

Health Status of Children in Hawai'i: 2007 National Survey of Children's Health



August 2010



Family Health
Services Division



NSCH Snapshot



Specific population groups of children in Hawai'i at greatest risk*

HEALTH STATUS

- 3 out of 4 publicly insured children are in excellent/very good health
- 64% of children below federal poverty level (FPL) have excellent/very good oral health
- 3 out of 4 publicly insured children were ever breastfed
- 40% of children below FPL are overweight/obese
- 1 out of 5 children 12-17 years of age are physically active everyday
- 17% of White children have no missed school days
- 2 out of 5 Native Hawaiian/Pacific Islanders are at moderate/high risk for delay
- 89% of children below FPL often exhibit positive social skills
- 1 out of 5 children 12-17 years of ages have special health care needs

HEALTH CARE

- 93% of children at 100%-199% FPL are currently insured
- 3 out of 4 children 12-17 years of age have adequate insurance
- 66% of children who are uninsured receive preventive care visits
- 2 out of 5 uninsured children have a medical home

COMMUNITY, SCHOOL AND FAMILY

- 70% of children below FPL participate in organized activities
- 2 out of 5 publicly insured children have moms in excellent/very good health
- 42% of publicly insured children have dads in excellent/very good health
- 1 out of 2 children below FPL have household members that use tobacco
- 40% of children 12-17 years of age have daily shared household meals
- 7 out of 10 children 1-5 years old at 100%-199% FPL have >1 hr/weekday screen time
- 58% of children below FPL have >1 hr/weekday screen time
- 4 out of 5 children below FPL usually/always feel safe in community
- 85% of Native Hawaiian/Pacific Islander children usually/always feel safe at school

* Based on the National Survey of Children's Health (NSCH) 2007 Hawai'i Data. Groups at greatest risk were defined by the worst estimate among all population groups (age, race, gender, Federal poverty Level, and Insurance Type). Specific details on estimates among other groups for comparison are found in this report.

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Foreword

The National Survey of Children's Health provides us with an excellent opportunity to explore important child health issues both nationally and in Hawai'i. The Hawai'i Department of Health's Family Health Services Division is pleased to present the Health Status of Children in Hawai'i: 2007 National Survey of Children's Health. This report uses 2007 data and highlights 22 child health indicators representing the following: 1) physical, mental, and dental health, 2) health care access, quality, and insurance coverage, and 3) community, school, and family life/health. Hawai'i data was examined for each indicator by age, race, gender, federal poverty level categories, and insurance type. Disparities among the specific population groups are highlighted for each indicator. The information presented in this report is meant to stimulate action by policy makers, planners, and the community who consistently strive to improve the health of children in Hawai'i.



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Director of Health

Overview of Survey: NSCH

The National Survey of Children's Health is a telephone survey first conducted in 2003 by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics. The survey was administered again in 2007 to continue monitoring the health of children in the United States. This report examines the most recent data (2007) at the national and state (Hawai'i) level.

The NSCH is sponsored by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA), the entity responsible for improving the health of mothers, children, and their families. Data from the NSCH served to address a critical need for information regarding child health that would allow robust estimates and comparisons for both state and national levels. The goals of the NSCH are fourfold:

- 1) to assess children's health status at the national and state level,
- 2) to provide information for policy makers, advocates, and researchers regarding children, families, and neighborhoods,
- 3) to generate baselines for federal and state performance measures, Health People 2010 objectives, and states' needs assessments, and
- 4) to complement the National Survey of Children with Special Health Care needs.¹

Through use of the CDC's State and Local Area Integrated Telephone Survey (SLAITS) program, 91,642 interviews representing an estimated 73,758,616 children nationwide were completed for the NSCH from April 2007 to July 2008. Households with children in the 0-17 year old age range were selected using a random-digit-dialed sample. Respondents were parents or caregivers knowledgeable of the child's health, their health care, and living situation. The majority of respondents (94%) were the child's mother or father. As low as 1,725 but no more than 1,932 interviews were completed in each sampling area, which included each of the 50 states and the District of Columbia. Overall response rates ranged from 39.4% to 61.9%, averaging to 46.7% nationally and 42.2% locally (Hawai'i).²

Discussion regarding the structure of the NSCH started in 2001 and involved input from state and federal maternal and child health program directors, representatives of family organizations, child health services researchers, and survey design experts. The child health indicators measured by the NSCH are comprehensive and include assessment of physical, emotional, and behavioral health, involving questions ranging from parental health to neighborhood safety. The survey spans the following eight major topics: 1) demographics, 2) physical and mental health status, 3) health insurance, 4) health care utilization and access to health care, 5) medical home, 6) family functioning, 7) parent health, and 8) neighborhood characteristics. Revisions to

Overview of Survey: NSCH

the initial NSCH for the 2007 survey were ongoing from as early as 2005 and included input from the Data Resource Center (DRC) on Child and Adolescent Health, NSCH data users, researchers at CDC, and technical experts who made recommendations to MCHB.

Over 80 indicators of child health status are addressed by the 2007 NSCH. In order to standardize the analysis of NSCH data, the DRC developed recommended code for data analysis for each indicator. Standardization of analysis is helpful because it enables easier cross-comparisons of survey results in the literature. This report used the DRC's 2007 National Survey of Children's Health SAS Code for Data Users as a guide for analysis of the indicators presented.¹

To reflect each state's unique population of non-institutionalized children under 18 years of age, a single sampling weight was ascribed to each record and used for weighted estimates. Weights were adjusted for many factors such as non-response, households without land lines, and demographics including age, gender, and race. The use of weights allows the extrapolation of results from the survey to population level estimates.

More information regarding the NSCH can be found at the DRC web site at www.nschdata.org. The DRC is a rich interactive resource that offers customized data profiles for state and national level NSCH data. The public use file and methodology for NSCH can be found on the SLAITS web site at www.cdc.gov/nchs/slaits/nsch.htm. For a snapshot of NSCH 2007 results, a chart book titled *The Health and Well-Being of Children: A Portrait of States and the Nation 2007* can be found at <http://mchb.hrsa.gov/nsch07>.

Population Characteristics

Estimates for Hawai'i Based on NSCH 2007 Data

	Estimated Population (N)	Weighted Percent Estimate (%)	95% Confidence Interval	Respondents (n)	Missing Responses (n)
Age					
0-5 Years	98,353	35.1	32.2-38.2	550	None
6-11 Years	88,378	31.6	28.8-34.5	569	
12-17 Years	93,136	33.3	30.6-36.1	703	
Race					
White Only	64,087	23.9	21.2-26.7	362	81
Black Only	7,506	2.8	1.9-4.1	34	
Asian Only	52,362	19.5	17.5-21.7	461	
NH/PI Only	51,994	19.4	16.9-22.0	328	
Multiracial	92,747	34.5	31.6-37.6	556	
Gender					
Male	145,942	52.2	49.1-55.2	948	2
Female	133,751	47.8	44.8-50.9	872	
% Federal Poverty Level					
<100%	39,625	14.2	11.9-16.8	169	None
100%-199%	62,609	22.4	19.8-25.1	360	
200%-399%	101,380	36.2	33.4-39.2	683	
400%+	76,253	27.3	24.8-29.8	610	
Insurance Type					
Public	60,149	21.7	19.1-24.6	328	28
Private	205,950	74.4	71.5-77.1	1,394	
Uninsured	10,728	3.9	2.9-5.2	72	
Total*	279,867	100	N/A	1,822	
Additional Characteristics					
Mother Born in US	205,555	79.2	77.6-81.5	1,289	160
Mother Born Outside of US	54,064	20.8	18.5-23.4	373	
Father Born in US	187,820	82.8	80.1-85.3	1,212	352
Father Born Outside of US	38,939	17.2	14.8-19.9	258	
Primary Language English	262,274	94.0	92.5-95.3	1,697	2
Non-English Primary Language	16,608	6.0	4.7-7.5	123	
Hispanic or Latino Origin	35,248	12.8	10.8-15.1	225	45
Parent with <12 Yrs Education	5,866	2.2	1.5-3.2	49	93
Parent with 12 Yrs Education	56,797	21.1	18.4-24.2	254	
Parent with >12 Yrs Education	205,972	76.7	73.6-79.5	1,426	
Welfare Cash Assistance	19,044	11.9	9.1-15.4	83	905
No Assistance	141,421	88.1	84.6-90.9	834	

Note: NH/PI = Native Hawaiian/Pacific Islander

*Total is based on responses for age and is similar but not identical to totals for other variables that have missing values.

Population Characteristics

In this section, population characteristics estimated from 2007 NSCH data are presented for Hawai'i. Information regarding 1,822 Hawai'i children were included in the 2007 NSCH data, representing an estimated 279,867 children.

Age

Ages were grouped into three levels: 1) 0-5 years old, 2) 6-11 years old, and 3) 12-17 years old. Although a greater proportion of children from surveyed households in Hawai'i fell within the 12-17 year old age group, weighted estimates for the population showed that the age dispersion was relatively even between age groups with the 0-5 year old group capturing the highest percentage (35.1%) of children. An estimated 31.6% of children were in the 6-11 year old group and 33.3% were in the 12-17 year old group.

Race

The NSCH data contained specific racial categories for Hawai'i. Racial groups were described as follows: 1) White only, 2) Black only, 3) Asian only, 4) Native Hawaiian/Pacific Islander only, and 5) multiracial. More than 300 children were sampled from each racial group except for the Black only category in which information regarding only 34 children were obtained. An estimated 2.8%, the lowest proportion among the racial groupings, of children in Hawai'i were Black only. Multiracial children, according to NSCH estimates, represented the highest proportion (34.5%) of Hawai'i's children. Relatively similar proportions were found for White only (23.9%), Asian only (19.5%), and Native Hawaiian/Pacific Islander only (19.4%) children. Further delineation of each racial group (e.g., type of Asian) is not possible for this data.

Gender

Estimates showed that 52.2% of children in Hawai'i were male, and 47.8% of children were female.

Percent of Federal Poverty Level

Federal poverty level (FPL) percentages were categorized into four groups: 1) less than 100% FPL, 2) 100%-199% FPL, 3) 200%-399% FPL, and 4) 400% FPL or more. The poverty status of a household was determined by household income and the number of people living in the household. The Department of Health and Human Services developed three separate federal poverty guidelines for Hawai'i, Alaska, and the remaining 48 states (and the District of Columbia). The values for %FPL in this

Population Characteristics

report account for regional differences in poverty thresholds. In cases where poverty level was not reported for a household, a value was imputed based on a routine developed for groupings of FPL by the DRC. In Hawai'i, nearly 40,000, or 14.2%, of children were living in households below the federal poverty level in 2007. The highest proportion of children (36.2%) were living at 200-399% FPL. The second highest proportion of children (27.3%) belonged to the 400%+ FPL group followed by 22.4% in the 100-199% FPL group.

Insurance Type

The majority of children in Hawai'i had private health insurance coverage. Specifically, 74.4% of children were estimated to be privately insured, 21.7%, or just over 60,000, were publicly insured, and 3.9%, or just over 10,000, of children were uninsured in the state.

Additional Characteristics

In this report, we only focus on the five primary characteristics already described. However, there are additional information available in the data set that can be used in analyses. The overall estimates for the state of Hawai'i for some of these additional population characteristics are also included in the table. The proportion of children with mothers (79.2%) compared to fathers (82.8%) born in the United States was relatively similar. A great majority (94.0%) of children lived in households where English was the primary language spoken. An estimated 12.8% of children were of Hispanic or Latino Origin. Most children had at least one parent with more than 12 years of education (76.7%). More children had a parent that had exactly 12 years of education (21.1%) than children whose parents had less than 12 years of education (2.2%). An estimated 11.9% of children lived in a household where someone received cash assistance from a state welfare program at some point in the previous 12 months.

Data Notes

Results for each indicator in the report are presented in a two-page format. The first page displays the estimate for all children in the State of Hawai'i with comparison to the rest of the nation. Please note that national estimates throughout this report do not include Hawai'i data, as Hawai'i is compared separately and independently in the analyses. The second page of results for each indicator represents an examination of Hawai'i data by the population characteristics of interest. Bar graphs are used to visually depict differences for three groups. The text provides a brief description of the differences depicted in the graphs and when applicable, those not shown in graphs.

95% Confidence Intervals

The error bars shown in each bar graph illustrates the 95% confidence intervals (95% CI) to show the variability in the estimate of interest. A 95% CI contains the true value within the population of interest 95% of the time and thus carries with it a 5% error rate. Confidence interval can be helpful in making quick comparisons between different subsets of a variable (e.g., to compare estimates for different insurance types). Essentially, if the 95% confidence intervals for estimates do not overlap, there is a statistically significant difference between the estimates of interest (at the $p < 0.05$ level). In general, if the 95% confidence intervals overlap, there is no significant difference between the estimates being compared, although this is not necessarily the case for situations involving minimal overlap of the confidence intervals.

Pairwise Comparisons and Statistical Testing

Each indicator in this reported was examined by population characteristics of interest (e.g., insurance type) that contain different groups (e.g., type of insurance: public, private, uninsured). Pairwise comparisons were used to compare every pair combination for each indicator using a two sample t-test with a $p < 0.05$ threshold for statistical significance. The significant differences are highlighted in the text.

Unreliable Estimates and Relative Standard Error (RSE)

Asterisks are used to mark estimates that do not meet standards for reliability and precision for specific population groups due to small number of respondents for the indicator. Specifically, any estimate with a relative standard error (RSE) of over 30% was deemed unreliable. The RSE is a measure of variability of an estimate and is calculated as the standard error divided by the estimated mean. Caution needs to be used in interpretation for estimates that are deemed unreliable

Health Status

Overall Health Status

Ages 0-17 Years

Background

Child health is a crucial issue that transcends world, national, state, and local levels and affects the quality of life of youth. It also has long-lasting impacts that extend into adulthood.^{3,4} Differences in children's health associated with socioeconomic status and race, among other factors, remain a national concern and addressing the root causes of these disparities is at the forefront of a recent push by the American Academy of Pediatrics.⁵

Overall health status is a multifaceted topic composed of and influenced by many factors including the physical, intellectual, and emotional development of children.

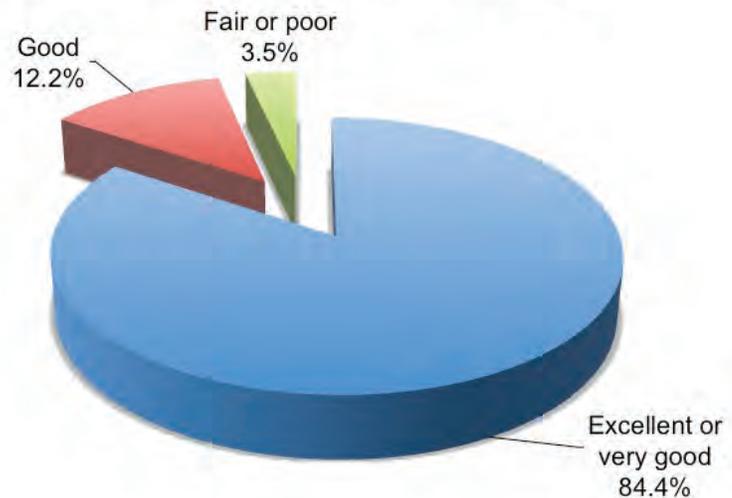
Measurement

Parents of 0-17 year olds were asked to describe their child's general health as excellent/very good, good, and fair/poor.

National Comparisons

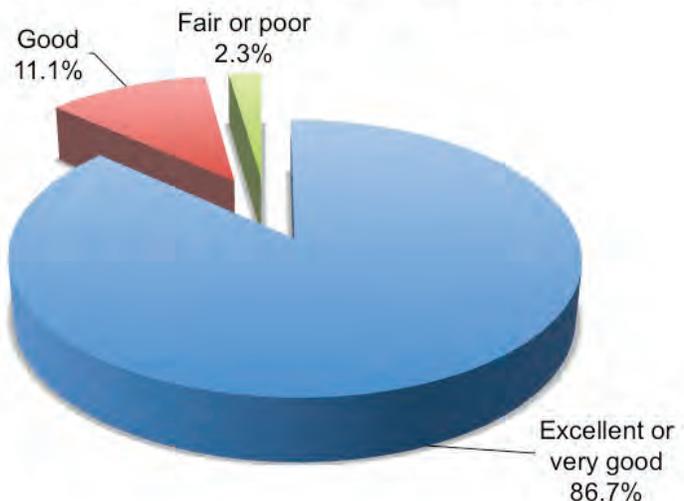
In Hawai'i, 86.7% of children were reported in excellent or very good

Overall Health Status, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Overall Health Status, Hawai'i NSCH 2007



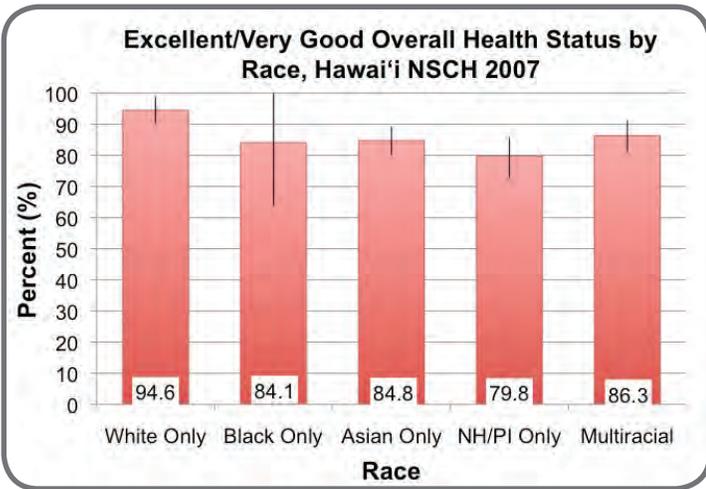
Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

health, which is significantly higher than the national estimate of 84.4%.

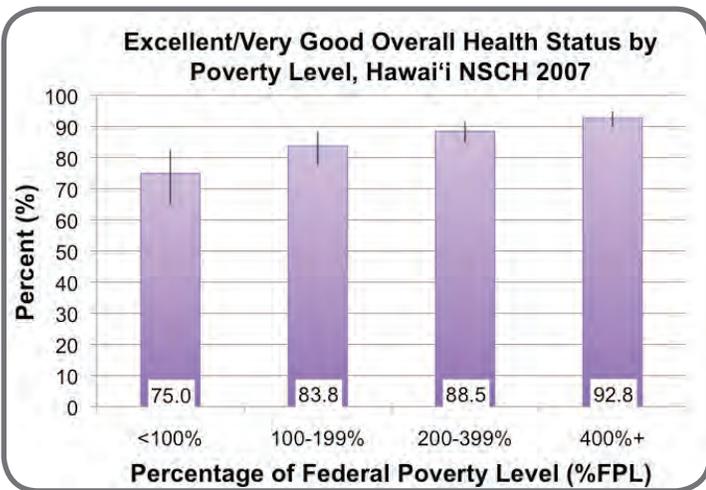
In Hawai'i, 11.1% of children were rated as in good health, followed by 2.3% who were rated as in fair or poor health. National data showed that 12.2% of children were in good health while 3.5% of children were in fair or poor health.

Overall Health Status of Children:

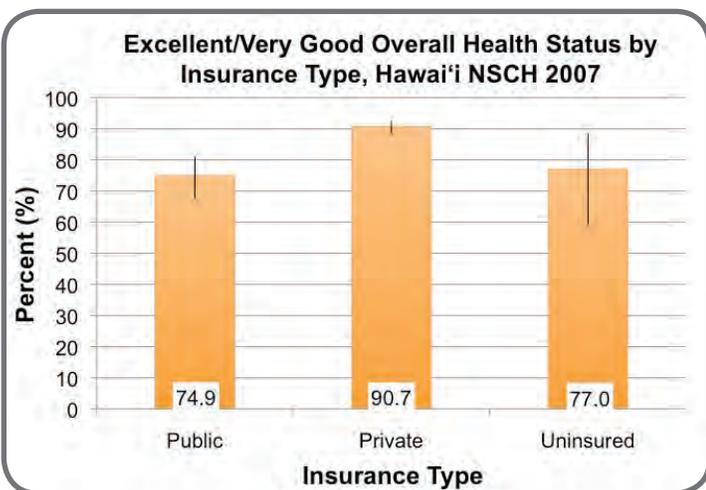
**86.7% (Hawai'i)
vs
84.4% (Nation)**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Status

Overall Health Status: Disparities

Data for Hawai'i show that disparities exist for children with overall excellent or very good health with respect to race, federal poverty level, and insurance type.

Race

White children (94.6%) were more likely to be in excellent or very good health compared to other racial groups. Differences in health between White children compared to Asian (84.8%), Native Hawaiian/Pacific Islander (79.8%), and multiracial children (86.3%) were statistically significant.

Federal Poverty Level

Excellent or very good health increased with federal poverty level (FPL). A significantly higher proportion of children living above 400% FPL (92.8%) were in excellent or very good health compared to those at the 200-399% (88.5%), 100-199% (83.8%), and <100% (75.0%) poverty levels.

Insurance Type

More privately insured children were in excellent or very good health compared to other groups. The difference between privately insured children (90.7%) and publicly insured children (74.9%) was statistically significant.

Other

There were no significant differences between gender and age groups for children with excellent or very good health status in Hawai'i.

Health Status

Overall Oral Health Status

Ages 1-17 Years

Background

Oral health is a critical component of general health and quality of life, and affects a child's ability to function in school and at home.^{6,7} Disparities in oral health are marked and remain a national concern. For instance, children from lower income families tend to have twice as many dental caries and are less likely to receive treatment when compared to higher income groups.⁷

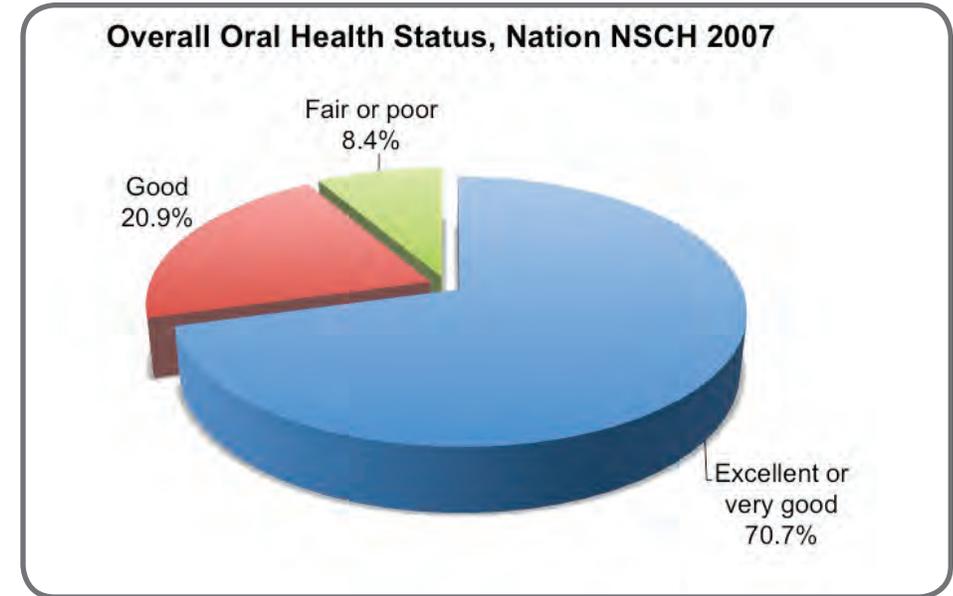
Measurement

Parents with 1-17 year old children were asked to report the condition of their child's teeth as excellent, very good, good, fair, or poor.

