 25	7.3	8.1	12.2
25-34	7.8	6.6	11.1
35-44	17.7	16.1	15.6
45 or older	71.2	386.6	595.2

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

[2]Data for 2010 are not comparable to previous data due to a change in the birth certificate. Earlier years are combined for greater accuracy, due to the small number of deaths.

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

Population of Illinois Children Ages Birth through Two: Percentages by Resident Parents' Education and Child's Race/Hispanic Origin: 2011-2013

	Less than high school	High school diploma or equivalent	Some college, including vocational/ technical	Bachelor's degree or higher
Mothers' education	12.7	24.7	28.0	34.6
Race/ Hispanic origin				
White	-	19.4	29.0	48.9
Black	-	33.5	42.1	-
Hispanic	30.8	32.5	21.5	15.2
Fathers' education	12.0	21.8	25.0	41.2
Race/ Hispanic origin				
White	-	17.1	28.2	50.6
Black	-	-	-	-
Hispanic	34.2	32.0	17.2	16.6

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

Secure Parental Employment: Percentage of Illinois Children Living with Parents, Ages Birth Through Two, Living with at Least one Parent Employed Full-Time all Year,[1] 2007-2013

	2007	2008	2009	2010	2011	2012	2013
All children living with parent(s)	78.0	72.6	73.1	63.2	66.1	63.7	69.1
Race/Hispanic origin							
White	81.0	77.3	84.3	69.9	74.4	76.0	76.7
Black	58.2	-	-	58.8	-	-	-
Hispanic	83.0	73.6	61.6	50.7	59.6	54.9	62.6
With two parents working full time all year	18.8	21.9	18.5	10.4	16.9	19.8	16.2
Children living in families maintained by two parents	88.2	85.1	83.0	73.5	74.7	82.5	79.8
Race/Hispanic origin							
White	87.6	87.0	89.3	80.1	78.7	84.6	80.8
Black	-	-	-	-	-	-	-
Hispanic	88.5	78.0	73.4	56.2	63.9	72.6	73.9
With two parents working full time all year	23.7	28.3	23.3	13.6	21.2	27.7	21.0

1 Full-time, all-year employment is defined as usually working full time (35 hours or more per week) for 50-52 weeks. Source: Child Trends' analysis of Current Population Survey, March Supplement.

Percentage of All Illinois Births to Mothers Receiving Late or No Prenatal Care, Selected Years 1995-2010

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2010[1]
Total	4.4	4.2	4.0	3.9	4.1	4.0	3.3	2.9	2.8	2.7	2.6	2.4	62.8
Race/Hispanic origin													
White	2.1	2.1	1.8	1.9	2.1	2.0	1.7	1.6	1.5	1.5	1.5	1.5	2.9
Black	9.2	8.8	8.8	8.3	8.7	8.3	7.4	6.7	6.7	6.3	5.8	5.4	9.8
Hispanic	6.7	6.2	6.1	5.6	5.9	5.6	4.1	3.5	3.2	3.1	2.8	2.4	7.0
Asian or Pacific Islander	4.0	4.0	3.2	2.8	3.4	3.1	2.8	2.4	2.1	1.7	1.5	1.8	4.9
American Indian or Alaska Native	8.3	7.1	6.3	5.9	7.8	6.9	4.0	5.4	-	4.7	-	4.1	13.5
Age													
Under 15 years	17.6	16.5	17.4	15.8	16.3	19.6	16.1	14.7	14.2	13.3	10.9	14.4	23.9
15-19 years	8.7	8.4	8.3	8.1	8.3	8.0	7.0	6.0	5.9	5.5	5.4	5.0	10.0
20-24 years	6.1	5.6	5.7	5.5	5.9	5.6	4.7	4.1	4.2	3.9	3.6	3.4	7.3
25-29 years	3.3	3.3	3.0	2.9	3.1	3.0	2.6	2.3	2.1	2.2	2.0	1.9	4.5
30-34 years	2.4	2.4	2.1	2.1	2.2	2.1	1.8	1.7	1.7	1.6	1.5	1.4	3.2
35-39 years	2.6	2.6	2.5	2.3	2.6	2.6	2.2	1.9	2.0	1.8	1.8	1.8	3.6
40 years and over	2.6	3.7	3.4	3.4	3.2	3.1	3.0	2.9	2.1	2.5	2.7	1.8	4.2

"-" Indicates data not available.