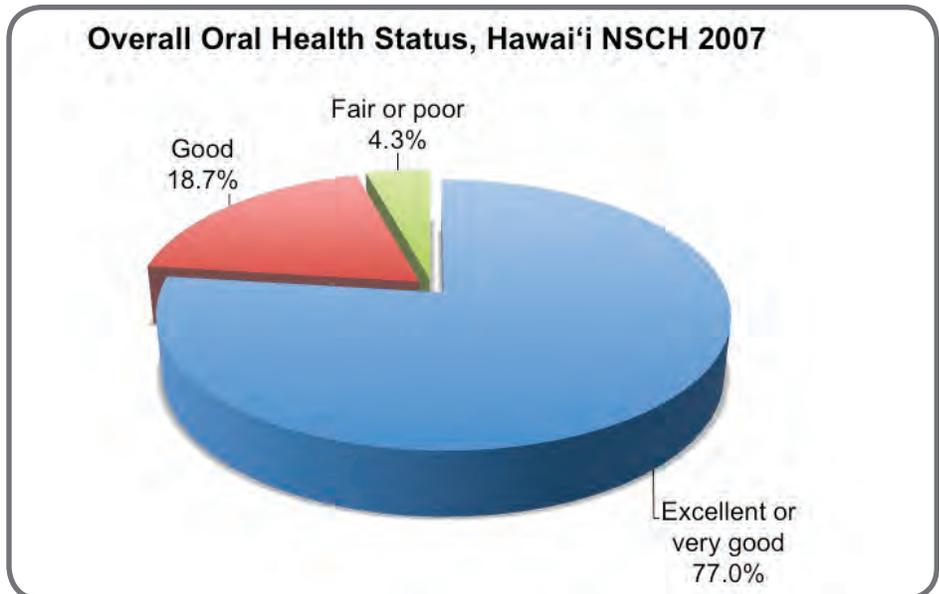
National Comparisons

In Hawai'i, 77.0% of children were reported to be in excellent or very good oral health, which is significantly higher than the national estimate of 70.7%.

Only 18.7% of Hawai'i's children have good oral health and just 4.3% have fair or poor oral health



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

ratings. National data showed that 20.9% of children have good, while 8.4% have fair or poor oral health.

Condition of Children's Teeth rated Excellent or Very Good:
77.0% (Hawai'i)
vs
70.7% (Nation)

Health Status

Overall Oral Health Status: Disparities

Data for Hawai'i showed disparities in excellent or very good reported oral health status for different age, race, and federal poverty levels.

Age

The youngest children had the best reported oral health. The proportion of children whose oral health was rated as excellent or very good was almost ten percent higher for children in the 1-5 year old category (81.3%) compared to those in the 6-11 year old group (72.5%), a difference that is statistically significant.

Race

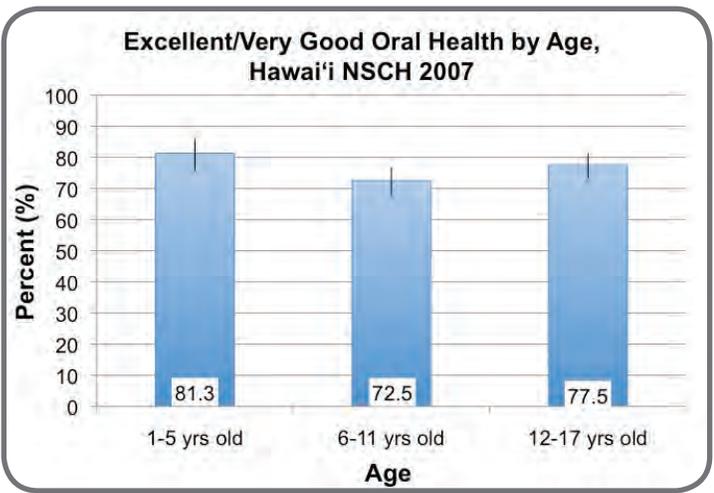
With regard to race, White children (84.3%) had better reported oral health than other racial groups. The difference between White and Asian (72.1%) and also between White and Native Hawaiian/Pacific Islander (71.8%) groups was statistically significant.

Federal Poverty Level

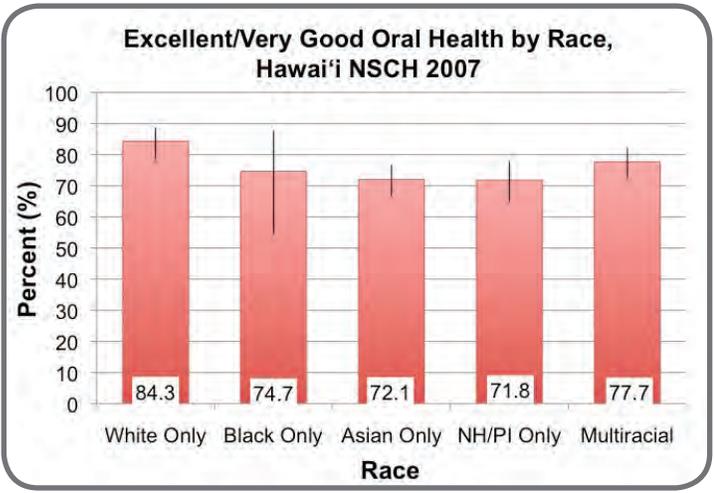
Oral health status increased with federal poverty level. Only 63.7% of children below 100% FPL had excellent or very good oral health compared to 100-199% FPL (71.8%), 200-399% FPL (79.3%), and 400%+ FPL (84.9%) groups. All comparisons between FPL groups were significant, except for <100% versus 100-199%.

Other

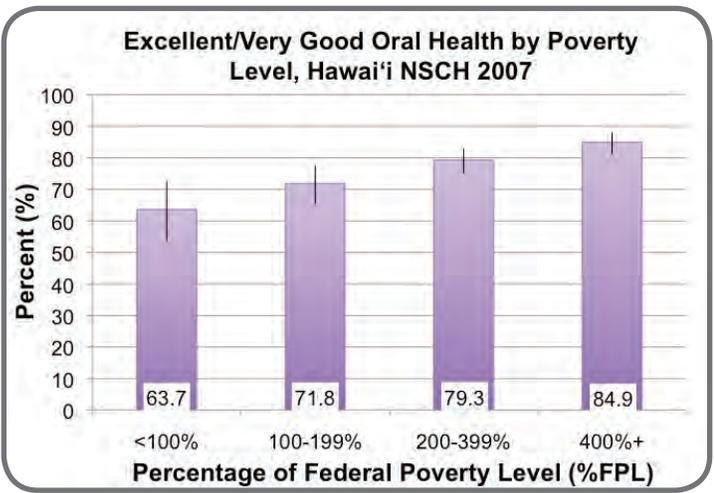
There were no significant differences in oral health status with respect to child's gender and insurance type.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Breastfeeding

Ages 0-5 Years

Background

Breastfeeding plays a key role in improved childhood health and can positively influence biological outcomes into adulthood.⁸ Studies have shown positive effects of breastfeeding on respiratory and gastrointestinal health in youngsters.⁹ Breastfed children have improved outlooks with regard to diabetes, cholesterol levels, cardiovascular health, and obesity later in life.⁹ Furthermore, breastfeeding has been shown to confer benefits with regard to maternal health, facilitating faster postnatal recoveries.⁹

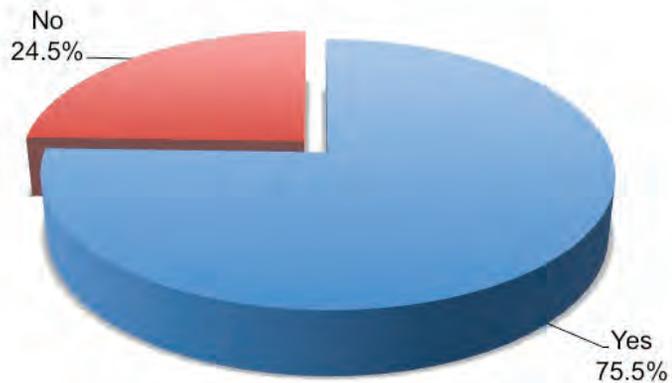
Measurement

Parents of children in the 0-5 year old range were asked if their child was ever breastfed or fed breast milk. Responses to this question included yes or no answers.

National Comparisons

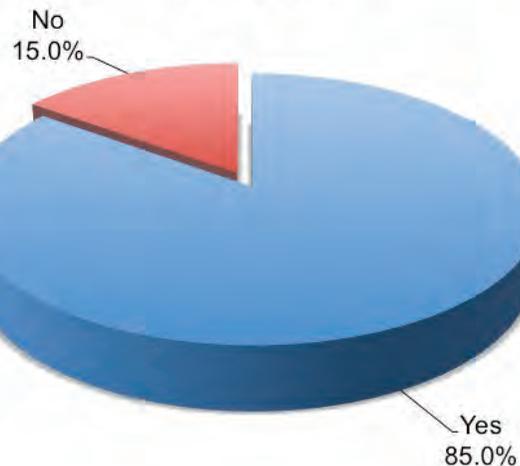
In Hawai'i, 85.0% of children were ever breastfed or ever received breast milk, which is significantly higher than the national estimate of 75.5%. The almost

**Children Who Were Ever Breastfed, Nation
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Children Who Were Ever Breastfed, Hawai'i
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

10% difference between the Hawai'i and the national estimate is considerable.

**Children
Ever
Breastfed:
85.0% (Hawai'i)
vs
75.5% (Nation)**

Health Status

Breastfeeding: Disparities

In Hawai'i, disparities in children who were ever breastfed or given breast milk exist between different federal poverty levels and types of insurance.

Race

Differences in ever breastfeeding between racial groups were seen but were not statistically significant. Asian children (90.8%) had the highest breastfeeding rate while Native Hawaiians/Pacific Islanders (80.2%) had the lowest rate.

Federal Poverty Level

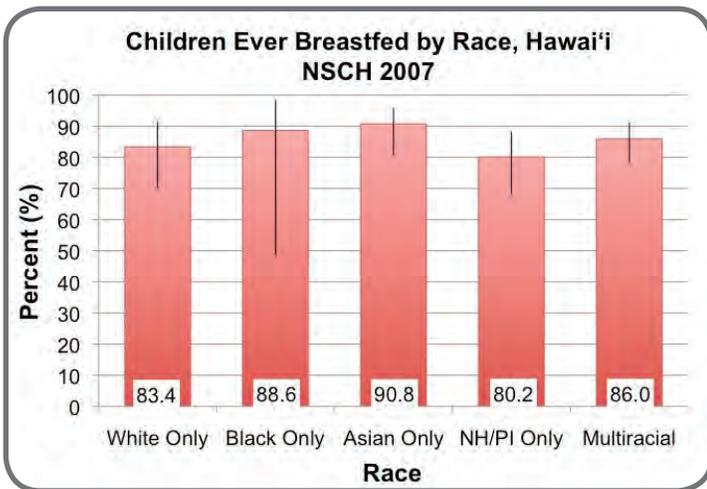
Breastfeeding increased with federal poverty level. Significantly more (93.7%) children in the 400%+ FPL were breastfed compared to >100% (80.8%), 100-199% (79.9%), and 200-399% (84.2%) FPL categories.

Insurance Type

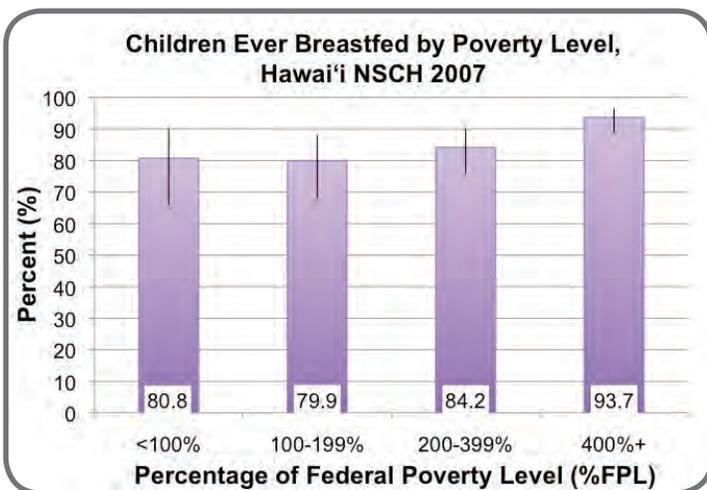
Privately insured children (89.1%) had the highest rate of breastfeeding. The difference between breastfeeding in privately insured children compared to publicly insured children (74.1%) was statistically significant.

Other

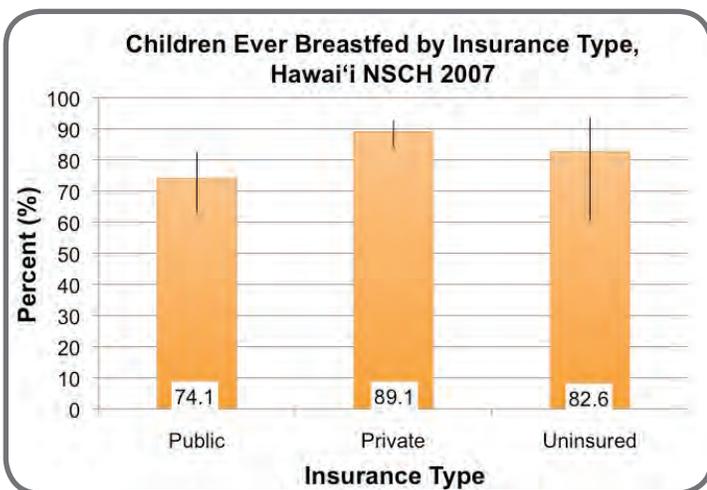
There were no statistically significant differences in ever breastfeeding by the gender of the child. Differences for age group of the child was not assessed for this indicator.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Status

Overweight/ Obese Children

Ages 10-17 Years

Background

Childhood obesity is of increasing concern as rates have more than tripled in the last forty years.¹⁰ Obesity in children has been related to an increased risk for type 2 diabetes, cardiovascular complications, asthma, and cancer.¹¹ Effects from childhood obesity are long-lasting and can have consequences even if normal weight is attained in adulthood.¹⁰

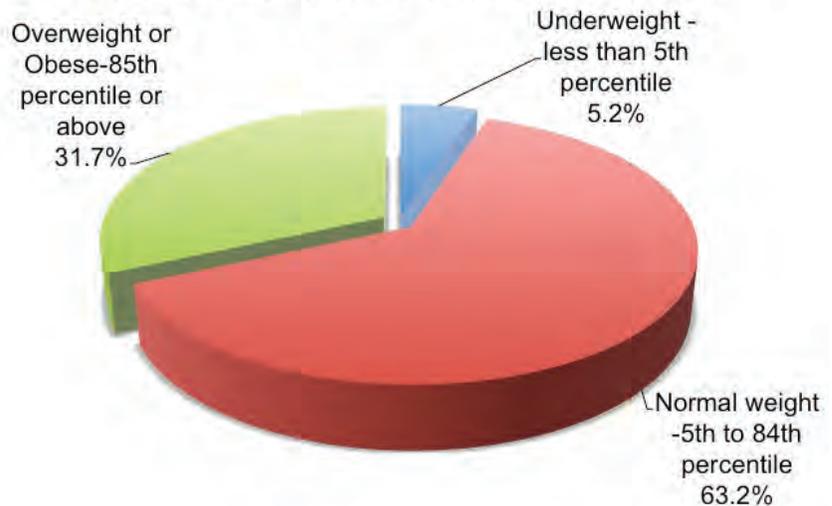
Measurement

Body Mass Index for age (BMI-for-age), which is age and gender specific, was calculated for children of ages 10-17 years old and was based on parent-reported height and weight. Weight status was categorized into the following categories: underweight (less than 5th percentile), normal weight (5th to 84th percentile), overweight or obese (85th percentile or above).

National Comparisons

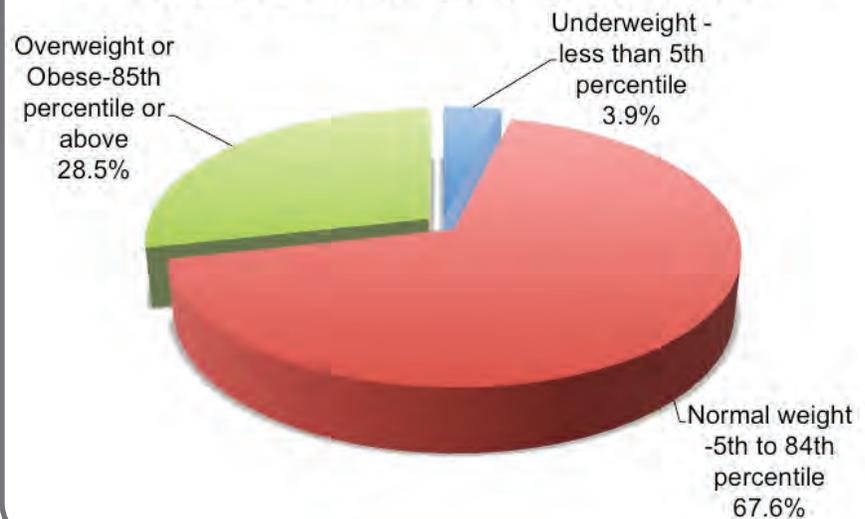
In Hawai'i, 28.5% of children were reported to be overweight or obese,

Body Mass Index for Age, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Body Mass Index for Age, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

which is less than but not significantly different from the national estimate of 31.7%.

An estimated 67.6% of children in Hawai'i were of normal weight while 3.9% were underweight. Nationally 63.2% children were of normal weight and 5.2% were underweight.

**Children who
are Obese/
Overweight:**

**28.5% (Hawai'i)
vs
31.7% (Nation)**

Health Status

Overweight/Obese Children: *Disparities*

Data for Hawai'i demonstrated disparities in children who were reported to be overweight/obese with respect to race, gender, federal poverty level, and insurance type.

Race

Native Hawaiian/Pacific Islander (NH/PI) children were more likely to be obese compared to other groups. Differences between White (25.0%) and Asian (16.5%) compared to NH/PI (38.6%), and the difference between Asian and multiracial (30.9%) children, were significantly different.

Gender

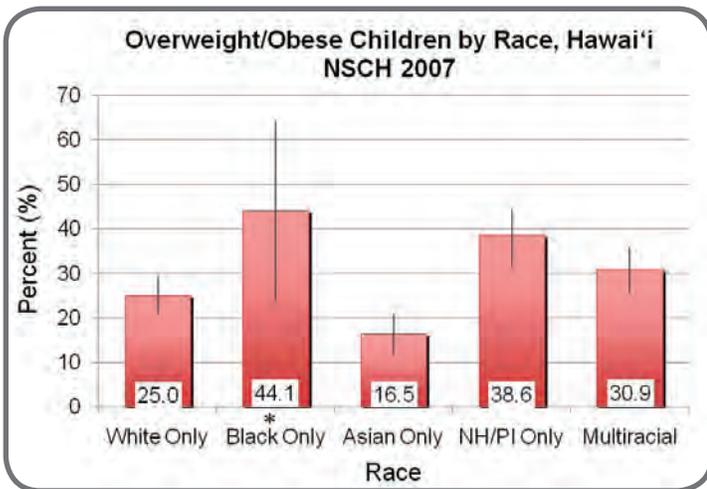
A significantly larger proportion of males (32.5%) compared to females (24.2%) were overweight/obese.

Federal Poverty Level

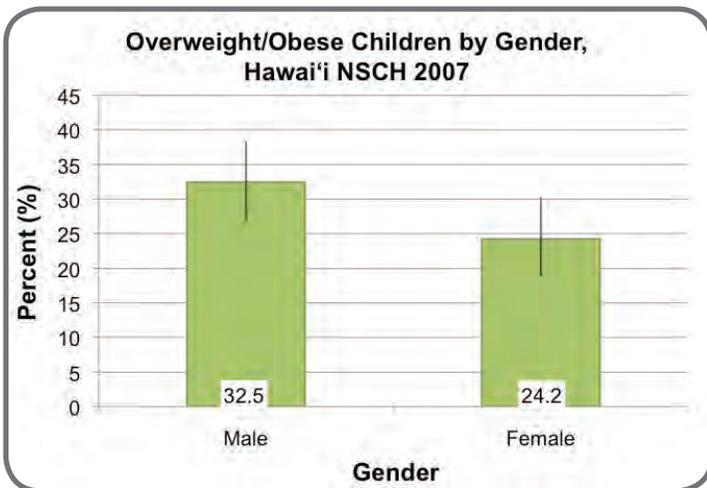
Overweight/obesity rates decreased with increasing FPL status. The <100% FPL (39.8%) and 100-199% FPL (34.3%) groups compared to the 400%+ (22.6%) group was statistically significant.

Other

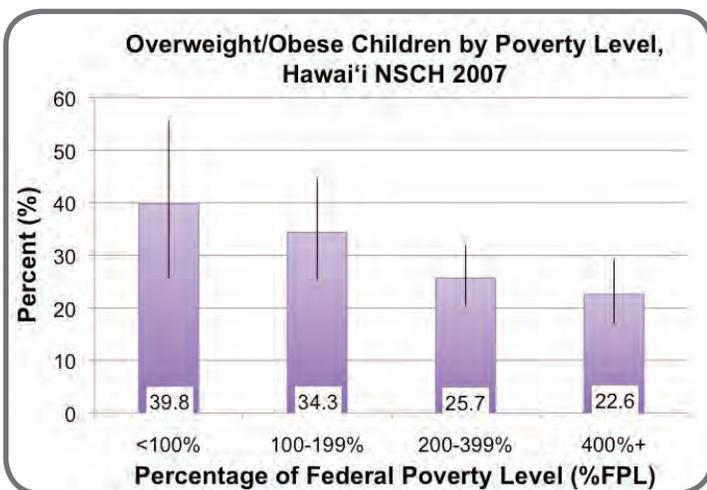
Overweight/obesity rates were highest for publicly insured children. Significantly more publicly insured (37.9%) compared to uninsured (18.9%) children were overweight/obese although the estimate for uninsured children was unreliable (>30% RSE). Differences for age group of the child was not assessed for this indicator.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Physical Activity

Ages 6-17 Years

Background

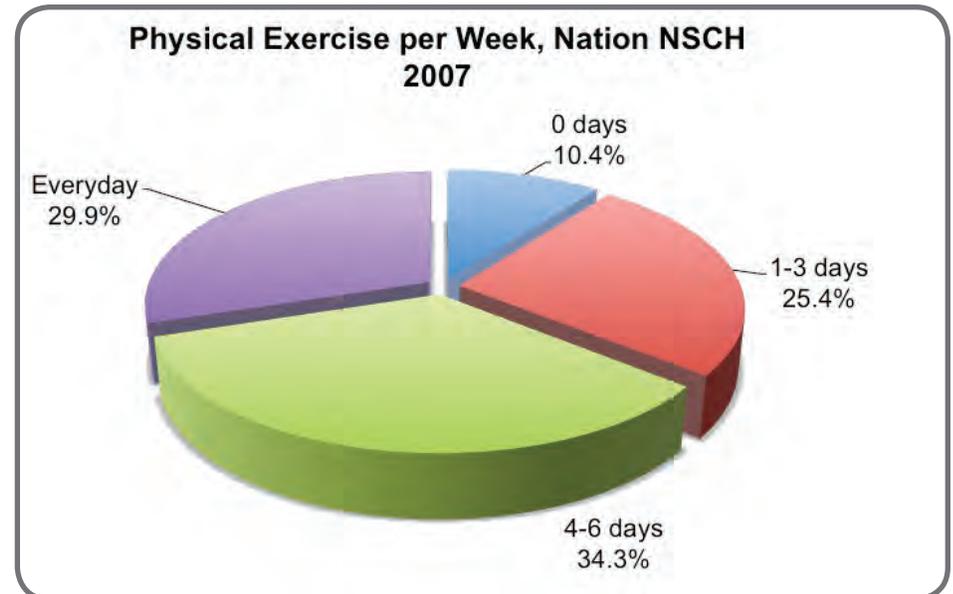
Physical fitness plays an important role in maintaining good overall health. The effects of physical activity in childhood are far-reaching and positively impact cardiovascular health, bone strength, and the development of lean body mass even into later years of life.^{12,13,14} Children who are more physically active have reduced blood pressure and rates of obesity in early adulthood.¹⁴

Measurement

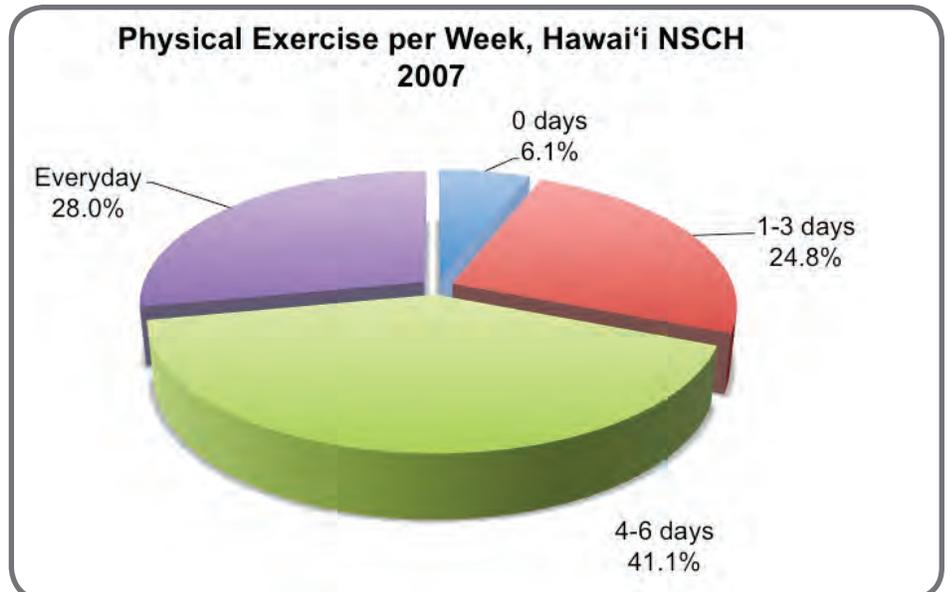
Parents of 6-17 year olds were surveyed as to how often during the past week their child participated in physical activity for at least 20 minutes that made him/her sweat and breathe hard. Responses were categorized as zero days, one to three days, four to six days, and everyday.

National Comparisons

In Hawai'i, 28.0% were reported to be physically active everyday, which was lower than but not significantly different from the national estimate of 29.9%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Hawai'i data for children who were physically active for zero days (6.1%), one to three days (24.8%), and four to six days (41.1%) were relatively comparable to national data for zero days (10.4%), one to three days (25.4%), and four to six days (34.3%).

**Physical Activity
Everyday in
Hawai'i:
33.9% (Males)
vs
21.5% (Females)**

Health Status

Physical Activity: *Disparities*

Data for Hawai'i showed disparities in daily physical activity for age, race, and gender.

Age

In Hawai'i, significantly more 6-11 year olds (35.0%) engage in physical activity everyday compared to 12-17 year olds (21.3%).

Race

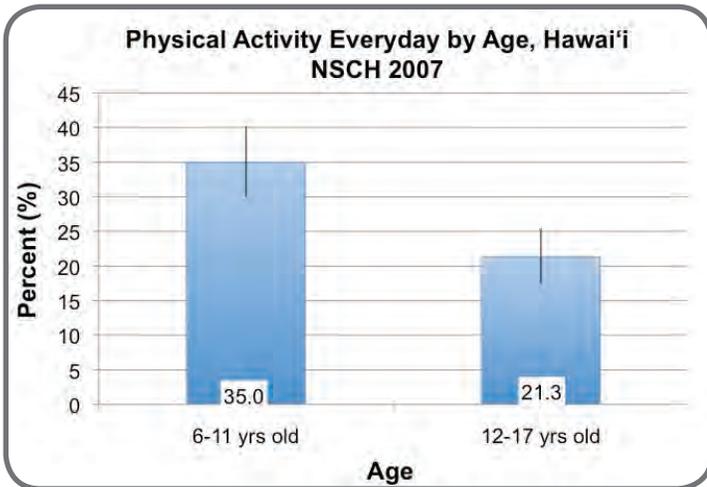
More White children (34.1%) engage in physical activity everyday compared to other racial groups. The difference in percentages between Whites versus Asians (21.3%) and multiracial (23.8%) children is statistically significant.

Gender

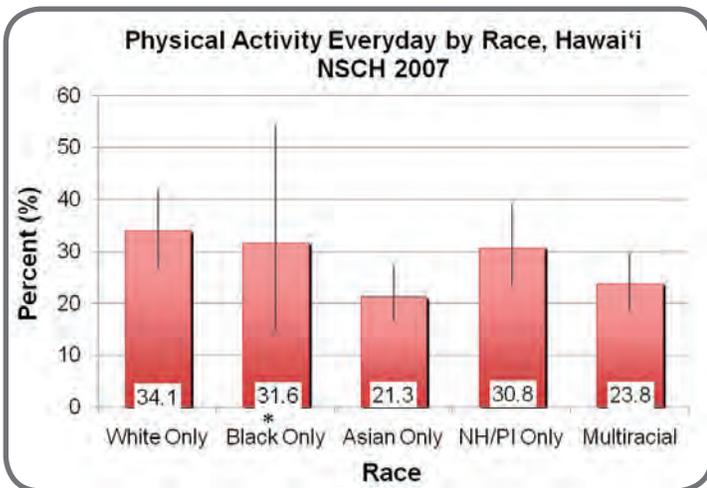
A significantly higher percentage of males (33.9%) engage in physical activity everyday compared to females (21.5%).

Other

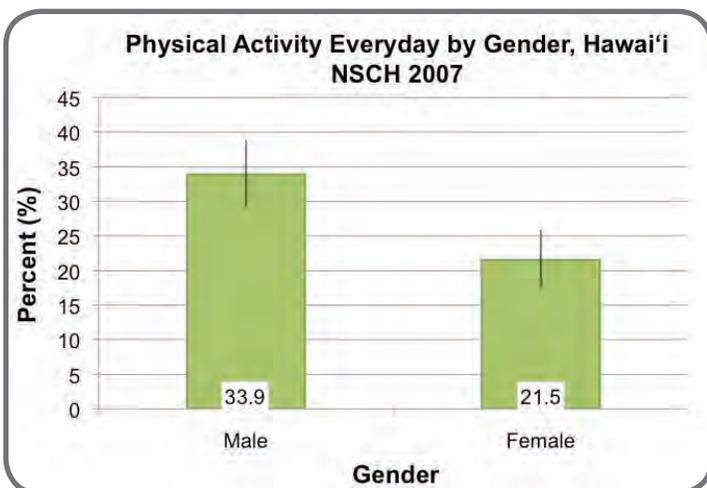
No significant differences were found for children who were physically active everyday with respect to levels of federal poverty level or type of insurance.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Missed School Days

Ages 6-17 Years

Background

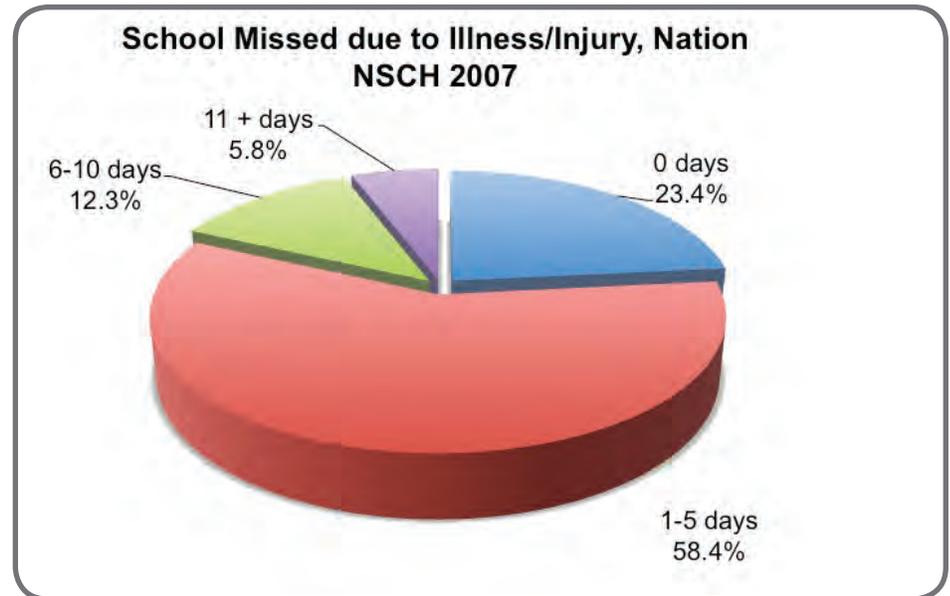
Childhood illness, whether mild and routine or serious and chronic, can mean missed class time. School absenteeism can impact the quality of life not only for children but also for their families. For instance, during influenza season, parents must increasingly take off from work to care for their children and households are often further burdened by secondary illnesses that ensue.¹⁵

Measurement

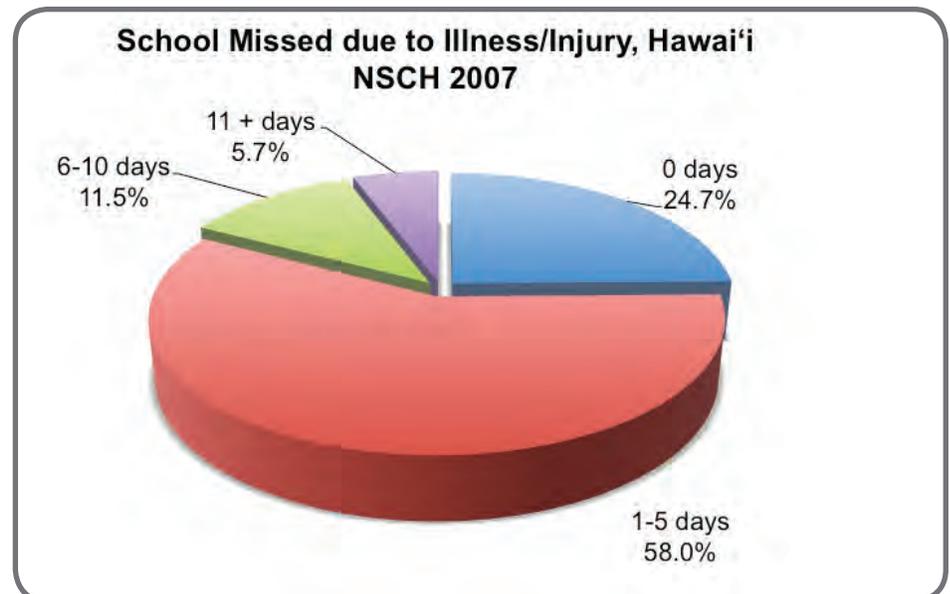
Parents of 6-17 year olds were asked to report the number of days their child missed school due to illness or injury in the past 12 months. Responses were categorized as: zero days, one to five days, six to ten days, and eleven or more days.

National Comparisons

In Hawai'i, 24.7% of children missed zero school days due to illness or injury, which is higher than but not significantly different from the national estimate of 23.4%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

In Hawai'i, 58.0%, 11.5%, and 5.7% of children missed one to five, six to ten, and eleven or more school days due to illness or injury. Nationally, 58.4%, 12.3%, and 5.8% of children missed one to five, six to ten, and eleven or more school days due to illness or injury.

**Zero Missed
School Days Due
to Illness/Injury in
Hawai'i:**

21.0% (ages 6-11)

vs

28.2% (ages 12-17)

Health Status

Missed School Days: *Disparities*

There were disparities within Hawai'i for children who did not miss any school days due to illness/injury in the past 12 months with respect to age, race, and insurance type.

Age

Significantly more 12-17 year olds (28.2%) did not miss school days due to injury or illness compared to 6-11 year olds (21.0%).

Race

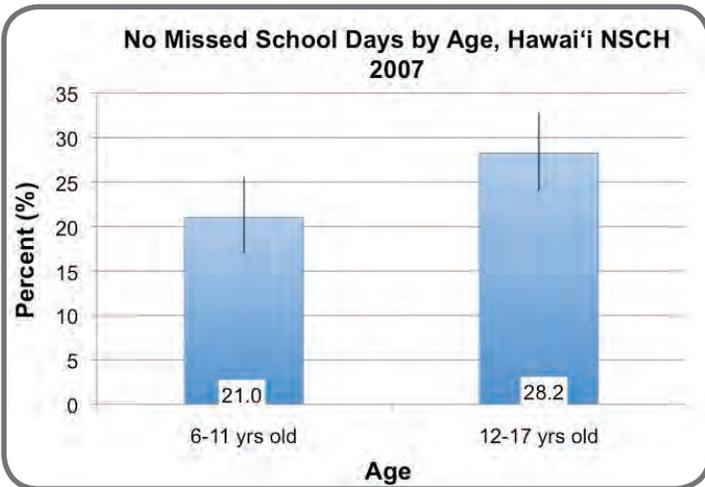
A higher proportion of Asian (32.9%) children missed zero school days compared to other racial categories. White children maintained the lowest percentage for zero missed school days (17.4%), a proportion that was significantly lower than that for Asians and multiracial (25.7%) groups.

Insurance Type

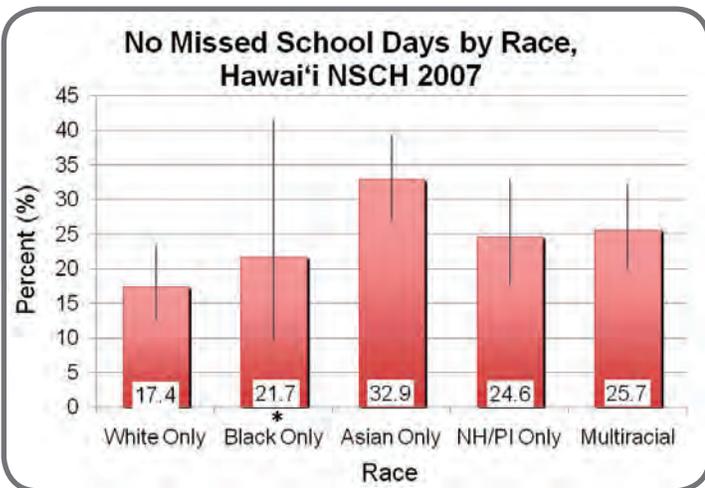
More uninsured children (42.2%) compared to other insurance groups had zero missed school days. The difference between uninsured children compared to privately insured children (23.6%) was statistically significant.

Other

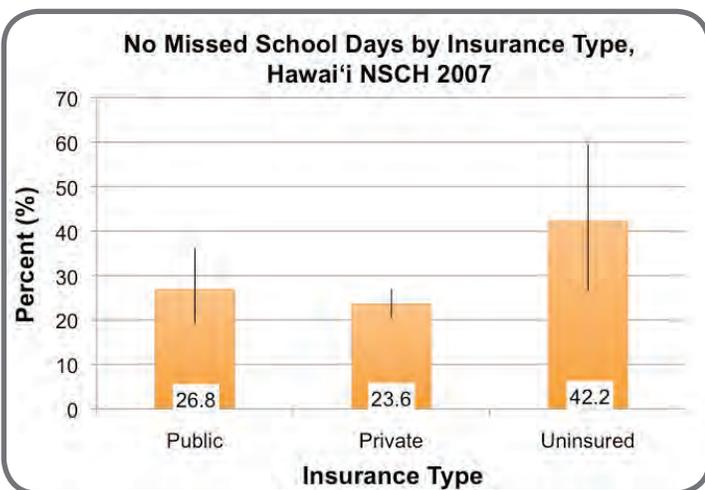
There were no statistically significant differences between gender and federal poverty level groups for children with no missed school days due to injury or illness.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Status

Risk for Delay

Ages 4 Months to 5 Years

Background

It is crucial to recognize and address childhood delay in development, behavior, or social skills. The earlier issues of concern are attended to, the more effective our efforts as a society will be in providing children the chance to reach their full potential. Health care providers, schools, and families play a crucial role in early intervention for developmental, behavioral, and social delay.¹⁶

Measurement

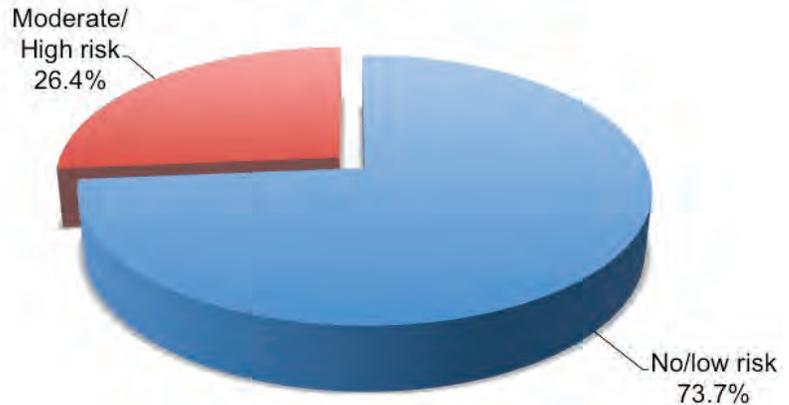
Parents of four month to five year old children were asked about concerns for their child's learning, development, or behavior. Parents were also asked about their concern about their child's speech, comprehension, motor skills, social skills, and ability to learn. Responses for concern were as follows: a lot, a little, or not at all. Screening for delay risk was based on the Parents' Evaluation of Developmental Status (PEDS). Risk groups were categorized as low/none or

moderate/high.

National Comparisons

In Hawai'i, parental responses indicated that 27.6% of children were at moderate or high risk for developmental, behavioral, or social delay, which is higher but not significantly different from the national estimate of 26.4%.

Risk for Developmental, Behavioral, or Social Delay, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Risk for Developmental, Behavioral, or Social Delay, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Risk for Delay in Hawai'i:

24.5%
(Privately Insured)

vs

37.9%
(Publicly Insured)

Health Status

Risk for Delay: *Disparities*

In Hawai'i, there were disparities in moderate/high risk for delay for race and insurance type.

Race

White children had the lowest risk for delay compared to other racial groups. Significantly more Asians (30.0%), Native Hawaiian and Pacific Islanders (42.0%), and multiracial (26.7%) children had moderate/high risk for delay compared to Whites (13.5%), although the estimate for Whites was unreliable (>30% RSE).

Federal Poverty Level

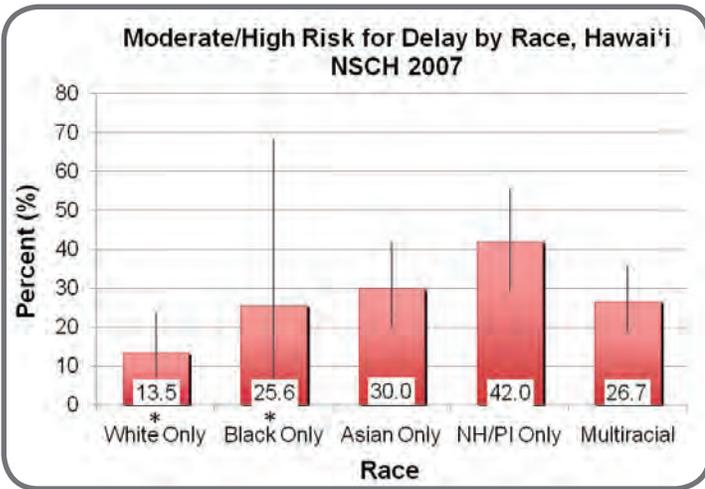
Differences in risk for delay were seen between federal poverty level groups but were not significantly different. Children from the 400%+ FPL group had the lowest rate for moderate/high risk for delay (20.6%), while those from the 200-399% FPL group had the highest rate (31.6%).

Insurance Type

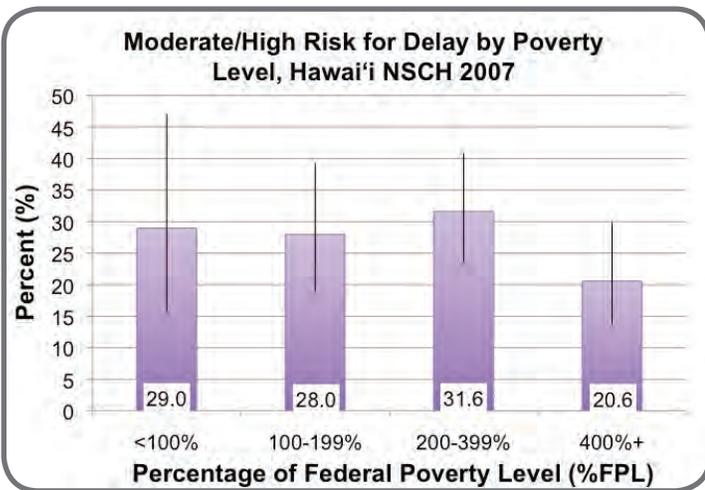
Publicly insured children (37.9%) had the highest rate for moderate/high risk for delay. Differences between publicly insured children compared to privately (24.5%) and uninsured (11.0%) children were significant, although the estimate for uninsured children was unreliable (>30% RSE).

Other

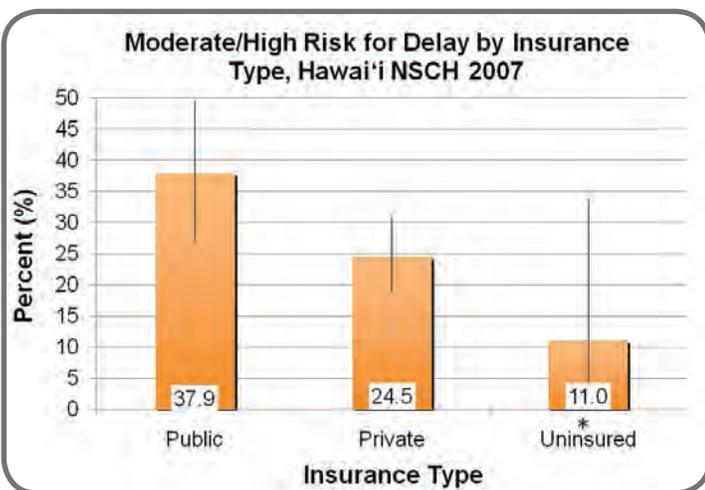
There were no statistically significant disparities in moderate/high risk for delay with respect to child's gender. Differences for age group of the child was not assessed for this indicator.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.

Health Status

Positive Social Skills

Ages 6-17 Years

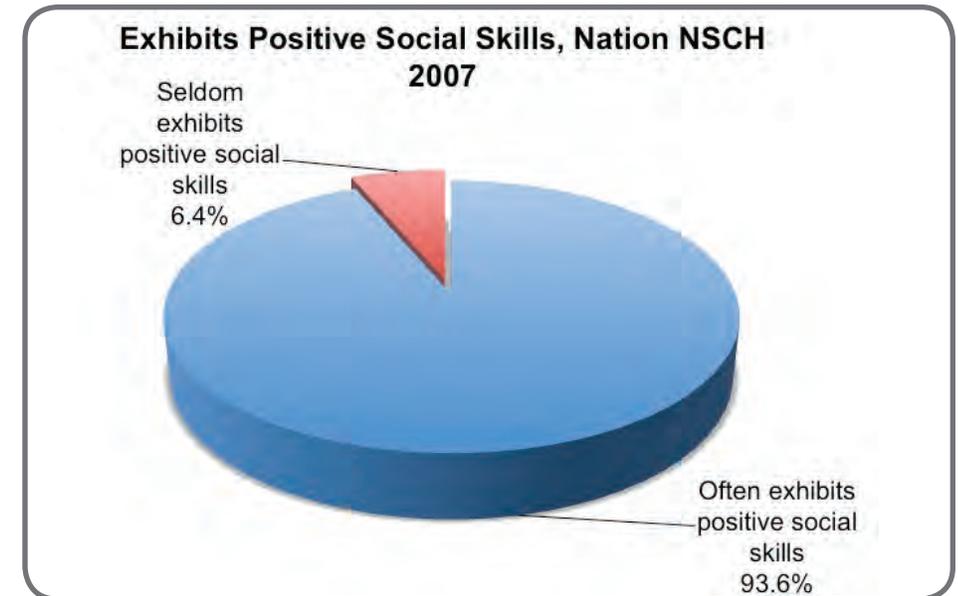
Background

Positive social skills are important throughout life and subscribing to them early on can have immediate and long term benefits. The facilitation of interpersonal skills in the household and academic settings, even in the elementary school years can reduce problems of emotional and mental health, crime, and substance abuse later on in life.¹⁷

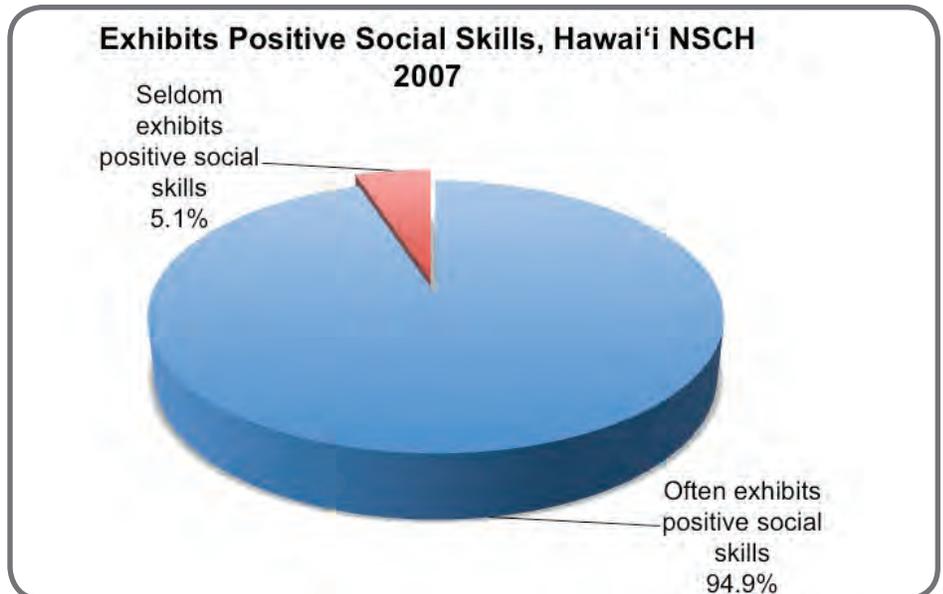
Measurement

Parents of 6-17 year olds were asked about the following four components of their child's social skills: respect for teachers and neighbors, getting along with other children, trying to understand other people's feelings, and trying to resolve conflicts with classmates, family or friends. Responses included the following: never, rarely, sometimes, usually, or always.