[1]Data are based on the 2003 Revision of the U.S. Standard Certificate of Live Birth for prenatal care, and data is not comparable to earlier years.

Neighborhood and Family Context

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

	Cohabitating parent	Married parents	Single parent or other
Illinois	14.7	60.8	24.6
U.S.	16.4	64.2	19.5

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

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

	2003	2007	2011/12
Illinois	75.3	79.6	83.7
U.S.	79.6	81.8	84.4

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

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

	Every day		4 to 6 days		Less than 4 days	
	Sing or tell stories	Read	Sing or tell stories	Read	Sing or tell stories	Read
Illinois	60.3	51.5	24.5	18.9	15.2	29.6
U.S.	65.5	46.3	18.4	19.4	4.2	11.6

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

Percentage of Children, Ages Birth through Two, by Time Spent In Front of the Television[1] and Using Electronic Devices[2] on an Average Weekday: 2011/12

	An hour or more		None	
	Electronic devices	TV	Electronic devices	TV
Illinois	10.9	51.1	77.7	30.0
U.S.	9.1	47.3	77.8	30.3

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

Parent Report of Unsafe Neighborhoods,[1] Among Children ages Birth though 2: 2003, 2007 and 2011/12

	2003	2007	2011/12
Illinois	16.0	12.7	9.7
U.S.	15.8	13.7	12.8

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

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

	Category III[2]	Category IV[3]	Total in poverty areas
Total children	19.6	4.6	24.3
Race/Hispanic origin[4]			
White	8.8	0.8	9.6
Black	40.2	21.4	61.6
Asian	9.8	1.1	10.9
American Indian or Alaska Native	16.6	2.3	18.9
Hispanic	30.6	2.7	33.4

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

Illinois Birth Rates (Births per 1,000) for Females Ages 10-19, Selected Years 1995-2010

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
15-19 Year-olds	58.4	55.3	52.7	51.8	49.7	47.9	45.7	42.2	40.2	40.1	38.5	39.8	40.2	38.5	35.9	33.0
Race/Hispanic Origin																
White	32.8	31.3	29.7	28.7	27.6	26.3	24.5	22.7	21.3	21.5	20.3	20.7	21.5	21.0	20.3	19.1
Black	124.7	115.1	111.3	110.1	101.1	97.1	91.6	84.8	80.8	78.3	74.0	78.2	78.9	74.5	68.8	63.4
Hispanic	103.3	98.0	90.8	89.0	89.1	89.7	89.8	81.8	78.2	78.2	75.4	74.7	71.6	66.5	58.5	51.0
Asian or Pacific Islander[1]	9.9	10.4	10.0	9.7	10.2	11.9	11.1	7.6	8.3	7.1	6.9	7.5	6.9	6.0	6.4	4.9
American Indian1	47.6	45.9	54.4	51.1	34.7	57.6	31.5	31.1	39.1	35.5	38.0	41.7	43.2	44.1	25.8	22.0
10-14 Year-olds	1.4	1.2	1.1	1.1	1.0	0.9	0.8	0.7	0.6	0.6	0.7	0.6	0.6	0.6	0.4	0.4
Race/Hispanic Origin																
White	0.3	0.2	0.2	0.3	0.2	0.2	0.1	0.2	0.1	0.1	0.2	0.2	0.1	0.2	0.1	0.1
Black	4.9	4.5	4.1	3.8	3.1	3.1	2.6	2.3	1.8	2.0	2.1	1.8	1.8	1.7	1.2	1.2
Hispanic	2.1	1.5	1.4	1.3	1.5	1.2	1.2	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.7	0.7

- indicates no data available
1 Totals for Asians, Pacific Islanders, and American Indians include Hispanics.
Sources: Number of births : Centers for Disease Control and Prevention, National Center for Health Statistics, CDC Wonder online database. Available at: http://wonder.cdc.gov/natality.html. Population estimates 2000-2010: U. S. Census Bureau. (2012). Intercensal estimtes (2000-2010): State. Available at: http://www.census.gov/popest/data/intercensal/state/state2010.html. Population estimates 1995-1999: U. S. Census Bureau. (2003). State and county intercensal estimates by demographic characteristics (1990-1999) . Available at: http://www.census.gov/popest/data/intercensal/st-co/characteristics.html.