If a child usually/always exhibited at least two of the four indicator components, then a classification of "often exhibits positive social skills," instead of "seldom



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

exhibits positive social skills," was ascribed to the child.

National Comparisons

In Hawai'i, parental responses indicated that 94.9% of children often exhibited positive social skills, which is higher than but not significantly different from the national estimate of 93.6%.

Positive Social Skills in Hawai'i:

90.4% (Native Hawaiian/Pacific Islanders)

vs

97.5% (Asians)

Health Status

Positive Social Skills: *Disparities*

Disparities were demonstrated in age, race, and federal poverty level for children who often exhibited positive social skills in Hawai'i.

Age

Significantly more children in the 6-11 year old group (96.8%) were reported to often exhibit positive social skills compared to children in the 12-17 year old group (93.2%).

Race

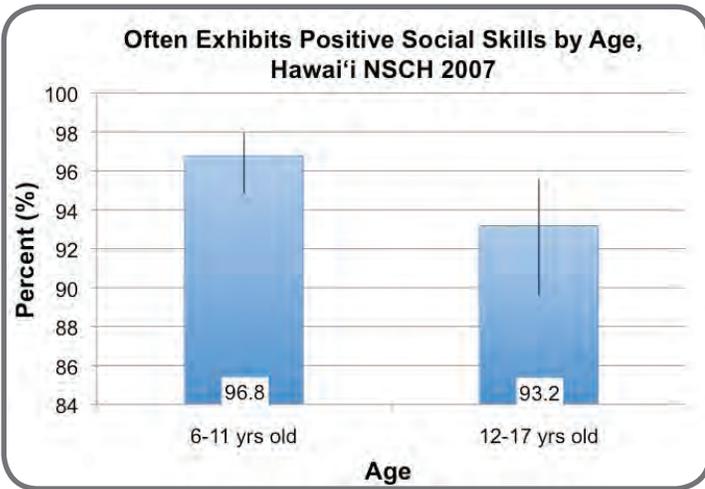
Less Native Hawaiian/Pacific Islander children (90.4%) exhibited positive social skills compared to other racial groups. The difference between Native Hawaiian/Pacific Islander children and Asian children (97.5%) was statistically significant.

Federal Poverty Level

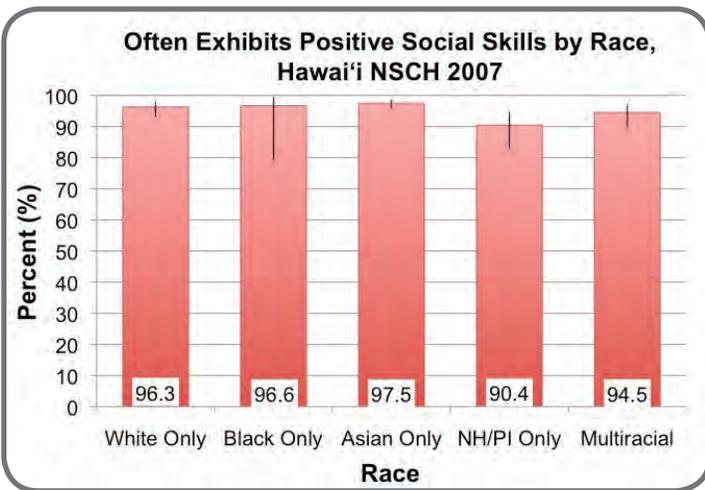
More children exhibited positive social skills in the 400%+ FPL group (98.1%) compared to other FPL groups. Differences between the 400%+ FPL group compared to <100% FPL (89.2%) and 200-399% FPL (95.1%) groups was statistically significant.

Other

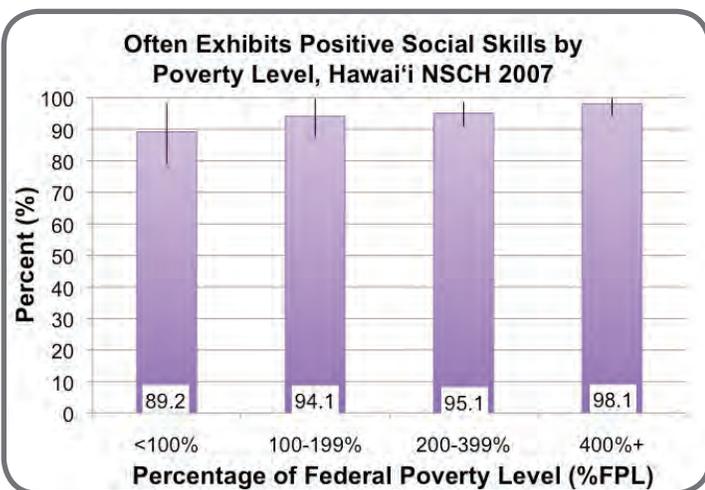
No statistically significant disparities in positive social skills were seen for child's gender and insurance type.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Status

Special Health Care Needs Status

Ages 0-17 Years

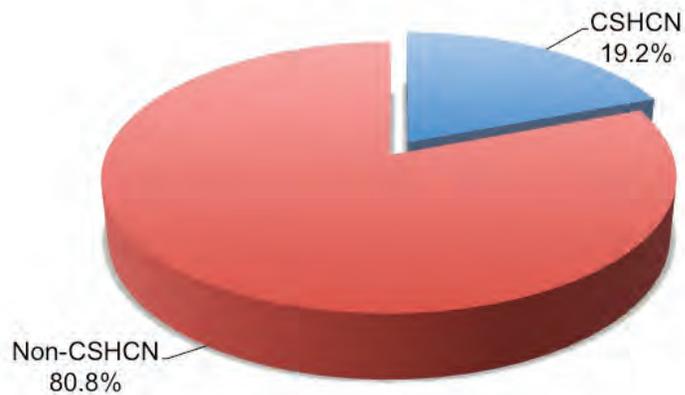
Background

Much research is invested into identifying children with special health care needs. Of children in the United States aged zero to seventeen, approximately 12% suffer from a chronic condition that requires increased service use or restricted activity.¹⁸

Measurement

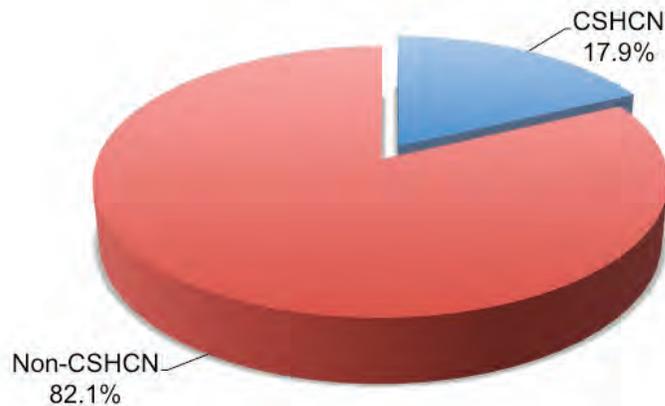
Parents of 0-17 year olds were asked a broad range of questions from five criteria pertaining to use of medication, special services, functional limitations, special therapies, and mental health services. A children with special health care needs (CSHCN) screener, developed to coincide with the Maternal and Child Health Bureau's definition of CSHCN, used the five criteria to categorize children in this survey as CSHCN or non-CSHCN. Essentially, if one or more of the five criteria were met, a child was classified as having CSHCN status.

Children with Special Health Care Needs Status, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Children with Special Health Care Needs Status, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, 17.9% of children were classified as children with special health care needs, which is lower than but not significantly different from the national estimate of 19.2%.

CSHCN in Hawai'i:
20.6% (Native Hawaiian/Pacific Islander)
vs
10.2% (Asian)

Health Status

Special Health Care Needs Status: Disparities

There were disparities in children classified as having special health care needs in Hawai'i with respect to age and race.

Age

More children were classified as special health care needs with increasing age. While 22.2% of 12-17 year old children were CSHCN, 19.4% of 6-11 year olds and just 12.5% of 0-5 year olds were CSHCN. Differences between all age groups were statistically significant.

Race

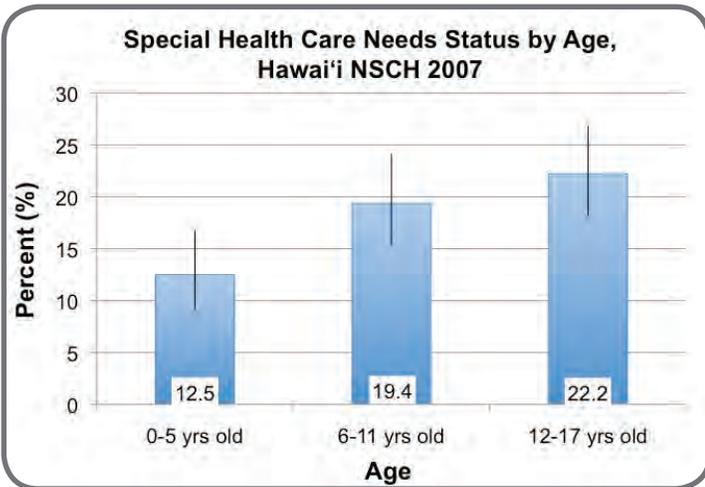
Less Asian children (10.2%) compared to other racial groups were CSHCN. Differences between Asians compared to Whites (18.6%), Native Hawaiian and Pacific Islanders (20.6%), and multiracial children (20.1%) were statistically significant.

Insurance Type

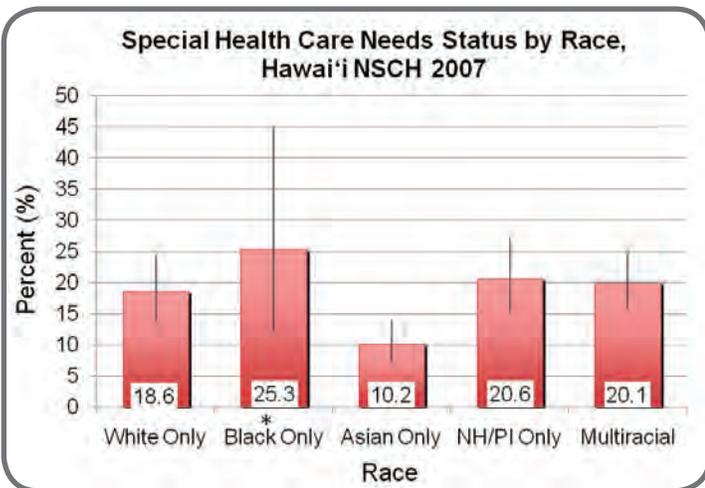
Children with private insurance (17.4%) had the lowest percentage of CSHCN compared to other insurance types although the differences were not statistically significant.

Other

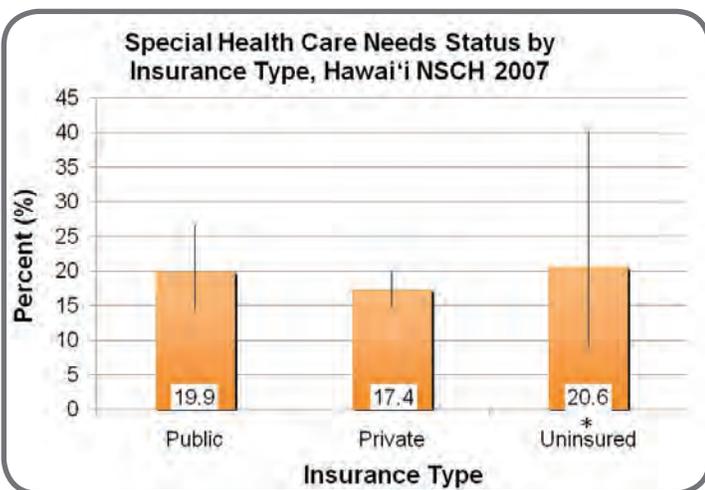
There were no statistically significant disparities in CSHCN rates in Hawai'i with respect to child's gender and federal poverty level.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.

Health Care

Health Insurance Status

Ages 0-17 Years

Background

Health insurance plays a critical role in a child's life as it allows easier access to health care services. Health insurance facilitates the health of our children by making routine care, such as immunizations and physicals, and acute care, in the case of sudden illness, more affordable and accessible. Uninsured children in the United States have the highest rates of unmet health care needs.¹⁹

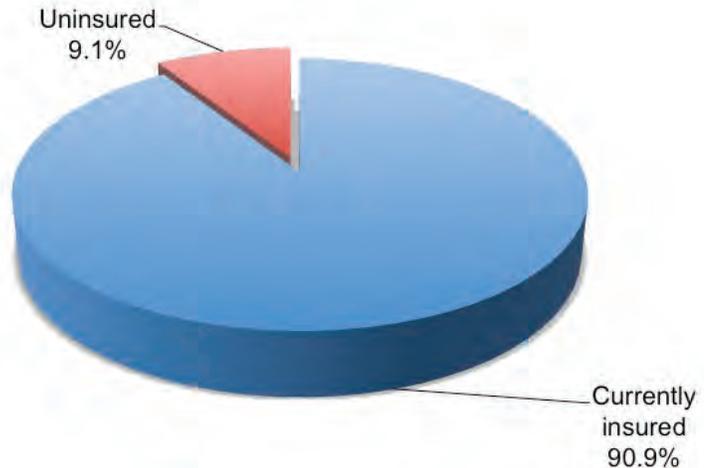
Measurement

Parents of 0-17 year olds were asked if their children were currently under any type of health insurance. Any kind of health care coverage, including prepaid plans such as HMOs, military insurance, or government plans for lower income families such as Medicaid were considered as health insurance.

National Comparisons

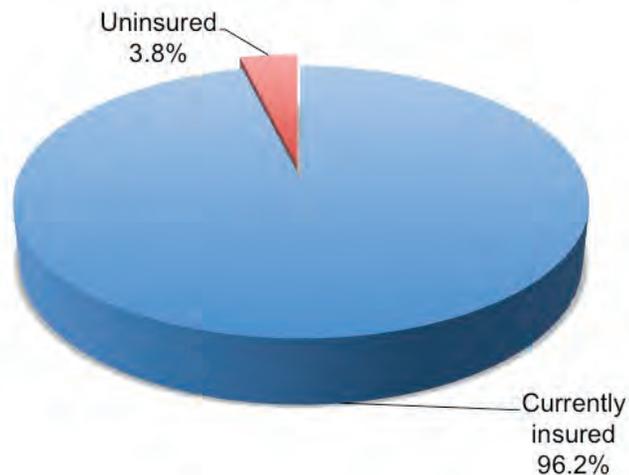
In Hawai'i, 96.2% of children were currently covered under some type of health insurance plan, which is significantly higher

Health Insurance Coverage, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Insurance Coverage, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

than the national estimate of 90.9%.

Children with Health Insurance:

**96.2% (Hawai'i)
vs
90.9% (Nation)**

Health Care

Health Insurance Status: *Disparities*

Data for Hawai'i showed a disparity for health insurance status by federal poverty level for children.

Race

More White children (97.9%) compared to other racial groups were currently insured, but no differences were statistically significant. Native Hawaiian/Pacific Islander children (94.8%) had the lowest rate for insurance coverage.

Gender

Slightly more females (96.5%) than males (95.9%) were currently insured, but this difference was not statistically significant.

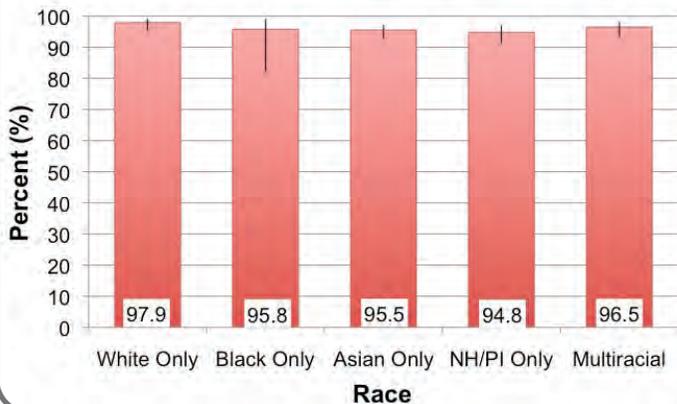
Federal Poverty Level

More children were insured in the 200-399% FPL group (97.8%) compared to other FPL groups. The difference between the 200-399% FPL compared to the 100-199% FPL group (93.0%) was statistically significant.

Other

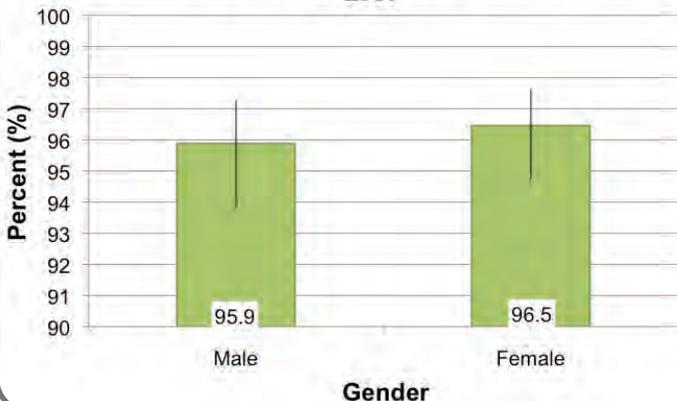
There were no statistically significant disparities between age groups for currently insured children. Differences based on insurance type for the child was not assessed for this indicator.

Currently Insured by Race, Hawai'i NSCH 2007



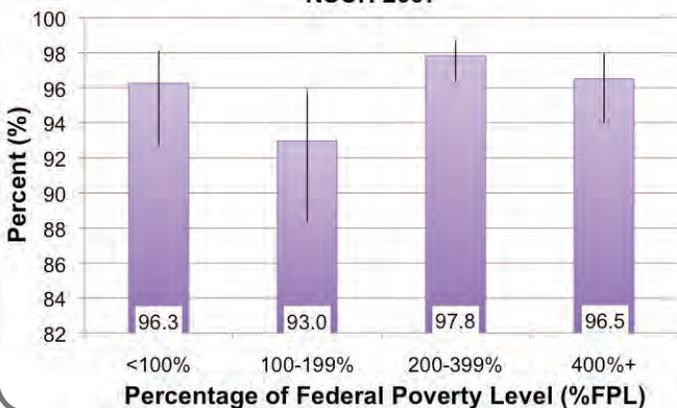
Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Currently Insured by Gender, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Currently Insured by Poverty Level, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Care

Adequacy of Insurance

Ages 0-17 Years

Background

It is not only important for a child to be insured, but it is also crucial for health insurance to adequately meet the child's needs. Adequate insurance becomes especially critical for those who heavily depend on health services such as children with special health care needs, and research shows there is much room for improvement.²⁰

Measurement

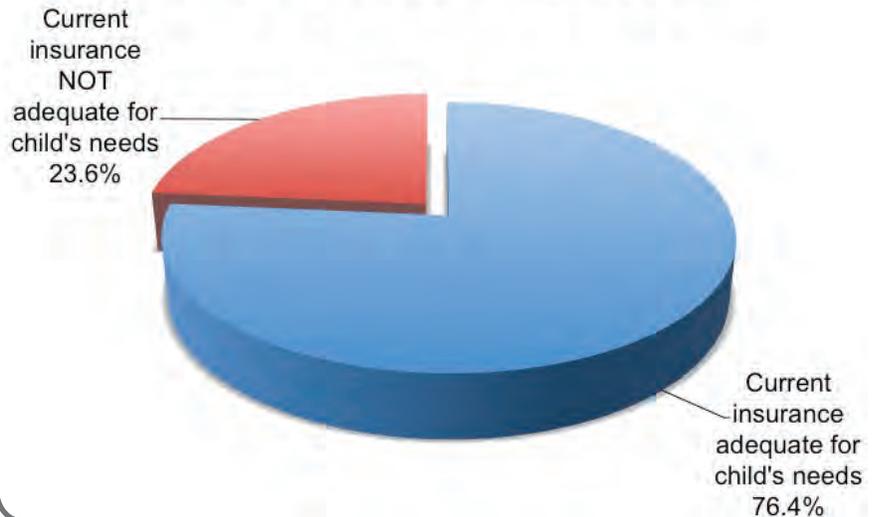
Insurance of children 0-17 years of age was assessed for adequacy. The following were determining components of assessing insurance adequacy: 1) child was currently insured, 2) insurance benefits usually or always met the child's needs, 3) benefits usually or always allowed appointments with necessary providers, and 4) out-of-pocket expenses were usually or always reasonable. Insurance was deemed adequate for the child's needs if all of the aforementioned

components were met.

National Comparisons

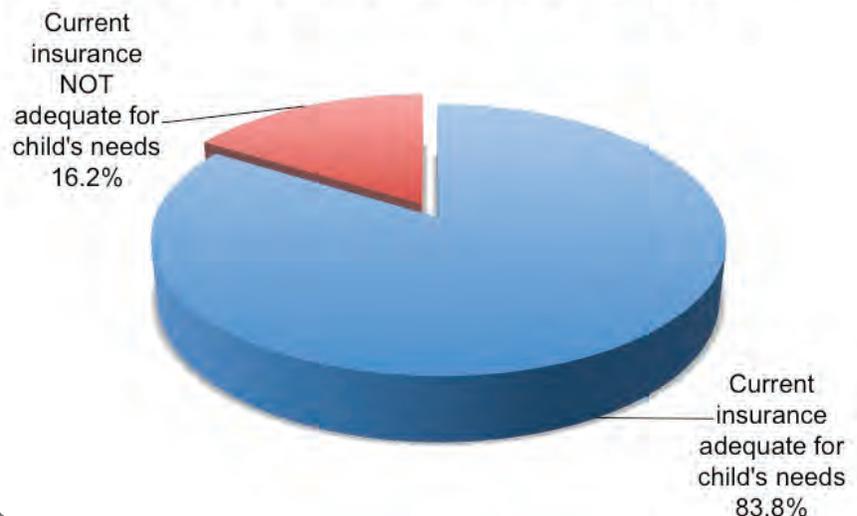
In Hawai'i, parental responses indicated that 83.8% of children's current health insurance was adequate for their needs, which is significantly higher than the national estimate of 76.4%.

Adequacy of Insurance, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Adequacy of Insurance, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Adequacy
of
Insurance:
83.8% (Hawai'i)
vs
76.4% (Nation)**

Health Care

Adequacy of Insurance: *Disparities*

In Hawai'i, there were disparities for adequacy of insurance among age, race, and federal poverty level groups.

Age

Significantly less 12-17 year olds (77.4%) had adequate insurance compared to 0-5 year olds (86.2%) and 6-11 year olds (88.0%).

Race

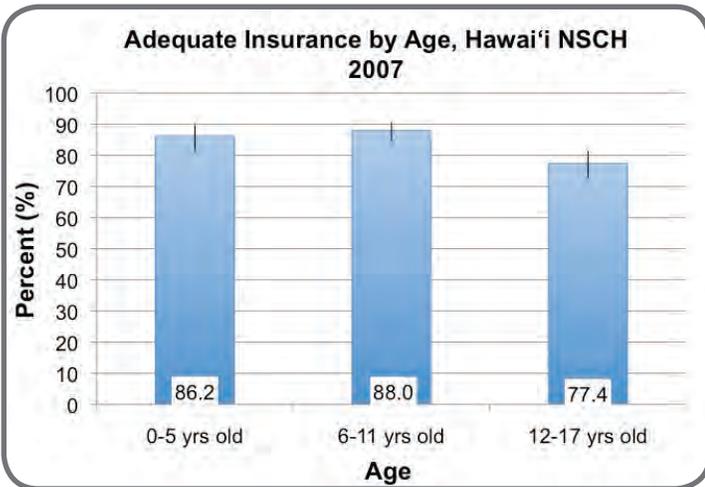
High percentages of White (89.2%) and Black children (97.9%) were covered by adequate insurance and these percentages were significantly different from each other and from all other racial categories including Asians (80.1%), Native Hawaiian/Pacific Islanders (79.6%), and multiracial children (83.0%).

Federal Poverty Level

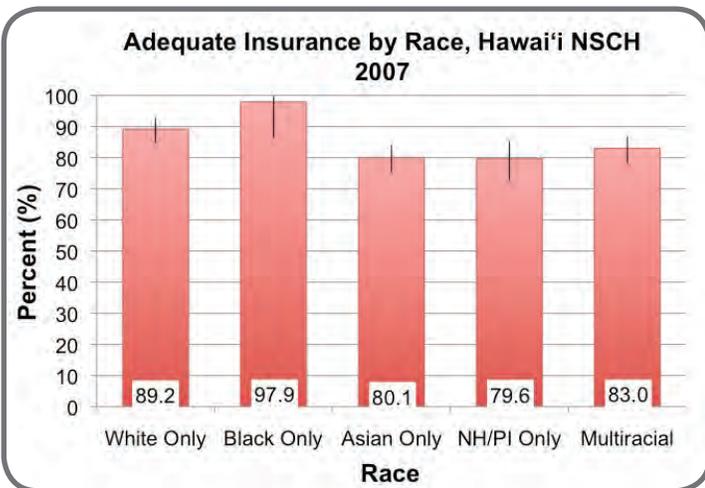
More children from the 400%+ FPL group (88.4%) had adequate insurance compared to other FPL groups. Differences between the 400%+ FPL group compared to the 100-199% FPL (77.8%) and 200-399% FPL (83.2%) group were statistically significant.

Other

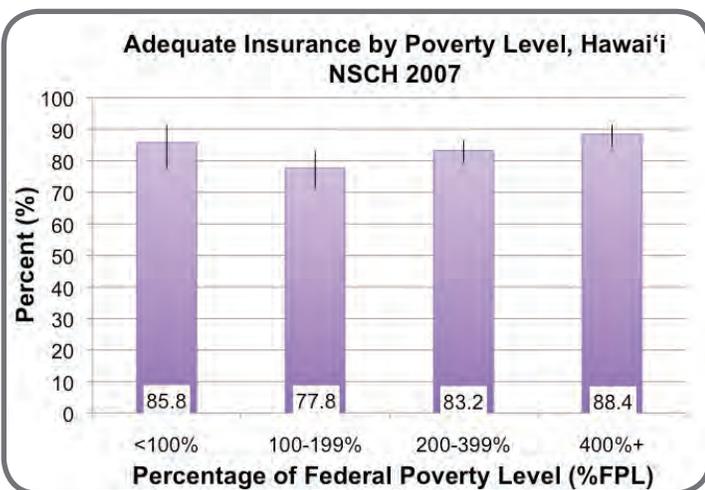
There were no statistically significant difference related to child's gender and insurance type for the adequate insurance indicator.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Health Care

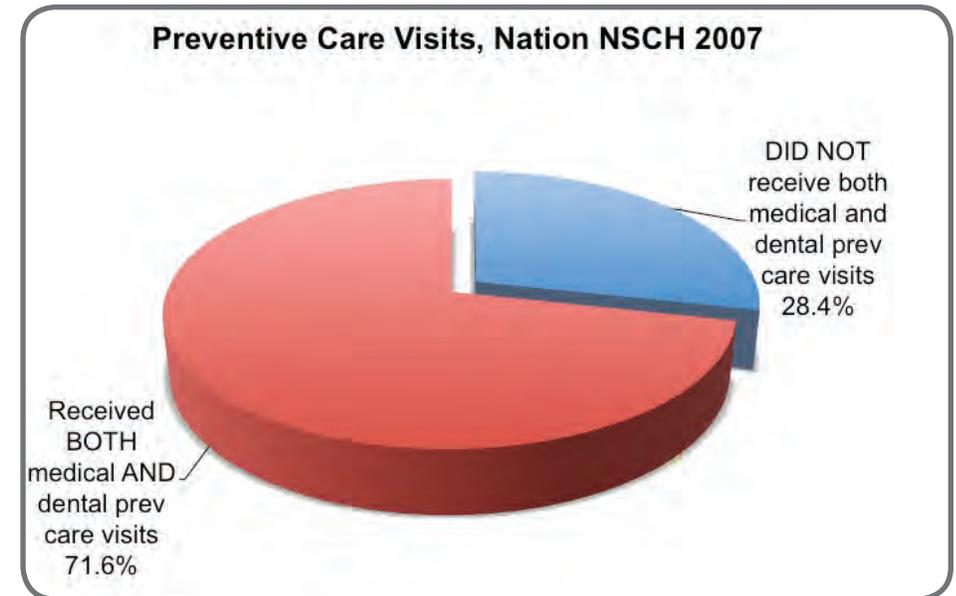
Preventive Care Ages 0-17 Years

Background

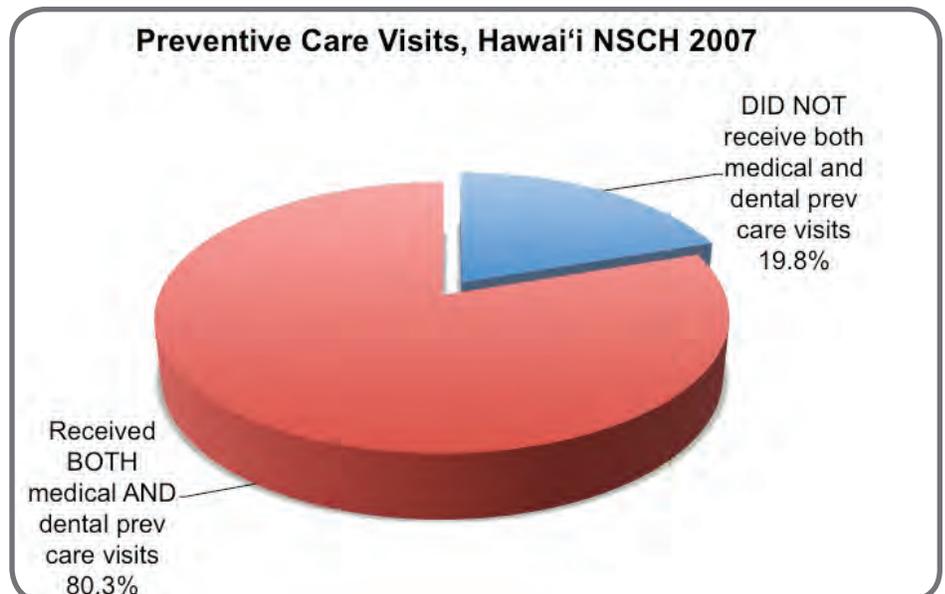
Preventive care visits are important for ensuring children are in good medical and oral health. Well-child visits, for instance, help to ensure proper immunizations and screening for delay or other health conditions.²¹ Tooth decay is the most common chronic disease of children in the nation, albeit generally avoidable through preventive care visits.²²

Measurement

Parents of 0-17 year olds were asked how many times their child received preventive medical and preventive dental visits in the past 12 months. Preventive medical visits included any time the child saw a doctor, nurse, or other health care provider for preventive medical care such as a physical exam or well-child checkup. Preventive dental visits included dental care, such as check-ups and dental cleanings. Children having received at least one medical as well as at least one dental preventive care visit were categorized



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

as having received both preventive visits.

National Comparisons

In Hawai'i, 80.3% of children received both medical and dental preventive care visits, which was significantly higher than the national estimate of 71.6%.

**Children with
Medical and
Dental Preventive
Care Visits:
80.3% (Hawai'i)
vs
71.6% (Nation)**

Health Care

Preventive Care: *Disparities*

In Hawai'i, disparities in age, federal poverty level, and insurance type were seen in the receipt of both medical and dental preventive care visits.

Age

Significantly less 0-5 year olds (71.9%) received both medical and dental preventive care visits compared to 6-11 year olds (85.0%) and 12-17 year olds (84.4%).

Federal Poverty Level

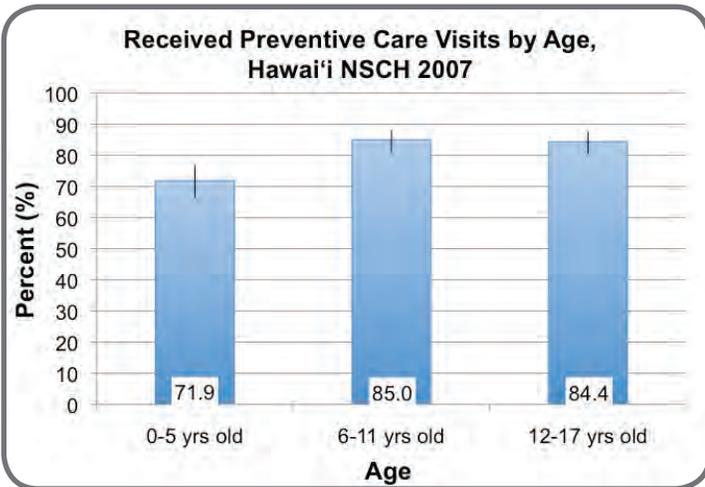
Less children in the 100-199% FPL (73.0%) group received both medical and dental preventive care visits compared to other FPL groups. Differences between the 100-199% FPL group compared to 200-399% (80.7%) and 400%+ (85.6%) FPL groups were statistically significant.

Insurance Type

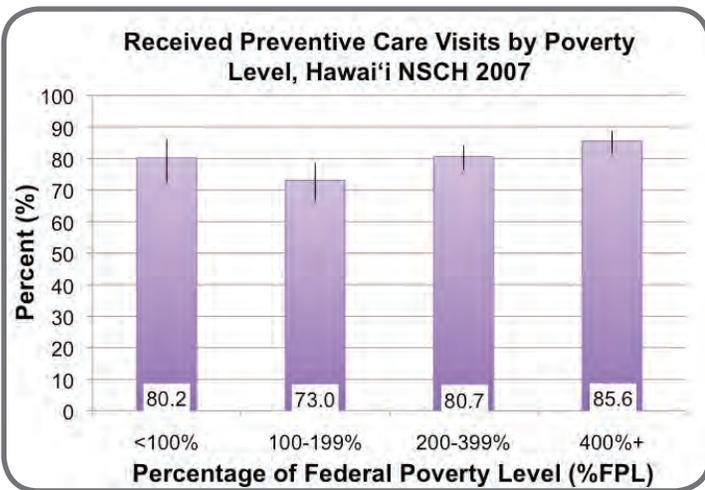
More privately insured children (81.3%) received both preventive medical and dental visits compared to other groups. The difference between privately insured children compared to uninsured children (65.5%) was statistically significant.

Other

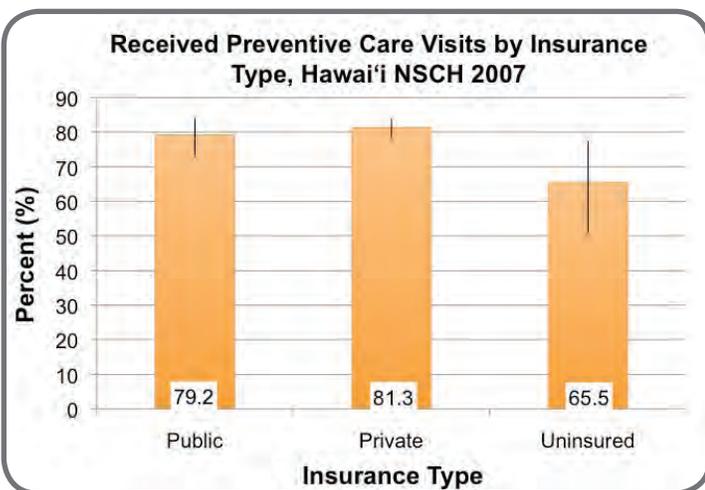
No statistically significant disparities were seen for children who received both medical and dental preventive care visits with respect to race and gender.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Medical Home

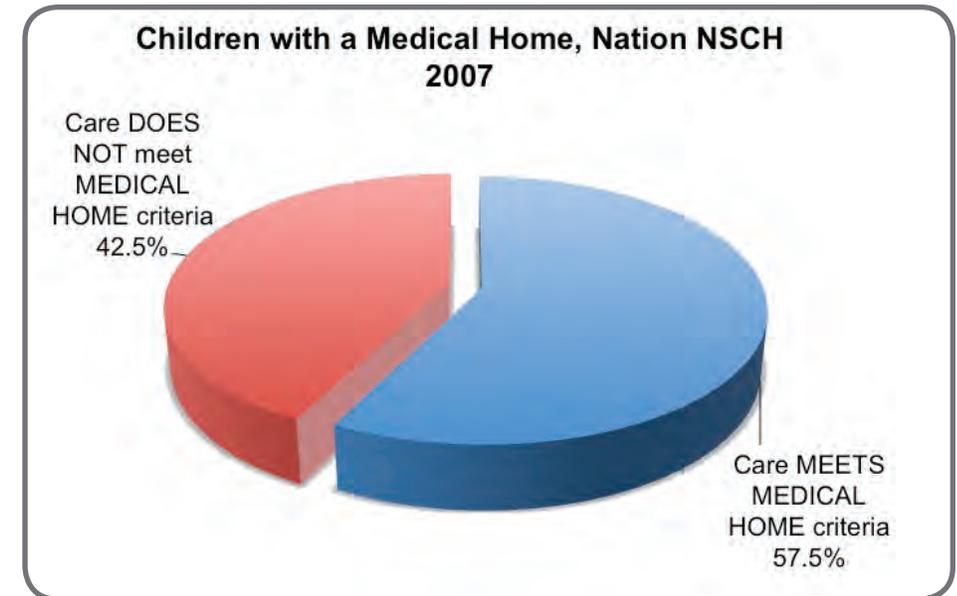
Ages 0-17 Years

Background

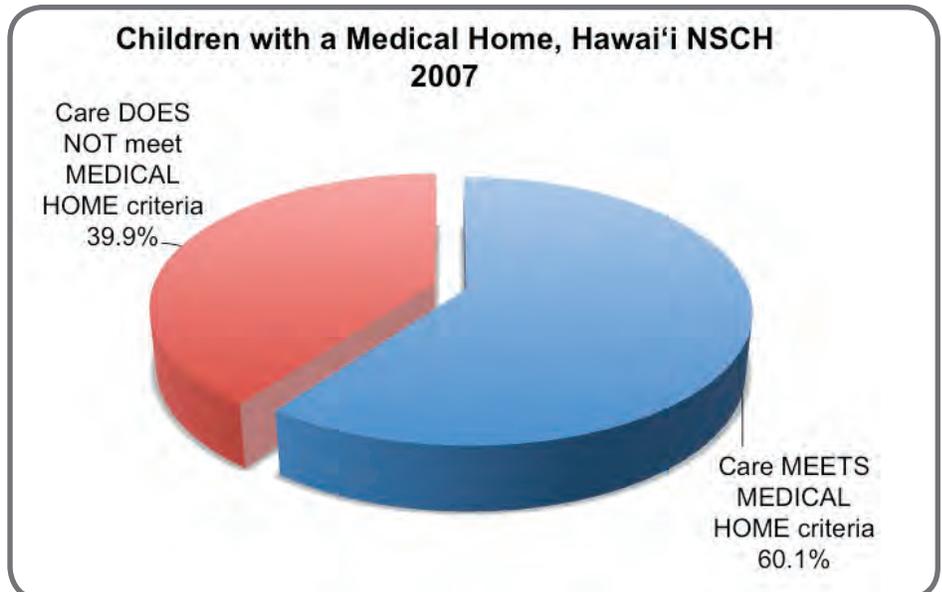
The medical home plays an integral role in early intervention and is essential for services rendered to at-risk youth in order to ensure that appropriate steps are taken for optimal outcomes for every child.²³

Measurement

Children 0-17 years old were deemed to have a medical home based on the definition of a medical home by the American Academy of Pediatrics (AAP) as ascertained by five component indicator variables comprised of 19 survey items. The five components for determining medical home status were based on the following indicators: 1) personal doctor or nurse, 2) usual source for sick and well care, 3) family-centered care, 4) problems getting needed referrals, and 5) effective care coordination when needed. Children were deemed to have a medical home if the first three components were met. In cases where referrals or care coordination were pertinent, the last two



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

components were also used.

National Comparisons

In Hawai'i, 60.1% of children have care that meets the AAP criteria for a medical home, which is higher than but not significantly different from the national estimate of 57.5%.

Children with a Medical Home in Hawai'i:
65.1%
(Privately Insured)
vs
46.8%
(Publicly Insured)

Health Care

Medical Home: *Disparities*

Disparities in Hawai'i for children with a medical home existed among age, racial, federal poverty level, and insurance type groups.

Age

Significantly less 12-17 year olds (52.6%) had a medical home compared to 0-5 year olds (63.7%) and 6-11 year olds (63.8%).

Federal Poverty Level

Medical home rates increased with federal poverty level. Less children at <100% FPL (40.7%) had a medical home compared to 100-199% (54.1%), 200-399% (64.3%), and 400%+ (69.2%) FPL groups. All FPL group differences were statistically significant except for the 200-399% FPL versus 400%+ FPL comparison.

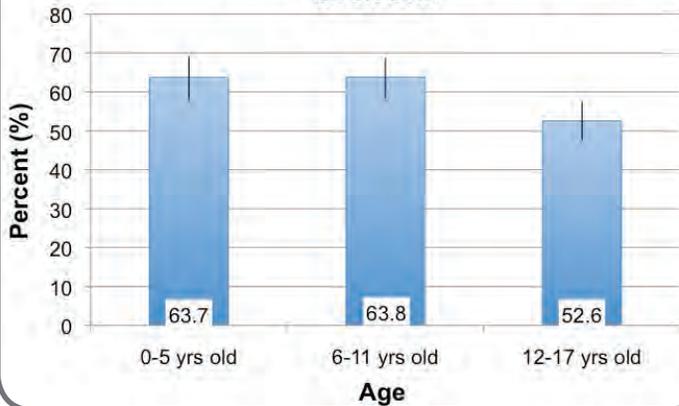
Insurance Type

Significantly more privately insured children (65.1%) had a medical home compared to publicly insured (46.8%) and uninsured (40.9%) children.

Other

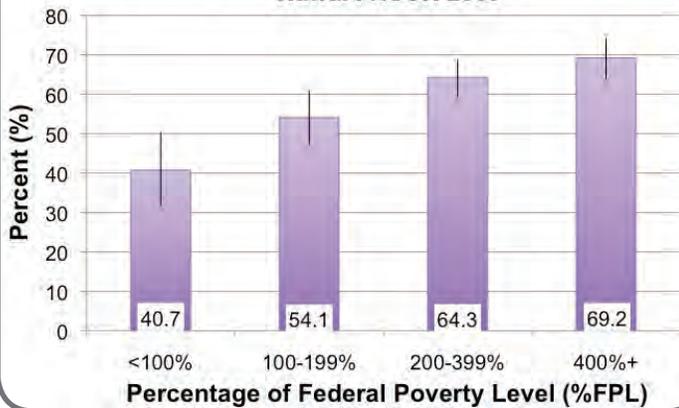
More Whites (62.9%) compared to Black (54.7%), Asian (59.8%), Native Hawaiian/Pacific Islander (53.4%), and multiracial (63.6%) children had a medical home. The difference between estimates for Native Hawaiian/Pacific Islander and multiracial groups was statistically significant. There was no significant disparity for medical home status with respect to child's gender.

Children with Medical Home by Age, Hawai'i
NSCH 2007



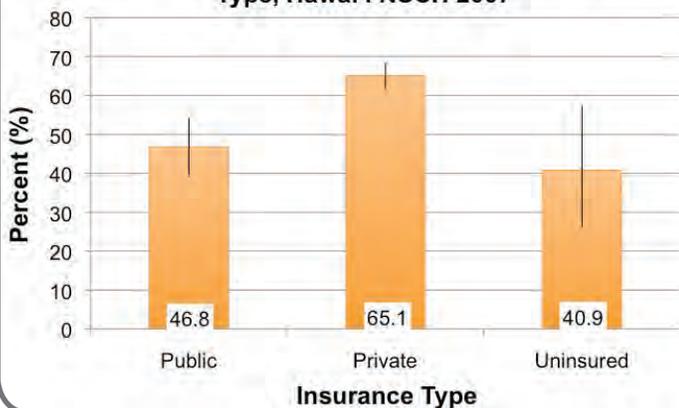
Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Children with Medical Home by Poverty Level,
Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Children with Medical Home by Insurance
Type, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Organized Activities

Ages 6-17 Years

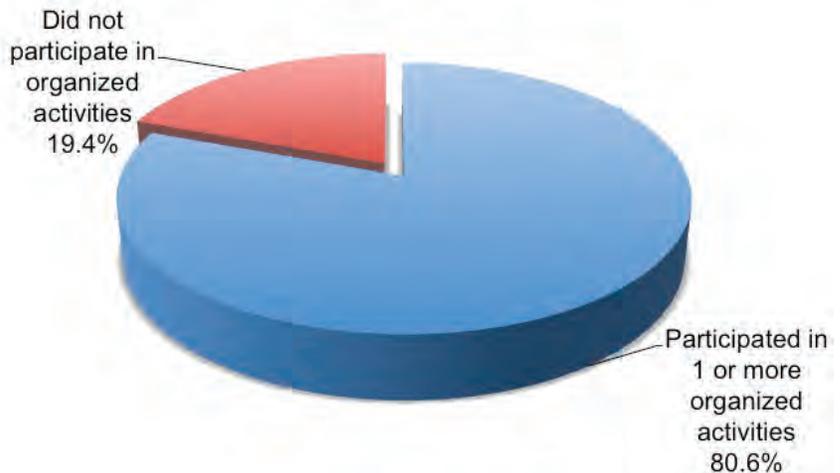
Background

Organized activities provide children with a healthy outlet outside of the traditional classroom setting. For instance, activities such as community service projects teach children the importance of contributing to a positive cause and convey participants with a sense of self accomplishment and confidence. Organized activities in the form of sports provide children with structured opportunities for regular exercise and help to emphasize healthy lifestyles. Extracurricular activities are associated with better educational outcomes, especially for at-risk youth.²⁴

Measurement

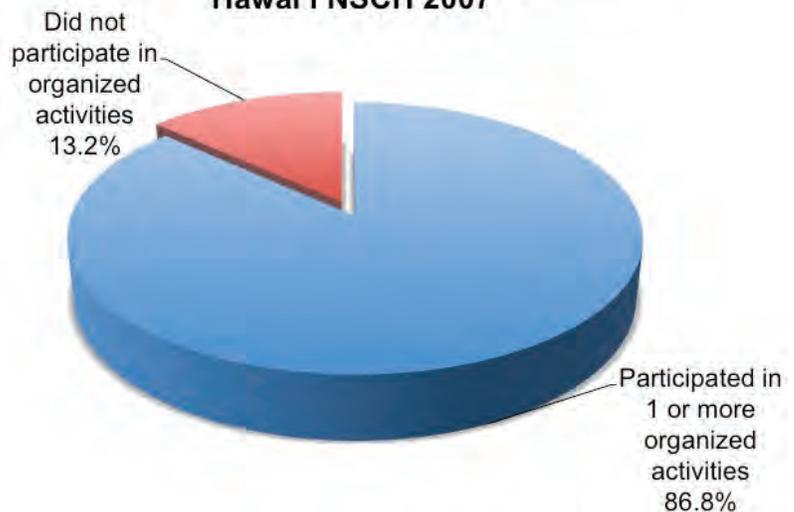
Data was gathered for children 6-17 years old with regard to participation in one or more organized activities outside of school. This indicator included activities such as sports teams, lessons, clubs, organizations, or any organized event or activity conducted after school or on the weekend.