Percentage of All Illinois Births that were to Unmarried Women, by Race and Hispanic Origin, Selected Years, 1990-2010

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total births	31.7	32.6	33.4	34.1	34.3	33.8	33.7	33.4	34.1	34.1	34.5	34.5	34.8	35.3	36.3	37.1	38.7	40.1	40.7	40.8	40.5
Race/Hispanic origin																					
White	15.9	16.6	17.0	17.7	18.3	18.5	18.7	18.8	19.2	19.4	19.8	20.0	20.5	21.1	22.1	22.5	24.0	25.3	25.9	26.1	26.2
Black	78.0	78.5	79.3	78.9	79.1	78.6	77.9	77.1	77.9	77.3	76.5	76.6	76.9	76.5	77.5	78.1	78.7	79.6	79.8	80.5	80.3
Hispanic	35.6	35.9	36.6	38.0	38.3	39.2	39.5	38.6	39.4	40.8	42.3	41.9	42.8	44.2	45.4	46.7	48.9	50.8	52.1	52.1	52.7

Sources: Data for 1990-2002: Centers for Disease Control and Prevention, National Center for Health Statistics, VitalStats, Birth Data Files. Retrieved from www.cdc.gov/nchs/data_access/vitalstats/VitalStats_Births.htm. Data for 2003-2010: National Center for Health Statistics, CDC WONDER online tool. Available at: http://wonder.cdc.gov/.

Percentage of Illinois Children Ages Birth Through Two, by Language Environment

	2006	2007	2008	2009	2010	2011
No one in the household 14 and older speaks English at home or speaks English 'very well'	11.7	10.9	10.1	9.3	9.6	8.1
English-only household	65.3	65.2	64.7	65.9	65.0	64.8
At least one Spanish speaker in household	22.7	23.8	22.6	22.6	22.3	23.2

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

Percentage of Illinois Children, Ages Birth Through Two, by Family Structure, 2007-2013

	2007	2008	2009	2010	2011	2012	2013
Two biological, step-, or adoptive parents	77.9	74.6	76.9	74.1	78.2	69.4	75.5
Single mother	19.6	20.7	17.1	20.6	19.2	27.2	19.9
Single father	0.7	1.1	2.5	2.8	0.8	0.6	2.3
No parent present	1.7	3.7	3.5	2.5	1.8	2.8	2.3

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

Percentage of Illinois Children, Ages Birth Through Two, by Family Structure, Total and by Race/Hispanic Origin, 2013

	Two biological, step-, or adoptive parents	Single mother	Single father	No parent present
Total	75.5	19.9	2.3	2.3
Race/Hispanic origin				
White	87.6	8.1	4.2	-
Black	38.4	46.0	2.8	12.8
Hispanic	71.6	27.2	-	1.2

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

Public/Private Supports

Illinois Infants and Toddlers Served by Head Start Programs: School Years 2007-2012

	2007	2008	2009	2010	2011	2012
Total served	5,916	6,380	6,464	7,704	8,540	9,078
Infants	1,155	1,226	1,255	1,746	2,311	2,431
Toddlers	4,761	5,154	5,209	5,958	6,229	6,647
Percent of eligible population served[1]	6.7	4.6	5.3	7.1	7.1	9.5
Infants	3.4	3.2	3.7	4.7	6.6	8.3
Toddlers	8.6	5.1	6.0	8.3	7.3	10.0

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

Number and Percentage of Illinois Infants and Toddlers Served by Early Intervention Services (Part C), 2005-2011

	2005	2006	2007	2008	2009	2010	2011
Total served	16,175	16,613	17,765	18,535	18,266	18,212	18,576
Infants	1,943	2,074	2,185	2,097	1,950	1,926	1,912
Toddlers	14,232	14,539	15,580	16,438	16,316	16,286	16,664
Percent of population served	3.0	3.1	3.3	3.4	3.4	3.7	3.8
Infants	1.1	1.2	1.2	1.1	1.1	1.2	1.2
Toddlers	3.9	4.0	4.4	4.6	4.5	4.9	5.1

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

Illinois Child Recipients of Food Stamps /SNAP Benefits, Ages Birth Through Four, 1997-2011