Organized Activities Outside of School, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Organized Activities Outside of School, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, 86.8% of children participated in one or more organized activities, which is significantly higher than the national estimate of 80.6%.

Children in One or More Organized Activities:

**86.8% (Hawai'i)
vs
80.6% (Nation)**

Community, School and Family

Organized Activities: *Disparities*

There were disparities in children who participated in one or more organized activities in Hawai'i with respect to race, federal poverty level, and insurance type.

Race

More White children (92.8%) participated in one or more organized activities compared to other racial groups. The difference between White compared to Asian (84.5%) and Native Hawaiian/Pacific Islander (83.2%) children was statistically significant.

Federal Poverty Level

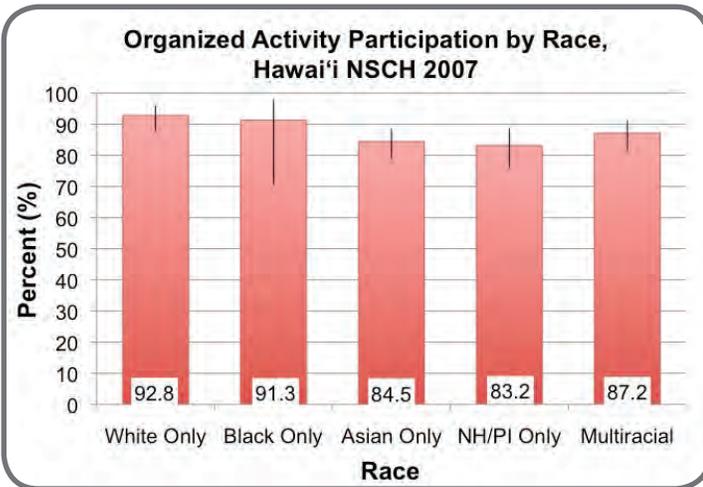
Participation in organized activities increased with federal poverty level. More children at 400%+ FPL (96.2%) compared to <100% (70.4%), 100-199% (79.4%), and 200-399% (90.0%) FPL groups participated in one or more organized activities. The differences between all FPL groups, with the exception of <100% FPL compared to 100-199% FPL, were statistically significant.

Insurance Type

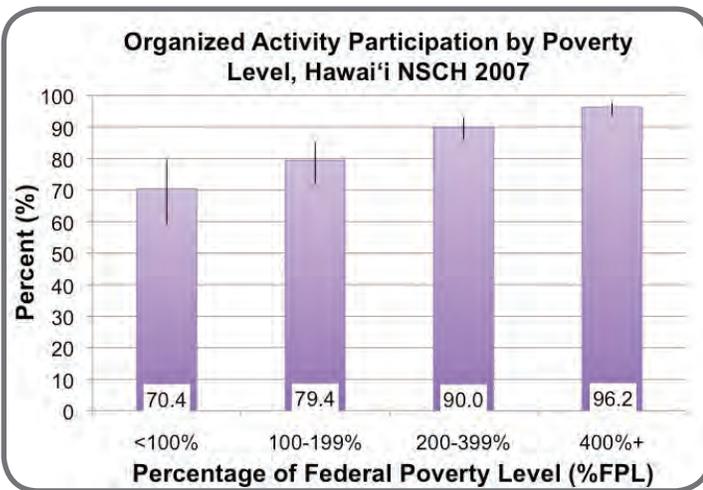
More privately insured children (89.7%) participated in one or more organized activities compared to other insurance groups. The difference between privately and publicly insured children (77.2%) was statistically significant.

Other

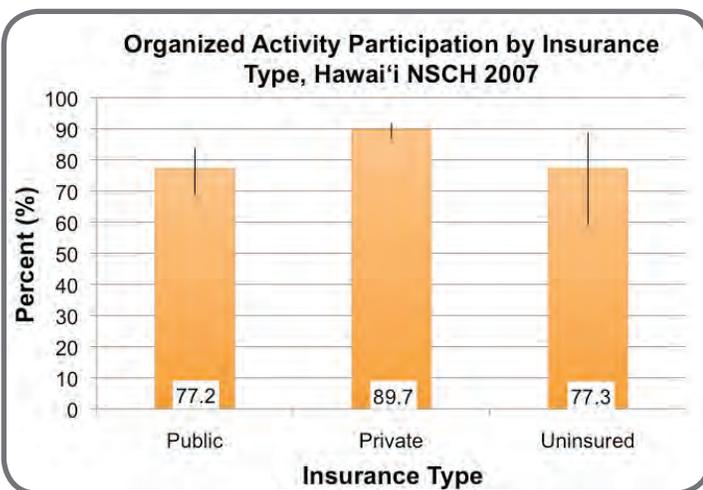
There were no statistically significant disparities for this indicator with respect to age and gender of the child.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Community,
School and
Family**

**Maternal Health
Status**

Ages 0-17 Years

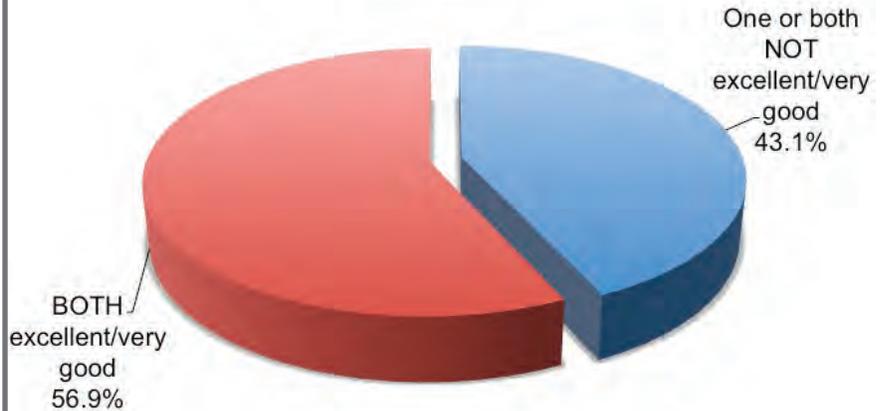
Background

The physical and mental health of mothers is important and is associated with the health of their children. Physically healthy mothers, such as those who regularly exercise and are not burdened by chronic disease, can engage in interactive activities with their child with greater ease. Poor mental health in mothers has been related to increased risk of developmental delay in their children.²⁵

Measurement

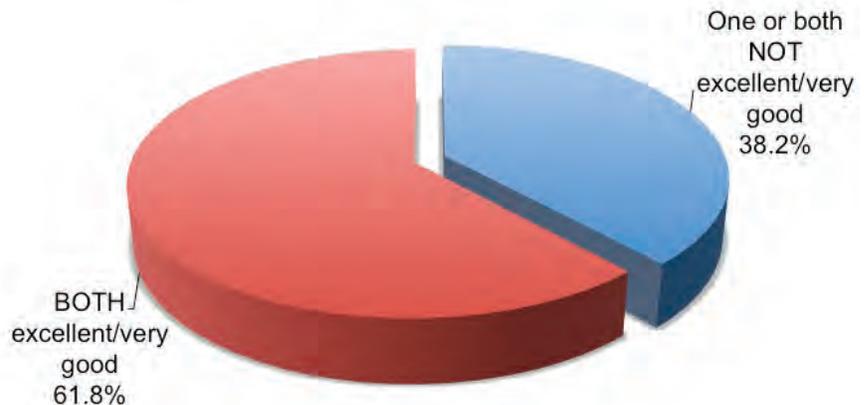
Maternal physical and mental health status for children 0-17 years old were separately rated as excellent/very good, good, or fair/poor. When the respondent was the biological, step, foster, or adoptive mother, a self rating was used, whereas non-mother respondents were asked to rate the child's mother. The proportion of children whose mothers were rated as excellent/very good for both physical and mental health status was examined.

**Maternal Physical and Mental Health, Nation
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Maternal Physical and Mental Health, Hawai'i
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, 61.8% of mothers were reported to be in excellent or very good physical and mental health, which was significantly higher than the national estimate of 56.9%.

**Maternal Health
Status Rated
Excellent or Very
Good:**
**61.8% (Hawai'i)
vs
56.9% (Nation)**

Community, School and Family

Maternal Health Status: *Disparities*

There were disparities in maternal health status in Hawai'i with respect to age, race, federal poverty level, and insurance type.

Race

Significantly more (70.1%) White children had mothers in excellent/very good health compared to Black (47.9%), Native Hawaiian/Pacific Islander (NH/PI) (52.6%), and multiracial (59.3%) children. Differences between Asian children (67.5%) compared to NH/PI and multiracial children were statistically significant.

Federal Poverty Level

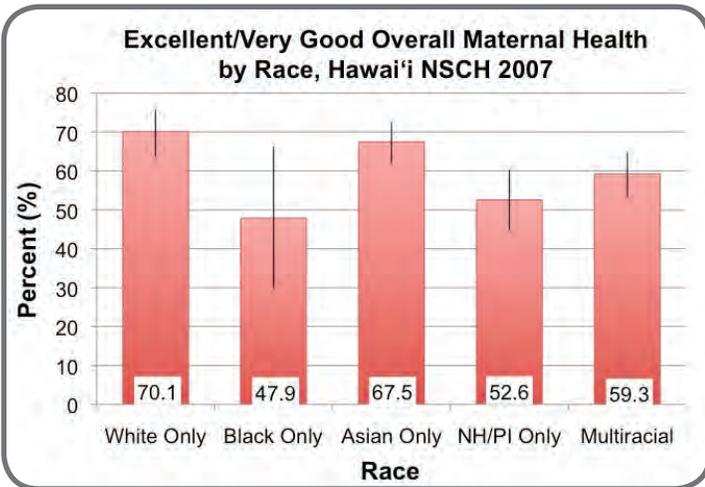
Maternal health status increased with federal poverty level. Less children at <100% FPL (45.7%) compared to 100-199% (54.4%), 200-399% (63.2%), and 400%+ (73.6%) FPL groups had mothers in excellent/very good health. Differences between all FPL groups were statistically significant with the exception of 100-199% FPL compared to adjacent FPL groups.

Insurance Type

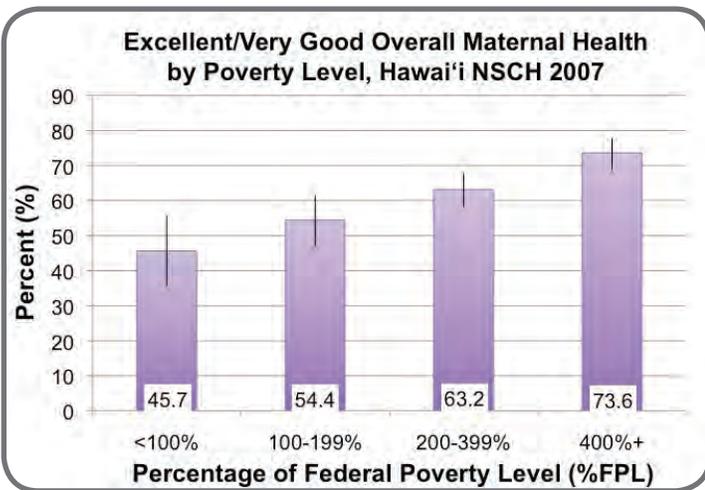
Significantly more privately insured children (67.2%) had mothers in excellent/very good health compared to publicly insured (43.8%) and uninsured (47.9%) children.

Other

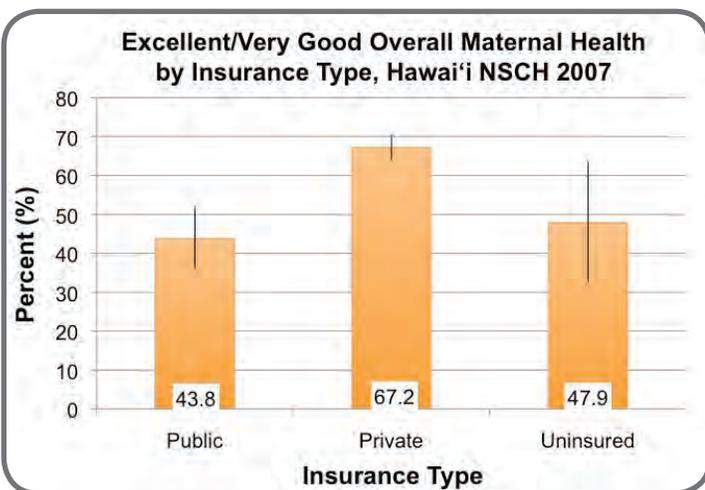
Excellent/very good maternal health status proportions declined with age of children. No statistically significant disparities with respect to child's gender were found.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Community,
School and
Family**

**Paternal Health
Status**

Ages 0-17 Years

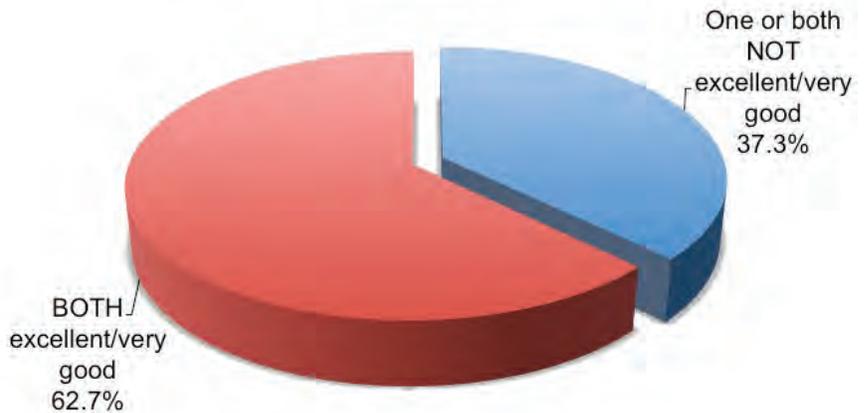
Background

Just as maternal health is important for the well-being of children, paternal health is an important component of children's health. Physically healthy fathers, such as those who regularly exercise and are not burdened by chronic disease, can engage in interactive activities with their child with greater ease. Depression in fathers is associated with psychiatric disorders in their children that surface later in life.²⁶

Measurement

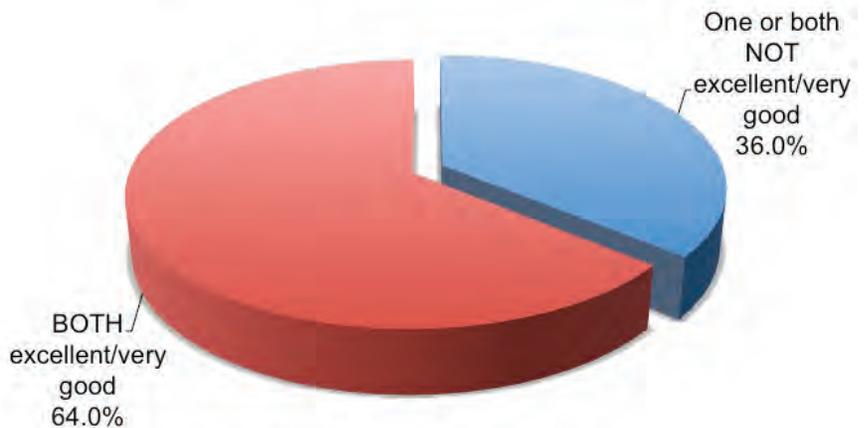
Paternal physical and mental health status in 0-17 year olds were separately rated as excellent/very good, good, or fair/poor. When the respondent was the biological, step, foster, or adoptive father, a self rating was used, whereas if the respondents were not the child's father, the respondent was asked to rate the child's father. The proportion of children whose fathers were rated as excellent/very good for both physical and mental health status was examined.

**Paternal Physical and Mental Health, Nation
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Paternal Physical and Mental Health, Hawai'i
NSCH 2007**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, 64.0% of fathers were reported to be in excellent/very good physical and mental health, which was greater than but not significantly different from the national estimate of 62.7%.

**Excellent/Very Good
Paternal Health
Status in Hawai'i:**
41.7%
(<100% FPL)
vs
71.0%
(400%+ FPL)

Community, School and Family

Paternal Health Status: *Disparities*

There were disparities in paternal health status in Hawai'i with respect to age, race, federal poverty level, and insurance type.

Race

Significantly more White children (77.7%) compared to Asian (61.5%), Native Hawaiian/Pacific Islander (54.8%), and multiracial (59.5%) children had fathers in excellent/very good health. The difference between Black children (76.1%) and Native Hawaiian/Pacific Islander children was statistically significant.

Federal Poverty Level

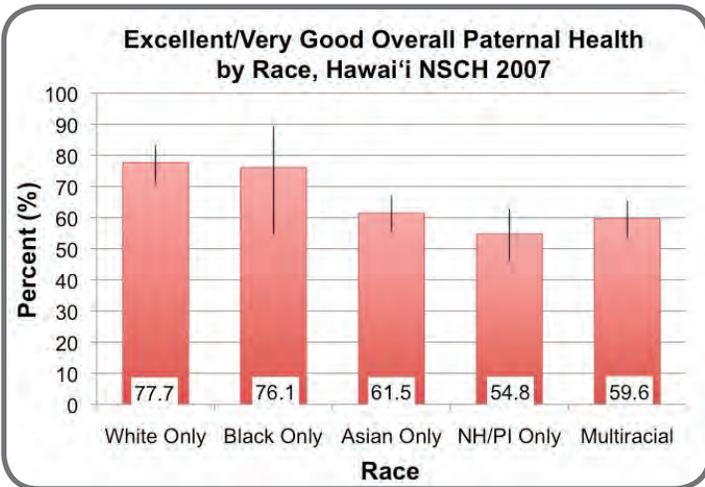
Paternal health status increased with federal poverty level. Less children at <100% (41.7%) compared to 100-199% (59.3%), 200-399% (66.3%), and 400%+ (71.0%) FPL groups had excellent/very good paternal health status. All differences between FPL groups were statistically significant with the exception of the 200-399% FPL group compared to adjacent FPL categories.

Insurance Type

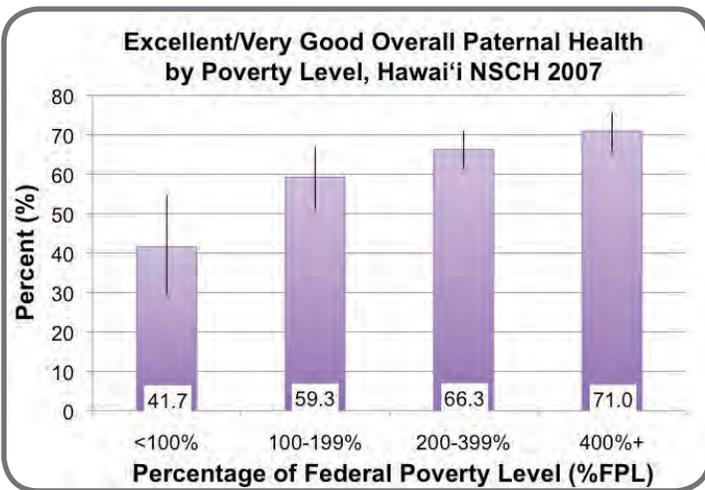
Significantly more privately insured children (69.2%) had excellent/very good paternal health status than publicly insured (41.0%) and uninsured (44.9%) children.

Other

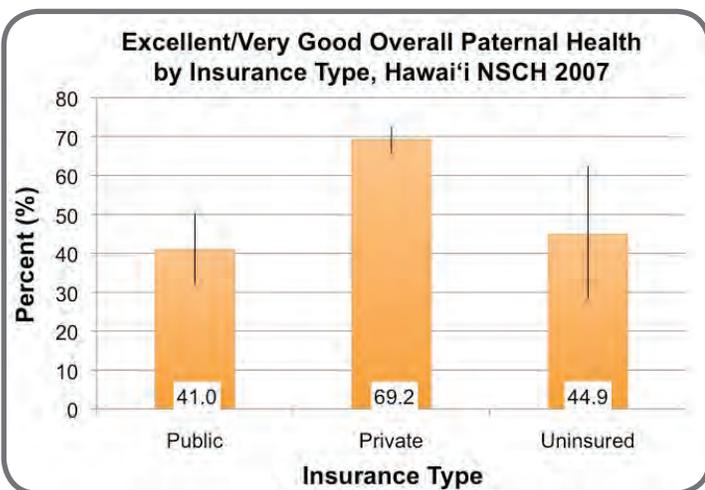
Excellent/very good paternal health status proportions declined with age of the child. No statistically significant disparities with respect to child's gender were found.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Household Tobacco Use

Ages 0-17 Years

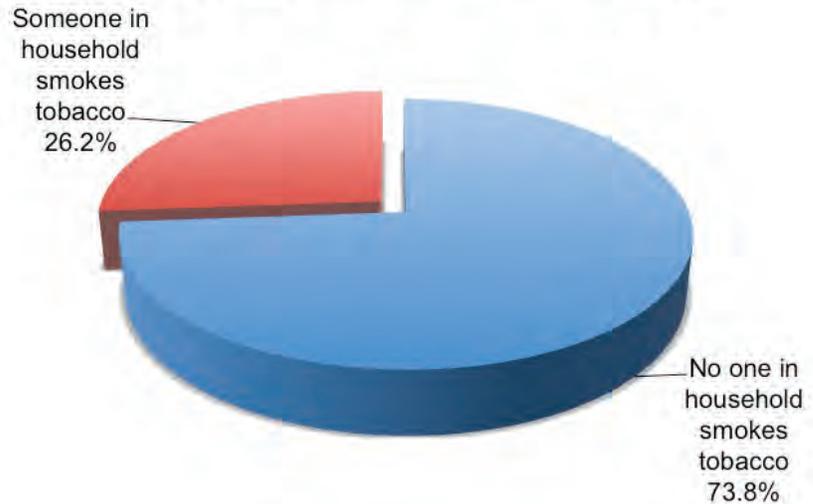
Background

Tobacco use, particularly cigarette smoking, has become a major health concern, especially because of its wide array of associated adverse effects. Individuals, including children, who are exposed to secondhand smoke, or environmental tobacco smoke (ETS), are at higher risk of cardiovascular and pulmonary diseases. Any parental smoking has been associated with an increase risk for the development of early onset asthma.²⁷ Maternal smoking has been associated with a higher risk of wheezing, serious asthma, and chronic cough.²⁷

Measurement

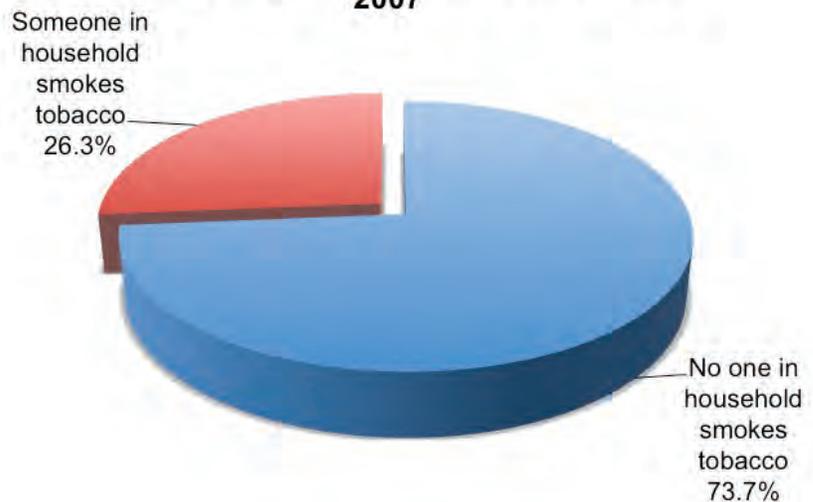
Parents of 0-17 year olds were asked about tobacco use within their child's household. Specifically, respondents were questioned if anyone living in their household was using cigarettes, cigars, or pipe tobacco. Responses were categorized as a yes or no answers.

Tobacco Use in Household, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Tobacco Use in Household, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, 26.3% of children lived in a household where someone used tobacco, which was similar to and not statistically different from the national estimate of 26.2%.

**Children in Tobacco
Use Households in
Hawai'i:
46.5%
(<100% FPL)
vs
15.7%
(400%+ FPL)**

Community, School and Family

Household Tobacco Use: *Disparities*

In Hawai'i, there were disparities in household tobacco use for children with respect to age, race, and federal poverty level.

Age

More 12-17 year olds (29.8%) lived in a household in which someone used tobacco. The difference between the 12-17 year olds group and the 6-11 year old group (22.7%) was statistically significant.

Race

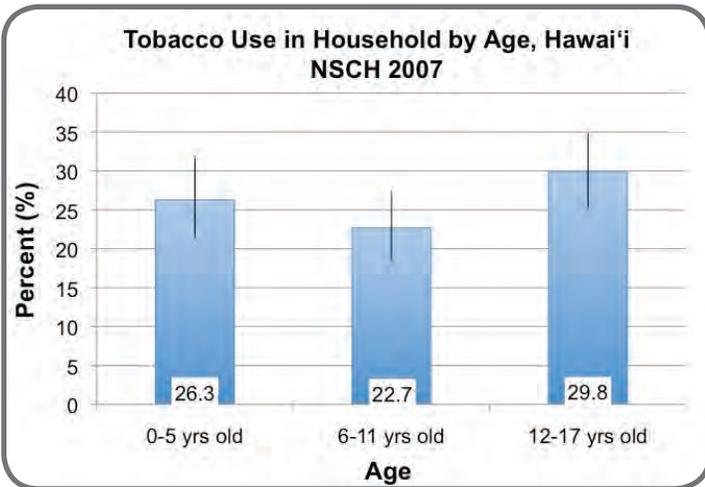
More Native Hawaiian/Pacific Islander children (31.5%) lived in a household in which someone used tobacco. The difference between proportions for Asians (22.6%) compared to Native Hawaiians/Pacific Islanders (31.5%) was statistically significant.

Federal Poverty Level

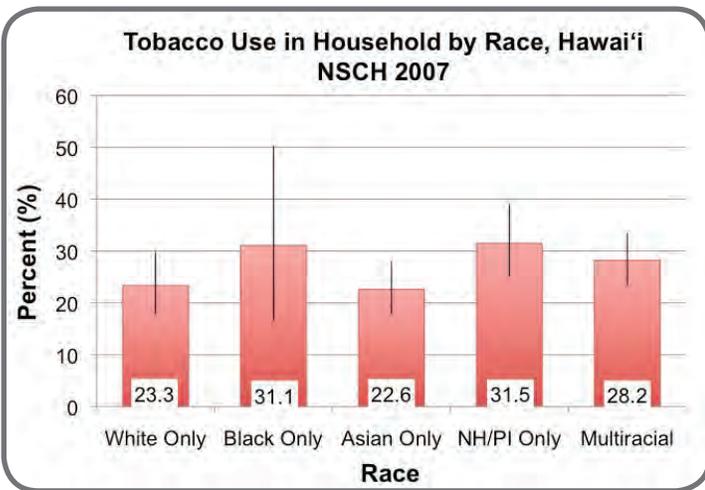
Tobacco usage decreased with increasing federal poverty level groups. More children at <100% FPL (46.5%) compared to 100-199% FPL (33.4%), 200-399% FPL (22.3%), and 400%+ FPL (15.7%) groups lived in a household in which someone used tobacco. Proportions from each FPL group were significantly different from each other.

Other

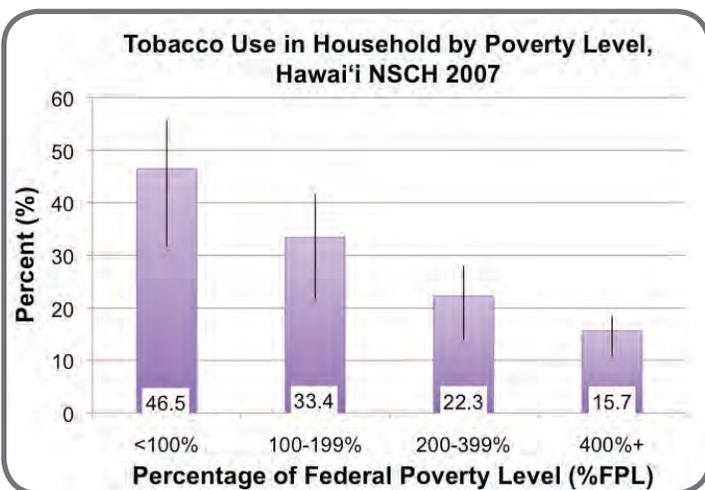
There were no statistically significant disparities for this indicator with respect to child's gender and insurance type.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Shared Meals

Ages 0-17 Years

Background

Family time is an important aspect of child well-being. Eating together as a family provides a structured, routine time frame for sharing feelings, good/bad news, and events in the lives of loved ones. Sharing daily meals with family members is associated with less mental health complaints in children.²⁸

Measurement

Parents of 0-17 year olds were asked how many times per week all household family members shared a meal. Responses were open ended with a maximum of seven days. Responses were categorized into the following categories: none, one to three days, four to six days, or every day.

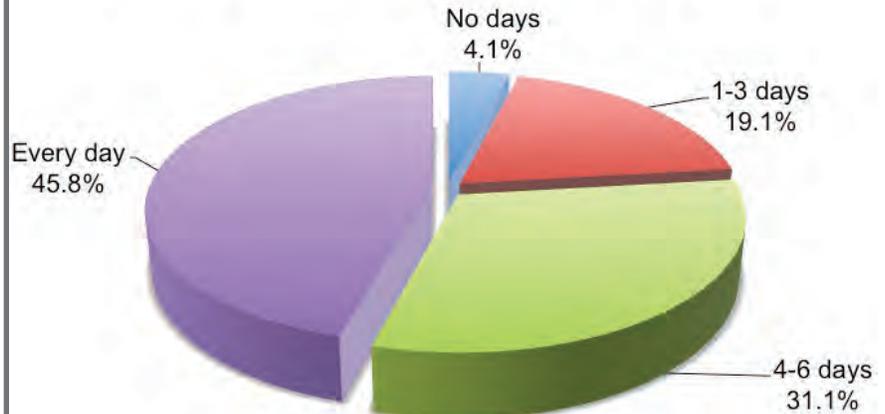
National Comparisons

In Hawai'i, 52.7% of children engaged in shared household meals daily, which was significantly higher than the national estimate of 45.8%.

In Hawai'i, proportionally less household meals

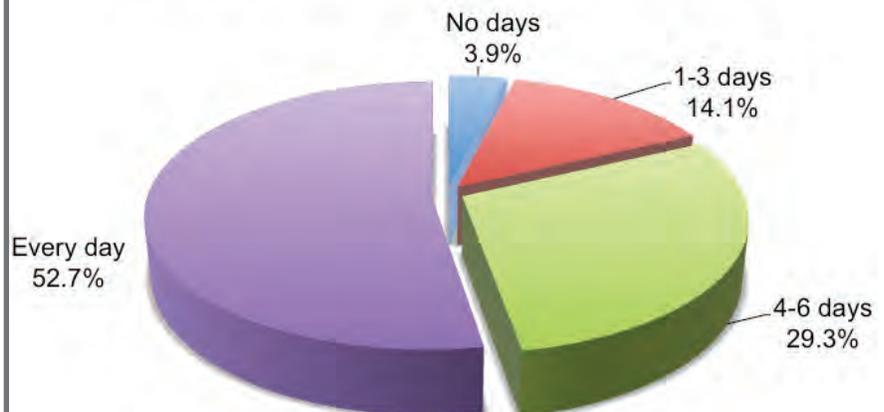
were shared for zero days (3.9%), one to three days (14.1%), and four to six days (29.3%) per week compared to national levels for shared household meals for zero days (4.1%), one to three days (19.1%), and four to six days (31.1%) per week.

Shared Meals per Week, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Shared Meals per Week, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Shared
Household Meals
Every Day:
52.7% (Hawai'i)
vs
45.8% (Nation)**

Community, School and Family

Shared Meals: *Disparities*

In Hawai'i, there were disparities in children whose households participated in daily shared meals with respect to age, race, federal poverty level, and insurance type.

Age

Daily shared meals in households decreased with increasing age. Proportions for 0-5 year old (66.0%), 6-11 year old (50.9%), and 12-17 year old (40.4%) groups that shared household meals daily were significantly different from each other.

Race

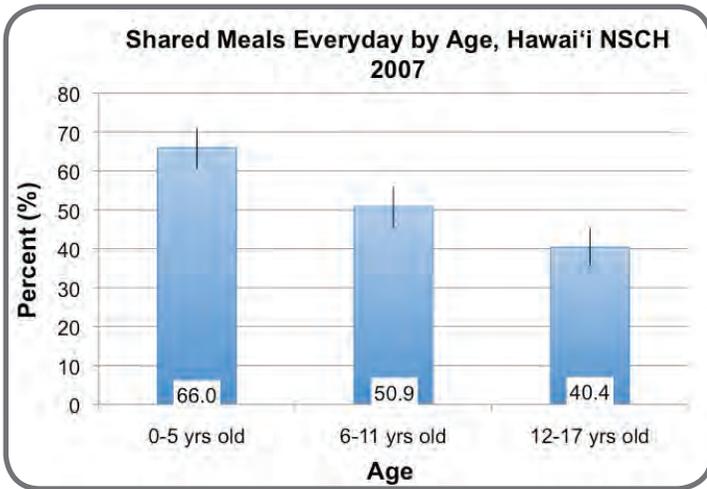
More Native Hawaiian/Pacific Islander (NH/PI) children (62.3%) had households that shared meals daily compared to other racial groups. NH/PI comparisons to Asian (51.9%) and multiracial (46.5%) groups were statistically significant.

Federal Poverty Level

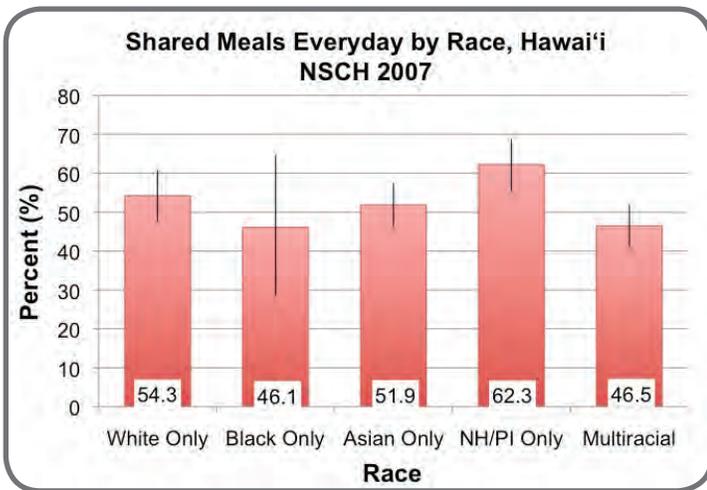
More children from lower federal poverty level groups shared daily meals as a household. The difference in proportions for the <100% FPL (62.4%) groups compared to the 200-399% (48.3%) and 400%+ (51.1%) FPL groups was statistically significant.

Other

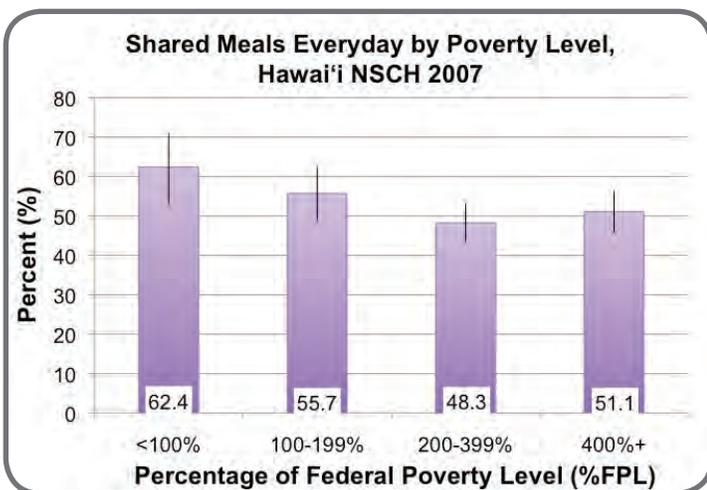
Significantly more publicly insured children (58.7%) had daily household shared meals compared to privately insured (50.6%). There were no statistically significant disparities in daily shared meals with regard to gender of the child.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Community,
School and
Family**

Screen Time

Ages 1-5 Years

Background

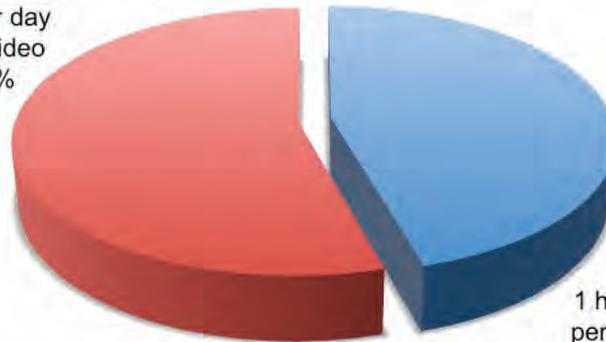
Excessive screen time confers significant risk to a child's health and well-being. Violence in media has been associated with violent and aggressive behavior in children and can wield a particularly hefty impact on younger children who cannot discriminate between fiction versus reality.²⁹ Furthermore, screen time has also been associated with childhood obesity.³⁰ The American Academy of Pediatrics (AAP) recommends completely restricting television viewing for children two years old or younger, and suggests the remainder of children watch no more than one to two hours of television per day.³¹

Measurement

Parents of 1-5 year olds were asked about how much time their child usually watches television or videos on an average weekday. Responses were grouped into one of the two following categories: 1) one hour or less per weekday, or 2) more than one hour per weekday.

**Average Weekday Screen Time for Children
1-5 years old, Nation NSCH 2007**

More than 1
hour per day
of TV/Video
54.4%

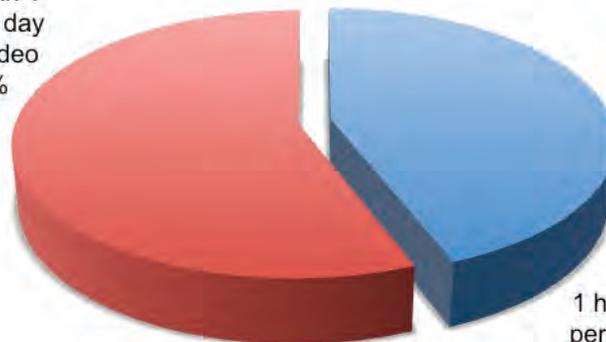


1 hour or less
per day of TV/
Video
45.7%

Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

**Average Weekday Screen Time for Children
1-5 years old, Hawai'i NSCH 2007**

More than 1
hour per day
of TV/Video
55.9%



1 hour or less
per day of TV/
Video
44.1%

Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, parental responses indicated that 55.9% of 1-5 year olds watched more than one hour per weekday of television/video, which was more than but not significantly different from the national estimate of 54.4%.

**>1 Hour Per
Weekday of TV/
Video in Hawai'i:
69.9%
(100-199% FPL)
vs
47.4%
(400%+ FPL)**

Community, School and Family

Screen Time: *Disparities*

Data from Hawai'i demonstrated a disparity in screen time for children who watched more than one hour of television/video on an average weekday with respect to federal poverty level.

Gender

While 59.2% of females, just 52.7% of males watched more than one hour of television/video per weekday, this difference was not statistically significant.

Federal Poverty Level

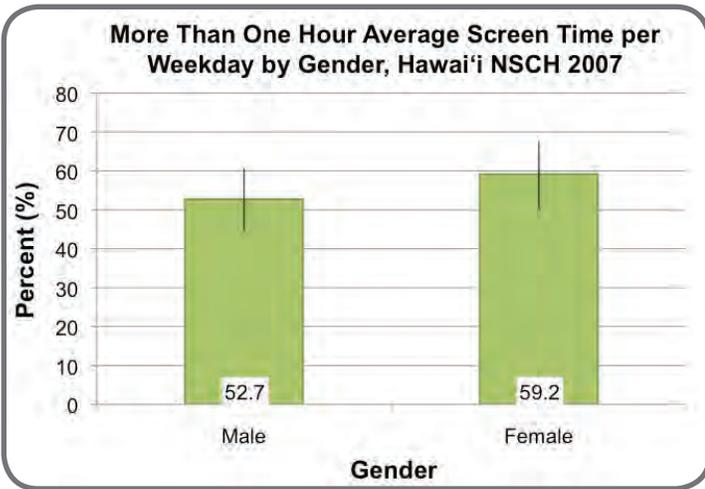
Less children in the 400%+ FPL (47.4%) group compared to other FPL groups watched more than one hour of television/video per weekday. The difference between the 100-199% FPL (69.9%) group compared to 200-399% FPL (53.0%) and 400%+ FPL (47.4%) groups were statistically significant.

Insurance Type

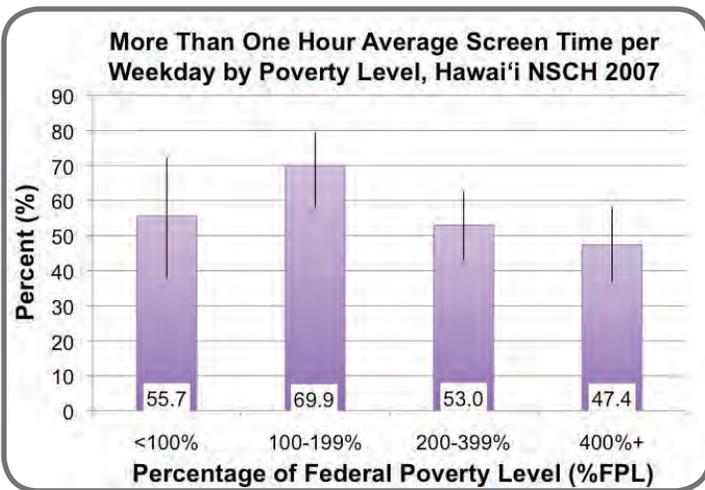
More publicly insured (58.1%) compared to privately insured (55.6%) and uninsured (47.0%) children watched more than one hour of television/video per weekday. The differences between these groups were not statistically significant.

Other

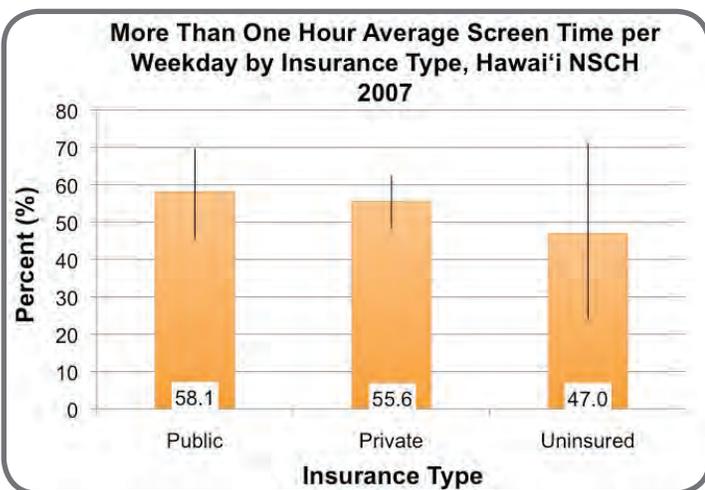
There were no statistically significant disparities for this indicator with respect to child's race. Differences for age group of the child was not assessed for this indicator.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Screen Time

Ages 6-17 Years

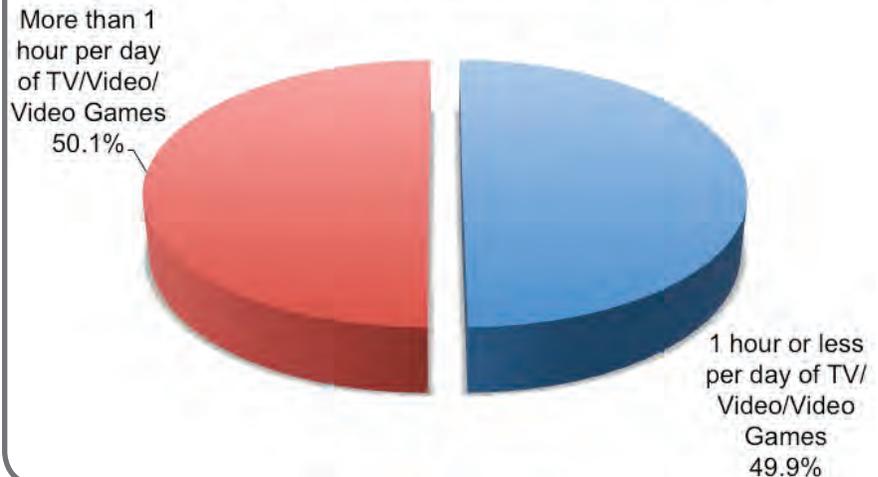
Background

Screen time and media content can negatively influence the behavior and health of children.^{29,30} Furthermore, increased screen time has been associated with poorer performance in school during adolescent years.³² Recommendations by the American Academy of Pediatrics (AAP) specify no more than one to two hours of television per day for children over 2 years of age, and complete avoidance for children 2 years of age and younger.³¹

Measurement

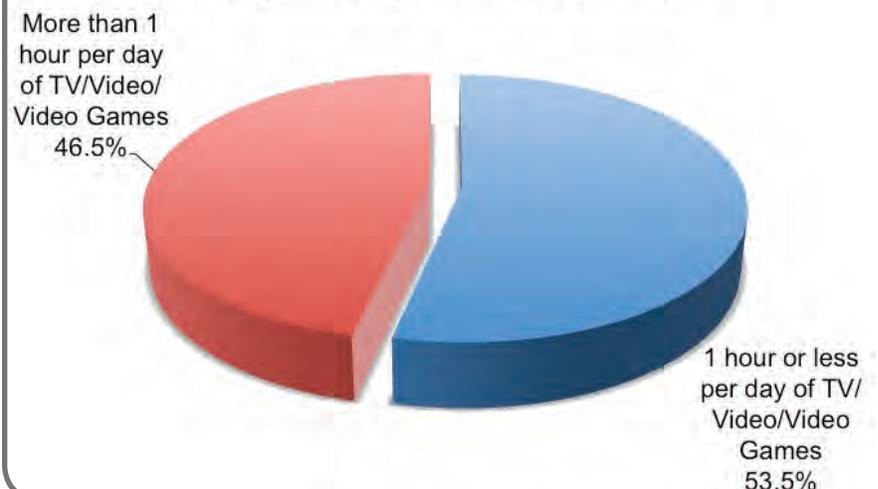
Parents of children ages 6-17 years old were asked about how much time their child usually watches television, watches videos, or plays video games on an average weekday. Note that reference to video games was included in this indicator but not for children in the one to five year old age group. Responses for this report were grouped as follows: 1) one hour or less per weekday, or 2) more than one hour per weekday.

Average Weekday Screen Time for Children 6-17 years old, Nation NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Average Weekday Screen Time for Children 6-17 years old, Hawai'i NSCH 2007



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

National Comparisons

In Hawai'i, parental responses indicated that 46.5% of children spent more than one hour per weekday watching television/video or playing video games, which was lower than but not significantly different from the national estimate of 50.1%.

**>1 Hour Per
Weekday of TV/
Video/Video Games
in Hawai'i:**
51.1% (Males)
vs
41.5% (Females)

Community, School and Family

Screen Time: *Disparities*

In Hawai'i, there were disparities in children that engaged in more than one hour of television/video/video games on an average weekday with regard to gender and federal poverty level.

Age

More children in the 12-17 year old age group (48.9%) compared to the 6-11 year old group (43.9%) engaged in more than one hour of television/video/video games per weekday. The difference between age groups was not statistically significant.

Gender

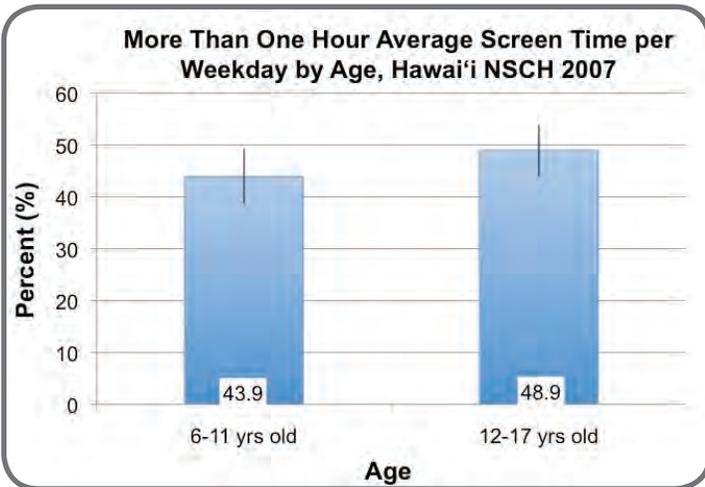
Significantly more males (51.1%) engaged in television/video/video games compared to females (41.5%) for children ages 6-17 years old.