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Child recipients younger than 5 years (in thousands)[1]	177	153	127	131	142	140	154	184	185	223	200	214	230	271	273
Children recipients as a percent of:															
Total child population younger than 5 years	18.8	15.9	13.5	13.0	17.1	15.1	16.8	19.4	20.3	25.3	20.7	22.1	25.4	34.9	31.5
Children younger than 5 in poverty	98.4	84.7	70.4	61.6		66.7	97.2								
Children younger than 5 less than 125% of the federal poverty level	75.5	66.2	55.1	51.0	78.1	53.8	72.7	92.7	85.6		94.3	82.3	80.7		

Sources: Data for 1997-2007: U.S. Department of Agriculture, Food and Nutrition Service. www.fns.usda.gov/ora/MENU/Published/snap/SNAPPartNational.htm; Data for2008- 2009: Letfin, J., Eslami, E., & Strayer, M. (2011). Trends in Supplemental Nutrition Assistance Program participation rates: 2002 to 2009. Department of Agriculture, Food and Nutrition Service. http://www.fns.usda.gov/ora/menu/Published/snap/FILES/Participation/Trends2002-09.pdf. Data for 2010: Eslami, E., Letfin, J. & Strayer, M. (2012). Supplemental Nutrition Assistance Program participation rates: Fiscal year 2010. Department of Agriculture, Food and Nutrition Service. Available at http://www.fns.usda.gov/ora/MENU/Published/snap/FILES/Participation/Trends2010.pdf. Data for 2011: Strayer, M., Eslami, E., & Letfin, J. (2012). Characteristics of Supplemental Nutrition Assistance Program households: Fiscal year 2011. Department of Agriculture, Food and Nutrition Service. Available at http://www.fns.usda.gov/ora/MENU/Published/snap/FILES/Participation/2011Characteristics.pdf

Number and Percentage of Eligible Illinois Infants and Toddlers Served by a Federal Child Care Subsidy Program: 2002-2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
Total infants and toddlers served	21,900	21,400	21,400	21,100	21,100	20,100	18,800	19,000	19,700	16,600
Infants	4,900	5,100	4,800	4,700	4,600	4,600	4,400	4,100	4,100	3,400
Toddlers	17,000	16,300	16,600	16,400	16,400	15,500	14,500	14,900	15,600	13,200
Percent of eligible infants and toddlers served[1]	14.6	11.2	13.6	12.2	15.3	11.5	13.1	9.6	9.9	8.4

*Data for 2011 is preliminary and may be modified in the future.
1Eligibility for subsidy in Illinois is based on a number of factors, including income, savings, and employment status. The estimate here is based on all infants and toddlers living in households with incomes of less than 185% of the federal poverty level.
Sources: Data for child care subsidies: ACF 801 administrative data (total number of children served multiplied by the % in each age range). Office of Child Care, Administration for Children and Families, Department of Health and Human Services. Child care and development fund statistics. Available at: http://www.acf.hhs.gov/programs/occ/resource/ccdf-statistics. Eligibility data: Child Trends analysis of the Current Population Survey, December Food Security Supplement.

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

	Medical	Dental
Illinois	94.1	29.2
U.S.	90.9	24.7

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

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

	2008	2009	2010	2011	2012*
Total infants and children served	221,031	235,688	235,363	226,578	221,101
Infants	85,934	85,693	82,916	78,999	76,159
Children	135,096	149,995	152,447	147,579	144,942
Percent of eligible infants and children served**	73.2	60.9	59.6	70.0	75.6
Infants	-	88.0	96.2	-	-
Children	54.4	51.8	49.4	54.2	59.3

*2012 are preliminary data
**Eligible children are estimated by all children less than five with family income less than 185% of the Federal Poverty Level.
Source: USDA. (2013).Monthly Data: Agency Level, Participation and Program Costs by Category per person. Available at: http://www.fns.usda.gov/pd/wicmain.htm. Eligible participants estimated with Child Trends Analysis of the Current Population Survey, Food Security Supplement.

Percentage of Children, Ages 10 Months Through Two Years, Who Received a Screener for Developmental Delay,[1] 2007 and 2011/12

	2007	2011/12
Illinois	28.1	47.4
U.S.	23.0	38.5

[1]Using a Standardized Developmental Screening tool.
Source: Child Trends' original analyses of data from the National Survey of Children's Health.

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

Illinois	21.3
U.S.	13.5

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