Federal Poverty Level

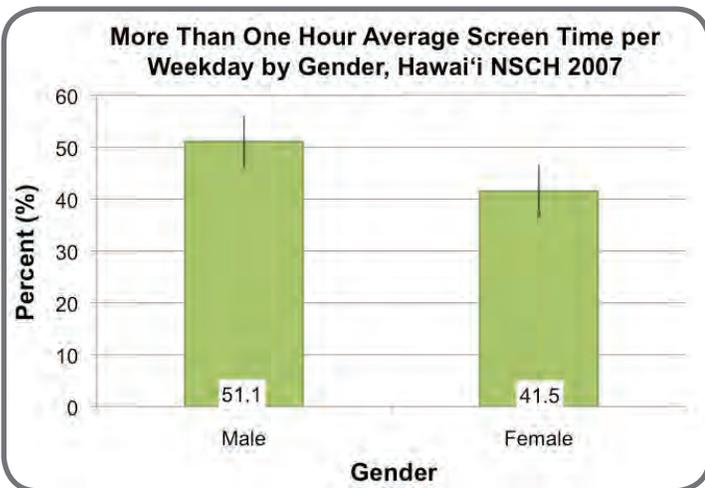
A lower percentage of children from the 400%+ FPL group (36.7%) compared to, and significantly different from, the <100% (58.4%), 100-199% (49.6%), and 200-399% (48.0%) FPL groups spent more than one hour on television/video/video games per weekday.

Other

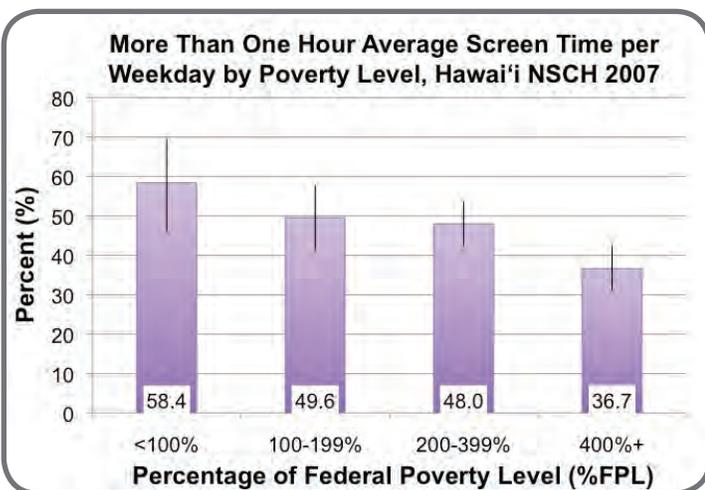
There were no statistically significant disparities for this indicator with regard to child's race and health insurance type.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Safe Communities

Ages 0-17 Years

Background

The community in which a child lives bears importance for their personal safety and also for their physical health. For instance, psychosocial stress in children from unsafe neighborhoods may be a critical risk factor for developing asthma.³³ Also, the community safety has been linked to overweight status in adolescents.³⁴

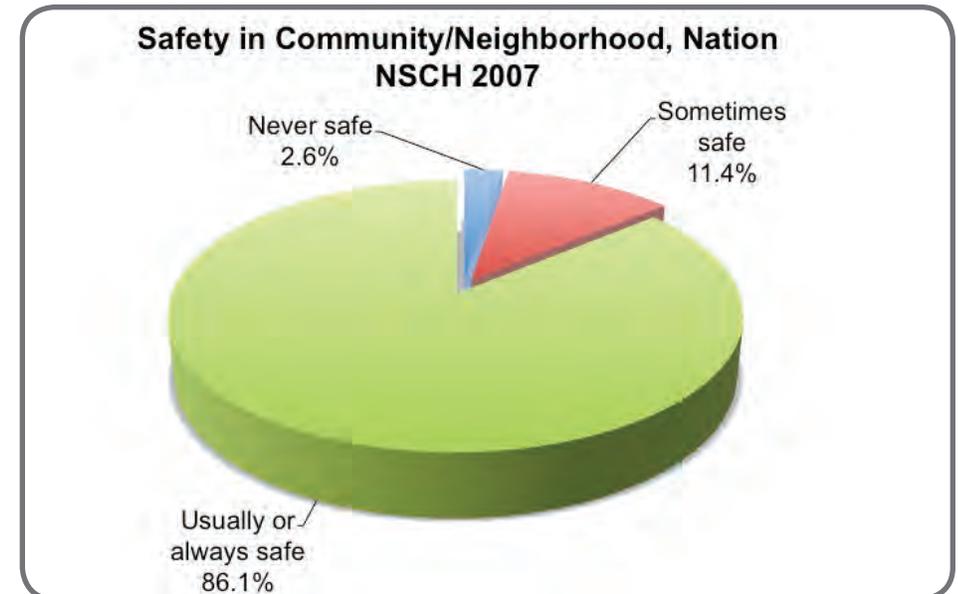
Measurement

Parents of 0-17 year olds were asked how often they felt their child was safe in their community or neighborhood. Responses were categorized as usually or always safe, sometimes safe, or never safe.

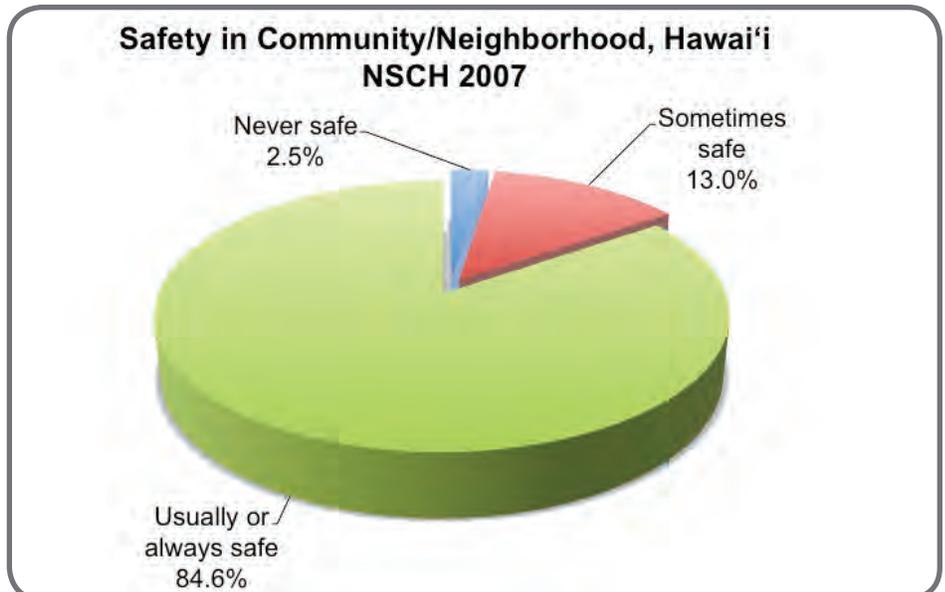
National Comparisons

In Hawai'i, 84.6% of children were reported as usually or always safe in their community/neighborhood, which is lower than but not significantly different from the national estimate of 86.1%.

In Hawai'i, 13.0% of children were sometimes



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

safe, while 2.5% were never safe in their community/neighborhood. Nationally, 11.4% of children were sometimes safe, while 2.6% of children were never safe in their community/neighborhood.

**In Hawai'i, Usually/
Always Safe in
Community:
76.6%
(<100% FPL)
vs
89.7%
(400%+ FPL)**

Community, School and Family

Safe Communities: *Disparities*

In Hawai'i, there were disparities in the proportion of children reported usually/always safe in their community/neighborhood with respect to race, gender, federal poverty level, and insurance type.

Race

Significantly more White (92.3%) and Black children (95.7%) compared to Asian (80.6%), Native Hawaiian/Pacific Islander (79.3%), and multiracial (83.9%) children were usually/always safe in their community.

Gender

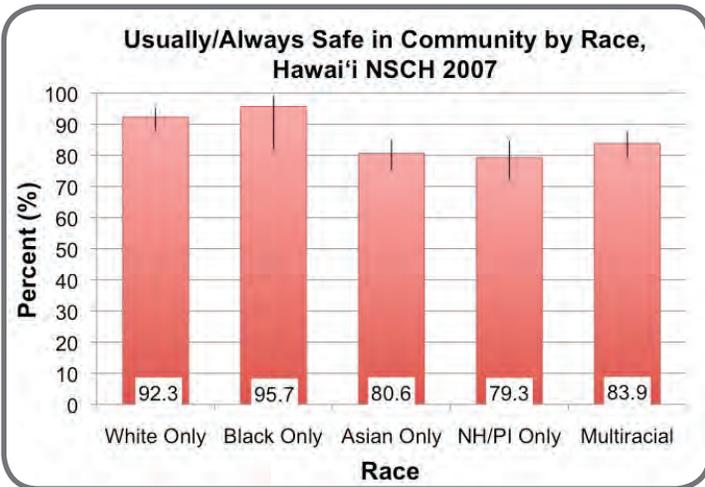
Significantly more males (86.9%) were reported as usually/always safe in their community compared to females (82.0%).

Federal Poverty Level

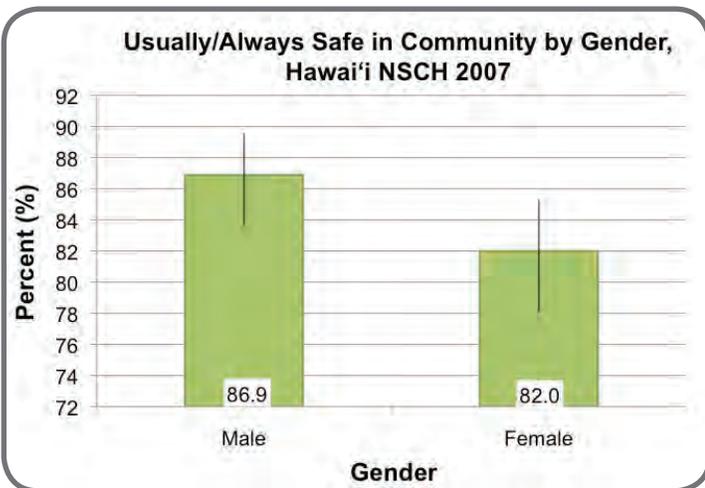
Significantly more children in the 200-399% (88.0%) and 400%+ (89.7%) FPL groups compared to the <100% (76.6%) and 100-199% (77.7%) FPL groups were reported as usually/always safe in their community.

Other

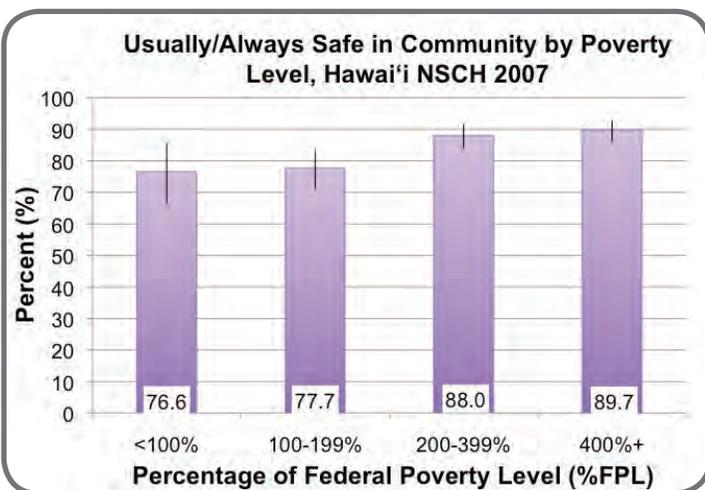
Significantly more privately insured children (87.0%) were reported as usually/always safe in their community compared to publicly insured children (77.3%). There were no statistically significant disparities for this indicator with respect to child's age.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Safe Schools

Ages 6-17 Years

Background

The well-being of children hinges partly on their safety at school, a factor that can impact academic engagement and overall health. For instance, children who are bullied are more likely to exhibit symptoms such as head and stomach pains, emotional anxiety/sadness, bed wetting, and difficulty sleeping.³⁵

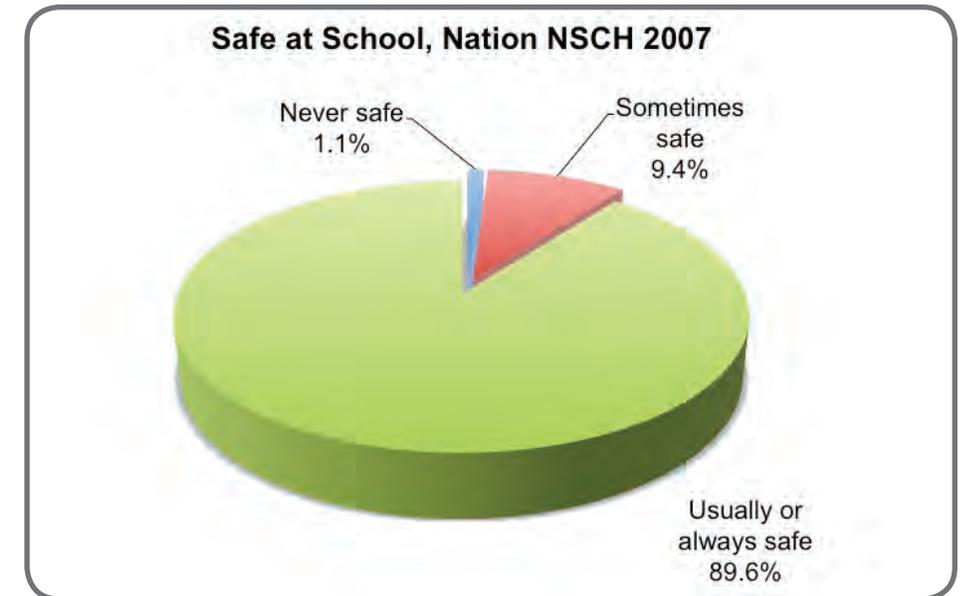
Measurement

Parents of 6-17 year olds, excluding home schooled children, were asked how often they felt their child was safe at school. Responses were categorized as usually or always safe, sometimes safe, or never safe.

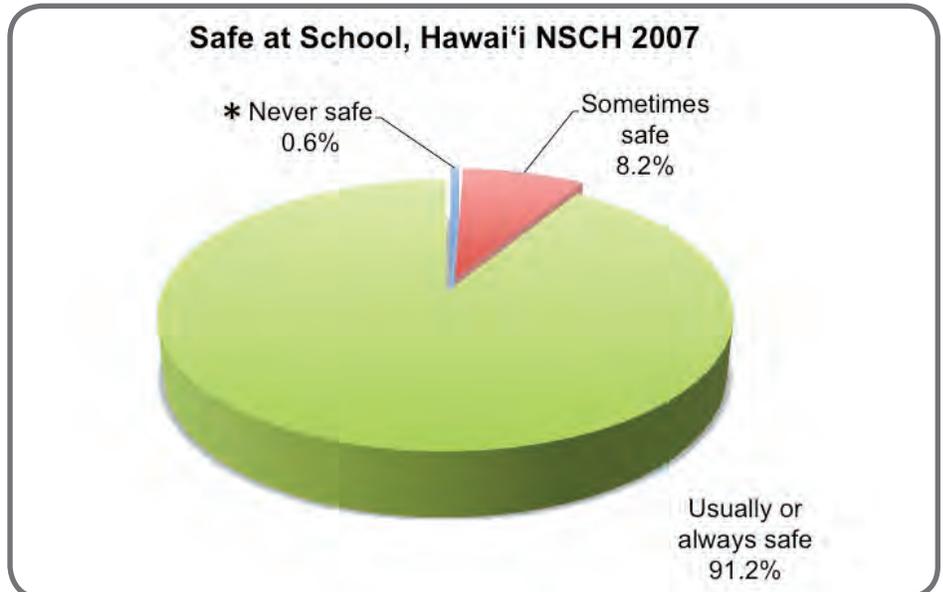
National Comparisons

In Hawai'i, 91.2% of children were reported as usually/always safe at school, which is higher than but not significantly different from the national estimate of 89.6%.

In Hawai'i, 8.2% of children were sometimes safe at school, while the estimate for children never



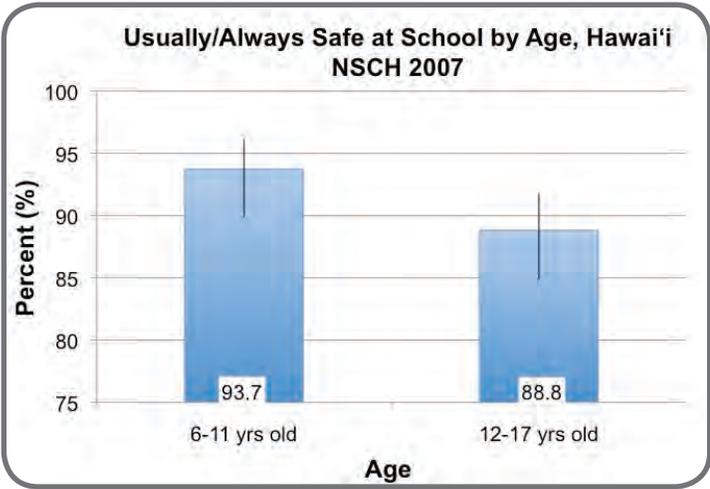
Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



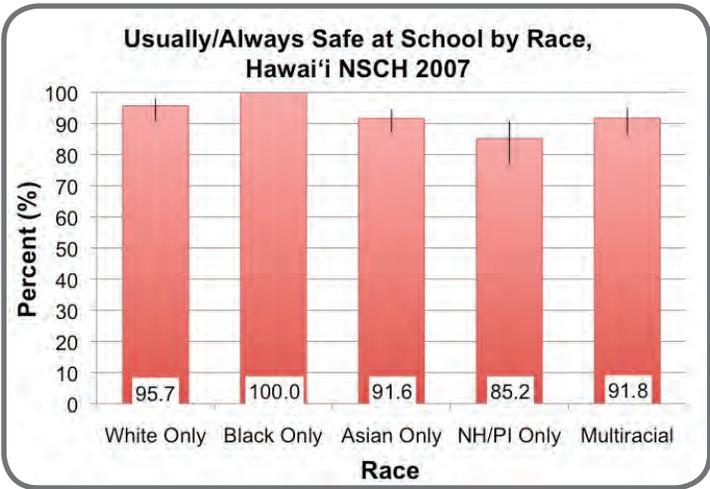
Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. *Estimate does not meet standards for reliability and precision, relative standard error > 30%.

safe at school was only 0.6% although the estimate is deemed unreliable due to the small number of children with that response. Nationally, 9.4% of children were sometimes safe while 1.1% of children were never safe at school.

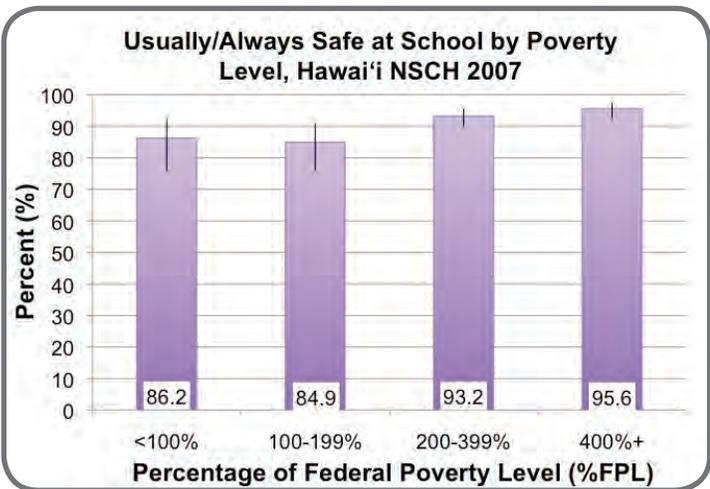
**In Hawai'i, Usually/
Always Safe at
School:
93.7%
(6-11 Year Olds)
vs
88.8%
(12-17 Year Olds)**



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.



Data Source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007.

Community, School and Family

Safe Schools: Disparities

In Hawai'i, there were disparities in the proportion of children that were reported as usually/always safe at school with respect to age, race, and federal poverty level.

Age

Significantly more children in the 6-11 year old group (93.7%) compared to the 12-17 year old group (88.8%) were reported as usually/always safe at school.

Race

Significantly more Black children (100%) compared to White (95.7%), Asian (91.6%), Native Hawaiian/Pacific Islander (85.2%), and multiracial (91.8%) children were usually/always safe at school. Also, the difference between White children compared to Native Hawaiian/Pacific Islander children was statistically significant.

Federal Poverty Level

Significantly less children in the 100-199% FPL (84.9%) compared to 200-399% FPL (93.2%) and 400%+ FPL (95.6%) groups were usually/always safe at school. Additionally, the <100% FPL (86.2%) group compared with the 400%+ group was statistically significant.

Other

There were no statistically significant disparities for this indicator with respect to child's gender and insurance type.

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Acknowledgements

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Acknowledgements:

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Linda Chock. MPH, RD; Chief, Women, Infants and Children Services Branch
Lloyd Miyashiro; Research Statistician, Children with Special Health Needs Branch
Annette Mente; Planner, FHSD
Keiko Nitta; Early Childhood Comprehensive Systems Coordinator, FHSD
John Yamauchi; Information Specialist, FHSD

Special Thanks:

Parents who completed the National Survey of Children's Health
State and Local Area Integrated Telephone Survey (SLAITS), NCHS/CDC
Maternal and Child Health Bureau, Health Resources and Services Administration

Suggested Citation:

Teranishi K, Hayes D, and Fuddy L. Health Status of Children in Hawai'i: 2007 National Survey of Children's Health. Honolulu, HI. Hawai'i Department of Health, Family Health Services Division. August 2010.

Additional Resources:

<http://hawaii.gov/health/family-child-health/>
<http://www.nschdata.org>

*Position supported by the Family Health Services Division; the MCH Epidemiology Program, Centers for Disease Control and Prevention; and the MCH Bureau, Health Resources and Services Administration.

Summary Comments

The National Survey of Children's Health (NSCH) data provides information on many common issues related to the health of children in Hawai'i and across the nation. This report illustrates estimates on many health status indicators for children in Hawai'i, shows comparison to the rest of the nation, and includes estimates within several population groups in Hawai'i. Compared to rest of the nation, Hawai'i performs better in many areas of child health status. However, this report demonstrates that there is often variability by age, ethnicity, family poverty status, and insurance type. In fact, even though the overall estimate for the State of Hawai'i may be better than the rest of the nation, specific population subgroups may have estimates worst than the rest of the State and the nation. The overall estimate for the State is made up of all groups averaged together and just focusing on the statewide estimate would mask the burden to some population subgroups. Some of the differences between population subgroups are pronounced and lend themselves to developing interventions to eliminate disparities and help improve the overall health of children and their families in Hawai'i . It is important to realize that these issues are complex and will require multiple strategies to effectively make a difference. This report serves to bring awareness to disparities in children's health in order to help frame future activities that can characterize why they exist and what can be done to eliminate them.

Resources need to be directed at improving the health status of our most vulnerable populations. This may require 1) The need for further analysis between poverty and other socio-economic determinants of health; 2) Improved access and availability of services; 3) Promotion of health throughout the life course; and 4) The development of effective culturally appropriate interventions through collaborations with community partners.

The Family Health Services Division (FHSD) is committed to provide valuable data and promote awareness of issues facing mothers, children, and their families. The NSCH data highlighted in this report is just one example of how data is being used in the State. Additional data and information is available and those interested are encouraged to contact the FHSD.

Health Status of Children in Hawai'i: 2007 National Survey of Children's Health



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This document is also available online at:
<http://Hawaii.gov/health/doc/ChildDisparitiesReport2007.pdf>

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This publication was made possible by grant number H18MC00012 from the U.S. Department of Health and Human Services (HHS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS.