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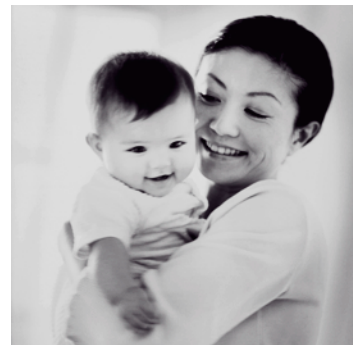
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**Preconception and Interconception
Health Status of Women Who Recently
Gave Birth to a Live-Born Infant —
Pregnancy Risk Assessment Monitoring
System (PRAMS), United States,
26 Reporting Areas, 2004**



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Preconception and Interconception Health Status of Women Who Recently Gave Birth to a Live-Born Infant — Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 26 Reporting Areas, 2004

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Abstract

Problem/Condition: In 2006, CDC published recommendations to improve health and health care for women before pregnancy and between pregnancies (*CDC. Recommendations to improve preconception health and health care—United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006;55[No. RR-6]*). The Pregnancy Risk Assessment Monitoring System (PRAMS) provides data concerning maternal behaviors, health conditions, and experiences for women in the United States who have delivered a live birth.

Reporting Period Covered: 2004.

Description of System: PRAMS is an ongoing, state- and population-based surveillance system designed to monitor selected maternal behaviors and experiences that occur before, during, and after pregnancy among women who deliver live-born infants in selected states and cities in the United States. PRAMS employs a mixed mode data-collection methodology; up to three self-administered questionnaires are mailed to a sample of mothers, and nonresponders are followed up with telephone interviews. Self-reported survey data are linked to selected birth certificate data and weighted for sample design, nonresponse, and noncoverage to create annual PRAMS analysis data sets that can be used to produce statewide estimates of perinatal health behaviors and experiences among women delivering live infants.

This report summarizes data from 26 PRAMS reporting areas that collected data during 2004 and that had achieved overall weighted response rates of $\geq 70\%$ and had weighted data available by the time the analysis was conducted in January 2007. Data are reported on indicators regarding 18 behaviors and conditions that are relevant to preconception (i.e., prepregnancy) health and health care and 10 that are relevant to interconception (i.e., postpartum) health and health care. The number of questions that were administered varied by site; certain questions were not asked for all reporting areas.

Results: With respect to preconception maternal behaviors and experiences, mean overall prevalence was 23.2% for tobacco use, 50.1% for alcohol use, 35.1% for multivitamin use at least four times a week, 53.1% for nonuse of contraception among women who were not trying to become pregnant, 77.8% for ever having a dental visit before pregnancy, 30.3% for receiving prepregnancy health counseling, 3.6% for experiencing physical abuse, and 18.5% for experiencing at least four stressors before pregnancy.

With respect to preconception maternal health conditions, mean overall prevalence was 13.2% for women being underweight (body mass index [BMI]: < 19.8), 13.1% for being overweight (BMI: 26.0–29.0), and 21.9% for being obese (BMI: > 29.0). Mean overall prevalence was 1.8% for having diabetes, 6.9% for asthma, 2.2% for hypertension, 1.2% for heart problems, and 10.2% for anemia. Among women with a previous live birth, the mean overall prevalence of having a previous low birth weight infant was 11.6% and of having a previous preterm infant was 11.9%.

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With respect to interconception maternal behaviors and experiences, mean overall prevalence was 17.9% for tobacco use, 85.1% for contraceptive use, 15.7% for having symptoms of depression, and 84.8% for having social support. Mean overall prevalence was 7.5% for the most recent infant being born low birth weight, 10.4% for having a recent preterm infant, 89.3% for having a check-up, 89.0% for receiving contraceptive use counseling, 30.4% for having a dental visit, and 48.6% for receiving services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Results varied by maternal age, race/ethnicity, pregnancy intention, and health insurance status. For certain risk behaviors and health conditions, mean overall prevalence was higher among women aged <20 years, black women, women whose pregnancies were unintended, and women receiving Medicaid; however, no single subgroup was consistently at highest risk for all the indicators examined in this report.

Interpretation: PRAMS results varied among reporting areas. The prevalence estimates in the majority of reporting areas and for the majority of indicators suggest that a substantial number of women would benefit from preconception interventions to ensure that they enter pregnancy in optimal health. The results also demonstrate disparities among age and racial/ethnic subpopulations, especially with respect to prepregnancy medical conditions and access to health care both before conception and postpartum. Differences also exist in health behaviors between women who reported intended and unintended pregnancies.

Public Health Action: Maternal and child health programs can use PRAMS data to monitor improvements in maternal preconception and interconception behaviors and health status. The data presented in this report, which were collected before publication of CDC's recommendations to improve preconception health and health care in the United States, can be used as a baseline to monitor progress toward improvements in preconception and interconception health following publication of the recommendations. These data also can be used to identify specific groups at high risk that would benefit from targeted interventions and to plan and evaluate programs aimed at promoting positive maternal and infant health behaviors, experiences, and reproductive outcomes. In addition, the data can be used to inform policy decisions that affect the health of women and infants.

Introduction

In 2006, CDC published 10 recommendations to improve health and health care for women in the United States before and after pregnancy (1) (Box). CDC developed these recommendations on the basis of a review of published research and the opinions of specialists from the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. The report outlined four goals: 1) improve the knowledge, attitudes, and behaviors of men and women related to preconception health; 2) ensure that all women of childbearing age in the United States receive preconception care services (i.e., evidence-based risk screening, health promotion, and interventions) that will enable them to enter pregnancy in optimal health; 3) reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children; and 4) reduce disparities in adverse pregnancy outcomes (1).

The recommendations address both preconception and interconception care. Preconception care is defined as a set of interventions to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management. Interconception care

refers to the time between pregnancies, including, but not restricted to, the postpartum period.

The goal of the recommendations is to improve the health of the woman and increase the likelihood of a good pregnancy outcome by encouraging positive behaviors and controlling or preventing health problems before pregnancy. Providing women with postpartum care serves a similar purpose and has the added advantage of targeting for intervention women who have had previous poor infant or maternal outcomes and are at risk for subsequent poor outcomes (2).

Risk Factors

Maternal behaviors known to be related to poor birth outcomes include tobacco use, alcohol use, and failure to consume adequate folic acid through multivitamins or diet. Evidence suggests that successful interventions targeting these behaviors prior to pregnancy are associated with improved health of the woman and her infant. For example, tobacco use during pregnancy is associated with preterm birth, small size for gestational age, and low birth weight (3–5). Tobacco use also contributes to the occurrence of spontaneous abortion, stillbirth, fetal death, and sudden infant death syndrome (6–9); approximately 5% of infant deaths in the United States

BOX. Summary of CDC's recommendations to improve preconception health and health care — United States, 2006

- **Individual responsibility across the lifespan.** Encourage every woman, man, and couple to have a reproductive life plan (i.e., a plan that reflects their intentions regarding the number and timing of pregnancies in the context of their personal values and life goals).
- **Consumer awareness.** Increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts.
- **Preventive visits.** As a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes.
- **Interventions for identified risks.** Increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high-priority interventions (i.e., those with evidence of effectiveness and greatest potential impact).
- **Interconception care.** During the interconception period, provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth).
- **Prepregnancy checkup.** Offer, as a component of maternity care, one prepregnancy visit for couples and persons planning pregnancy.
- **Health insurance coverage for women with low incomes.** Increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and interconception care.
- **Public health programs and strategies.** Integrate components of preconception health into existing local public health and related programs, including emphasis on interconception interventions for women with previous adverse outcomes.
- **Research.** Increase the evidence base and promote the use of the evidence to improve preconception health.
- **Monitoring improvements.** Maximize public health surveillance and related research mechanisms to monitor preconception health.

Source: CDC. Recommendations to improve preconception health and health care—United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. *MMWR* 2006;55(No. RR-6).

can be attributed to maternal tobacco use (10). Use of alcohol during pregnancy is associated with spontaneous abortions, birth defects, and developmental disorders, many of which occur early in gestation before the woman is aware that she is pregnant (11,12). Frequent alcohol use during pregnancy is associated with fetal alcohol syndrome (FAS), which is characterized by impaired growth and mental retardation in the infant (13,14). Inadequate folic acid intake before pregnancy increases the risk for neural tube defects (NTDs) in the infant (15). NTDs affect an estimated 3,000 pregnancies annually, and 95% of children born with an NTD are born to couples with no history of these birth defects (16,17). Taking a multivitamin or otherwise increasing folic acid intake to 400 μ g daily can reduce the incidence of NTDs by 50% (18).

Other conditions associated with poor pregnancy outcomes include having an unintended pregnancy, experiencing physical abuse, and experiencing high levels of stress. Women who experience an unintended pregnancy are more likely than those with an intended pregnancy to have poor maternal nutrition, to use alcohol during pregnancy, and to have adverse maternal and infant outcomes (19). Physical abuse before pregnancy is related to an increased risk for low birth weight and increased maternal and infant mortality and morbidity (20). High levels of stress during pregnancy can result in an alteration of immune regulation in the fetus (21), and persistent disparities in health outcomes among minority women have been postulated to be associated with psychosocial indicators such as stress (22).

Certain maternal health conditions (e.g., diabetes, hypertension, and obesity), if uncontrolled, can lead to poor infant outcomes and have a long-term negative impact on a woman's health. Uncontrolled diabetes during pregnancy can result in a threefold increase in birth defects and maternal health problems (23,24). These risks are greatly reduced through proper diabetes management (25). Obesity before pregnancy and in early pregnancy is associated with late fetal death, antepartum stillbirth, early neonatal death, large-for-gestational-age infants, birth defects, preeclampsia, and hypertensive and thromboembolic disease (26–29). Diabetes and obesity are closely linked, and persons at high risk for either condition should be screened early to ensure a healthy prepregnancy weight. In addition to these conditions, having had a previous preterm, low birth weight, or small-for-gestational-age infant is a predictor of having a subsequent poor birth outcome (30–32).

Health-Care Utilization

CDC's 2006 recommendations underscore the need to create a demand for accessible preconception health services among consumers, aid implementation of effective interven-

tions to improve women's health, ensure that clinicians offer such services, and ensure that these services are covered by health insurance (1). Talking to a health-care provider before becoming pregnant and obtaining appropriate counseling and screening can assist in identifying harmful behaviors and uncontrolled medical conditions that can be managed before pregnancy (33–36). Similarly, a prepregnancy dental visit can identify periodontal disease, which has been linked with an increased risk for low birth weight and preterm birth (37–39). Ensuring optimal maternal oral health before conception also has other potential benefits to both the woman and her infant (40).

Because a woman might have a subsequent pregnancy, services in the postpartum period (e.g., a postpartum check-up, screening for postpartum depression, counseling about birth control, and accessing services such as the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) all are opportunities to help women maintain or regain good health (41–46). Approximately 17% of women in the United States aged 18–64 years lack health insurance, which limits their ability to access health-care services (47). A substantial proportion of these women have health insurance coverage only during and shortly after pregnancy. For preconception and postpartum interventions to succeed, women should have access to preventive and curative medical services before and after pregnancy.

Although data regarding certain Pregnancy Risk Assessment Monitoring System (PRAMS) indicators have been reported previously (48–50), this report groups multiple indicators related to preconception and interconception into a single document and provides estimates for 2004. The data presented in this report can be used as a baseline to monitor progress and assist states and federal agencies in setting priorities for policy and program planning related to improving preconception and interconception health and health care in the United States.

Methods

Project Description

PRAMS is an ongoing state- and population-based surveillance system designed to monitor selected self-reported maternal behaviors and experiences that occur before, during, and after pregnancy among women who deliver live-born infants in selected states and cities in the United States. PRAMS is administered in collaboration with state health departments by CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health. The project supports the activities of CDC's Safe Motherhood

Initiative, which aims to reduce infant mortality and low infant birth weight.

Since its inception in 1987, PRAMS has expanded from six reporting areas to 39 participating sites* in 2007 (Figure). This number includes 37 states, one tribal-state collaborative project, and one city. Collectively, PRAMS represents approximately 75% of all live births in the United States. In 2004, the year for which data in this report were collected, 30 reporting areas (29 states and New York City) were conducting PRAMS projects, representing approximately 62% of all live births in the United States. This report includes data from 26 (87%) reporting areas† that had achieved an overall weighted response rate of $\geq 70\%$ in 2004 and had weighted data available by the time the analysis was conducted in January 2007 (Figure).

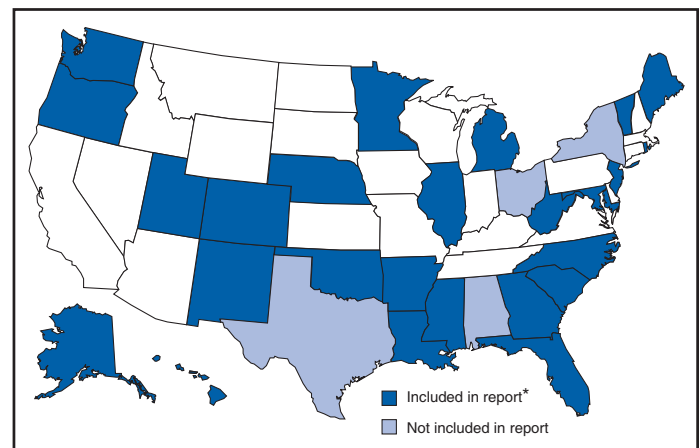
Indicators Studied

The PRAMS questionnaire collects information on multiple maternal behaviors, conditions, and experiences shortly before, during, and after pregnancies that resulted in the

* These 39 sites are Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York City, New York State, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota Tribal, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

† These 26 sites are Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, New York City, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Washington, and West Virginia.

FIGURE. Reporting areas participating in the Pregnancy Risk Assessment Monitoring System — United States, 2004



* Reporting areas included in the report had achieved weighted response rates of $\geq 70\%$ and had weighted data available by the time the analysis was conducted in January 2007.

delivery of a live birth. This report includes data on 28 indicators, including 18 indicators that concern the preconception period and 10 that concern the interconception period. These 28 indicators were selected on the basis of their potential impact on maternal and infant well-being and relevance to preconception and interconception health.

Preconception Indicators

The 18 preconception indicators encompass two broad categories: 1) behaviors and experiences (tobacco use, alcohol use, multivitamin use, nonuse of contraception among those women who were not trying to become pregnant, dental visit, health counseling, physical abuse, and stress) and 2) health conditions (being underweight, overweight, or obese; having diabetes, asthma, hypertension, a heart problem, or anemia; or having a previous low birth weight or preterm infant) (Table 1).

Interconception Indicators

The 10 interconception indicators include behaviors (tobacco use and contraceptive use) and experiences (symptoms of depression, presence of social support, recent low birth weight or preterm infant, check-up, counseling regarding contraceptive use, dental visit, and receipt of services from the Special Supplemental Nutrition Program for Women, Infants and Children [WIC]) (Table 1).

Data Collection

A detailed explanation of the PRAMS methodology has been published previously (51). All participating sites use a standardized data collection methodology developed by CDC. At each site, a monthly stratified sample of 100–300 new mothers is selected from recent birth certificates. PRAMS employs a mixed-mode data collection methodology in which up to three self-administered questionnaires are mailed to mothers, and nonrespondents are followed-up with a telephone interview. The first questionnaire usually is mailed 2–3 months after the delivery of a live-born infant to allow for collection of information about postpartum maternal and infant experiences. Efforts to contact women end 9 months postpartum in order to minimize recall bias. Survey data are linked to selected birth certificate data and weighted for sample design, nonresponse, and noncoverage. The PRAMS questionnaire is revised periodically to reflect changing priorities and emerging issues. All data highlighted in this report were collected with the phase five version of the questionnaire (52), which was implemented with the 2004 birth cohort.

Data Analysis

To minimize nonresponse bias, the CDC PRAMS team established 70% as the minimum overall weighted response rate for site data to be included in published results. This report includes data from 26 reporting areas that collected data during 2004[§] and that had achieved overall weighted response rates of $\geq 70\%$ and had weighted data available by the time the analysis was conducted in January 2007. The weighted response rate indicates the proportion of women sampled who completed a survey, adjusted for sample design.

PRAMS survey respondents are women who gave birth to a live infant within the previous 2–9 months. In this report, indicators concerning the time before the woman's pregnancy are referred to as preconception indicators; these indicators also are referred to as prepregnancy indicators because women were asked to recall events specific to the 1–12 months before their recent pregnancy, which could be considered to be only part of the preconception period. Indicators concerning the time after the birth of the infant are referred to as interconception indicators; these indicators also are referred to as postpartum indicators because they refer to events that occurred from the birth through 2–9 months postpartum but not to the entire interconception period.

Prevalence estimates are presented by reporting area. Data on certain indicators were available for all 26 reporting areas and were derived from core questions that all PRAMS reporting areas use. Other indicators were available only for selected reporting areas and were derived from optional site-selected questions. Definitions of each indicator and a list of reporting areas that collected data on each indicator are reported (Table 1).

Alcohol use was calculated on the basis of self-reported consumption of any alcohol during the 3 months before pregnancy among those women who reported having any alcoholic drinks during the previous 2 years. Binge drinking (i.e., consuming five or more drinks in one sitting) was not examined. In certain states, two questions were asked regarding oral health. Prepregnancy and postpartum dental visits were assessed only for those reporting areas that asked women first whether they had ever had their teeth cleaned by a dentist or dental hygienist and then whether they had their teeth cleaned before or after they became pregnant. In four additional reporting areas (Colorado, Maryland, New Jersey, and West Virginia), women were asked only whether they had had a dental visit before or during pregnancy and were not included in the analysis. For the physical abuse indicator, two report-

[§] Data from Georgia represent births during February–December, and data from New York City and West Virginia represent births during July–December.

ing areas (Oregon and Vermont) did not ask about abuse to teen mothers, and so no data on this indicator are shown for women aged <20 years for these reporting areas. Body mass index (BMI) was calculated on the basis of Institute of Medicine definitions (53). Three problematic categories were assessed: underweight (BMI: <19.8), overweight (BMI: 26.0–29.0), and obese (BMI: >29.0). For previous low birth weight and previous preterm birth, information was recorded from the mother's report on the questionnaire. Recent low birth weight and preterm birth were calculated on the basis of birth certificate data that are linked to PRAMS data. Because only data from one infant of twin and multiple births are selected randomly for PRAMS, estimates presented in this report might differ from reports by vital statistics agencies.

For each indicator, data are presented by four demographic variables: maternal age group, race/ethnicity, pregnancy intention, and health insurance status. Age group and race/ethnicity were ascertained from the birth certificate file. Race and ethnicity are combined as a single variable subdivided as non-Hispanic white, non-Hispanic black, non-Hispanic other, and Hispanic (of any race). Pregnancy intention was determined by a woman's answer to the survey question, "Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?" Out of four possible options, women who answered that they wanted to be pregnant either then or sooner were considered to have an intended pregnancy, and women who answered either that they wanted to be pregnant later or that they did not want to be pregnant then or at any time in the future were considered to have an unintended pregnancy. For the indicator regarding prepregnancy nonuse of contraception, women who were not trying to become pregnant and not using contraception were identified as those who answered "no" to the question, "When you got pregnant with your new baby, were you trying to get pregnant?" and "no" to the question, "When you got pregnant with your new baby, were you or your husband or partner doing anything to keep from getting pregnant?" Preconception health insurance status was classified as private, Medicaid, or none. Interconception health insurance status (i.e., coverage at time of delivery) was classified as private, Medicaid, or other.⁴

⁴ The difference between prepregnancy and delivery health insurance reflects the fact that prepregnancy health insurance questions allowed for the categorization of women into a "no health insurance" group whereas the health insurance-at-delivery question asked about source of payment, with options varying across reporting areas; consequently, women could not consistently be classified as having "no health insurance." Women who reported that they received both Medicaid and private health insurance during either period were included in the private health insurance group (54).

All analyses were produced using weighted PRAMS data. Percentages and standard errors were calculated by using PROC CROSSTAB in SUDAAN version 9.0 to account for the complex sampling design used by PRAMS (55). Weighted data were pooled from all reporting areas to calculate mean overall combined estimates and 95% confidence intervals (CIs). PROC DESCRIPT in SUDAAN was used to test for contrasts between demographic characteristics, only among the estimates for all reporting areas combined. The contrast was considered statistically significant for the demographic characteristic when the *p*-value was <0.05. Only differences in prevalence that were statistically significant are reported. When the number of respondents was <30 persons, prevalence was not reported. Prevalence based on <60 respondents are reported and footnoted. All missing observations are excluded.

Results

The presentation of results is divided into three sections: preconception behaviors and experiences, preconception health conditions, and postpartum behaviors and experiences. Data are presented on the mean overall prevalence of each indicator by site (Tables 2–4) and by indicators for all reporting areas with available data stratified by four maternal characteristics: age, race/ethnicity, pregnancy intention, and health insurance status (Tables 5–32). Unless otherwise indicated, data are presented for all 26 reporting areas. Periods noted regarding the preconception health indicators reflect how survey questions were asked; depending on the question, indicators might refer to the month before pregnancy, the 3 months before pregnancy, or the 12 months before birth.

Preconception Behaviors and Experiences

Tobacco Use

Respondents were asked if they had smoked ≥ 100 cigarettes during the previous 2 years and, if so, whether they had used any tobacco in the 3 months before their most recent pregnancy. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy tobacco use was 23.2% (range: 12.3% [Utah]–39.5% [West Virginia]) (Table 2).

Prevalence was highest among women aged <20 years (mean: 31.1%; range: 17.3% [New York City]–67.6% [Vermont]), white women (mean: 29.1%; range: 12.5% [Utah]–42.4% [Arkansas]), women whose most recent delivery was an unintended pregnancy (mean: 30.9%; range: 16.6% [New York City]–47.2% [Maine]), and women with Medicaid coverage

before pregnancy (mean: 36.0%; range: 12.5% [New York City]–64.6% [West Virginia]) (Table 5).

Alcohol Use

Respondents were asked if they had consumed any alcohol during the previous 2 years and, if so, if they had consumed alcohol during the 3 months before their most recent pregnancy. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy alcohol use was 50.1% (range: 25.3% [Utah]–66.8% [Vermont]) (Table 2).

Prevalence was highest among women aged ≥ 35 years (mean: 55.4%; range: 26.9% [West Virginia]–70.7% [Vermont]), white women (mean: 61.6%; range: 25.2% [Utah]–74.1% [Colorado]), and women with private health insurance before pregnancy (mean: 57.1%; range: 22.7% [Utah]–72.6% [Colorado]) (Table 6).

Multivitamin Use

Respondents were asked how often they had taken a multivitamin or prenatal vitamin. Results are reported for those who had taken a multivitamin or a prenatal vitamin four or more times a week in the month before their most recent pregnancy. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy multivitamin use was 35.1% (range: 26.7% [Arkansas]–43.6% [Rhode Island]) (Table 2).

Prevalence was highest among women aged ≥ 35 years (mean: 51.6%; range: 42.9% [Oklahoma]–63.6% [Vermont]), white women (mean: 41.3%; range: 31.5% [Oklahoma]–50.6% [New Jersey]), women whose most recent delivery was an intended pregnancy (mean: 46.0%; range: 37.1% [West Virginia]–53.9% [Minnesota and Rhode Island]), and women who had private health insurance before pregnancy (mean: 45.9%; range: 37.3% [Arkansas]–54.1% [Rhode Island]) (Table 7).

Contraceptive Nonuse

Respondents were asked if they were not trying to become pregnant. Those who indicated that they were not were then asked if they had been doing anything to keep from becoming pregnant when they became pregnant with their new infant. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy contraceptive nonuse among women who were not trying to become pregnant was 53.1% (range: 47.4% [Mississippi]–58.6% [Maryland]) (Table 2).

Prevalence did not vary by age group, race/ethnicity, or prepregnancy health insurance status. Prevalence was highest among women whose pregnancies were intended (mean: 69.8%; range: 61.9% [Georgia]–78.5% [North Carolina]) (Table 8).

Dental Visit

Respondents were considered to have had a prepregnancy dental visit if they reported having had their teeth cleaned by a dentist or hygienist at some time before their most recent pregnancy. Information was available in 10 reporting areas (Alaska, Arkansas, Maine, Michigan, Mississippi, Nebraska, South Carolina, Utah, Vermont, and Washington). In 2004, for all 10 reporting areas combined, mean prevalence of a prepregnancy dental visit was 77.8% (range: 68.3% [Arkansas]–84.2% [Vermont]) (Table 2).

Prevalence was highest among women aged ≥ 35 years (mean: 83.7%; range: 65.2% [Mississippi]–90.7% [Maine]), white women (mean: 83.4%; range: 74.3% [Arkansas]–87.3% [Washington]), women whose most recent delivery was an intended pregnancy (mean: 81.3%; range: 71.3% [Arkansas]–86.4% [Vermont]), and women who had private health insurance before pregnancy (mean: 84.9%; range: 77.7% [Arkansas]–86.7% [Utah]) (Table 9).

Health Counseling

Respondents were asked if they had talked with a health-care professional regarding preparing for a healthy pregnancy and infant before they became pregnant with their new infant. Information was available in five reporting areas (Louisiana, Maine, New Jersey, Utah, and Vermont). In 2004, for all five reporting areas combined, mean prevalence of prepregnancy health counseling was 30.3% (range: 24.1% [Louisiana]–34.8% [Maine]) (Table 2).

Prevalence was highest among women aged ≥ 35 years (mean: 42.2%; range: 35.8% [Utah]–46.4% [Vermont]). Prevalence was higher among white women (mean: 34.2%; range: 28.6% [Utah]–41.6% [New Jersey]) and women of other races (mean: 34.6%; range: 20.3% [Louisiana]–39.3% [New Jersey]) than among black women (mean: 23.3%; range: 16.2% [Louisiana]–33.2% [New Jersey]) and Hispanic women (mean: 19.4%; range: 18.4% [Utah]–20.6% [Louisiana]). Prevalence was highest among women whose most recent pregnancy was intended (mean: 43.0%; range: 35.6% [Utah]–46.9% [New Jersey]) and women with private health insurance before pregnancy (mean: 39.5%; range: 32.8% [Utah]–43.9% [Maine]) (Table 10).

Physical Abuse

Respondents were asked if they had been pushed, hit, slapped, kicked, choked, or physically hurt in any way by a husband or partner during the 12 months before their most recent pregnancy. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy physical abuse was 3.6% (range: 2.2% [Maine]–7.3% [Arkansas]) (Table 2).

Prevalence was highest among women aged <20 years (mean: 6.1%; range: 3.2% [Michigan]–10.9% [Oklahoma]). Prevalence was higher among black women (mean: 5.4%; range: 1.0% [Michigan]–10.9% [Oregon]) than among white women (mean: 2.7%; range: 0.7% [New York City]–7.2% [Arkansas]) and women of other races (mean: 4.1%; range: 0.2% [New York City]–13.0% [Minnesota]). Prevalence was highest among women whose most recent delivery was an unintended pregnancy (mean: 5.9%; range: 4.1% [Georgia]–9.5% [Maryland]) and women with Medicaid coverage before pregnancy (mean: 8.0%; range: 3.5% [Washington]–19.1% [Oklahoma]) (Table 11).

Stress

Prepregnancy stress was assessed on the basis of respondents indicating that they had experienced at least four of a list of 13 stressful events during the 12 months before the birth of their new infant. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy stress was 18.5% (range: 13.1% [Minnesota]–29.0% [Arkansas]) (Table 2).

Prevalence was highest among women aged <20 years (mean: 28.6%; range: 15.8% [Hawaii]–46.1% [Vermont]), black women (mean: 27.9%; range: 13.2% [Hawaii]–44.9% [Oklahoma]), women whose most recent delivery was the result of an unintended pregnancy (mean: 28.5%; range: 19.4% [New York City]–38.1% [Oklahoma]), and women with Medicaid coverage before pregnancy (mean: 33.8%; range: 15.3% [New York City]–48.5% [Oklahoma]) (Table 12).

Preconception Health Conditions

Underweight, Overweight, and Obesity

Respondents' BMI was calculated on the basis of their self-reported prepregnancy height and weight. Respondents were considered to be underweight if their BMI was <19.8 before they became pregnant, overweight if their BMI was 26.0–29.0, and obese if their BMI was >29.0.

Underweight. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy underweight was 13.2% (range: 10.8% [South Carolina]–17.0% [Arkansas]) (Table 3). Prevalence was highest for women aged <20 years (mean: 22.1%; range: 13.3% [Alaska]–33.3% [Utah]), women who classified their race as other (mean: 19.7%; range: 8.5% [Alaska]–36.4% [Maryland]) and women whose most recent pregnancy was unintended (mean: 14.2%; range: 9.8% [Alaska]–17.3% [Florida and Hawaii]). Prevalence was higher among women with Medicaid coverage before pregnancy (mean: 14.5%; range: 9.3% [Colorado and Vermont]–24.9% [Arkansas]) and women with no health insurance before pregnancy (mean: 14.9% range: 10.4% [Alaska]–22.8% [Hawaii])

than women with private health insurance before pregnancy (mean: 12.1%; range: 8.7% [South Carolina]–15.8% [Hawaii]) (Table 13).

Overweight. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy overweight was 13.1% (range: 11.0% [Utah]–15.0% [New York City]) (Table 3). Prevalence was higher among women aged 20–34 years (mean: 13.3%; range: 26.6% [Utah]–43.5% [Mississippi]) and women aged ≥35 years (mean: 13.7%; range: 23.8% [Vermont]–51.1% [Arkansas]) than among women aged <20 years (mean: 10.4%; range: 4.0% [Colorado]–15.6% [Rhode Island]). Prevalence was higher among black women (mean: 14.7%; range: 1.1% [Alaska]–20.3% [Michigan]) and Hispanic women (mean: 15.9%; range: 8.7% [Oklahoma]–22.5% [Arkansas]) than among white women (mean: 12.2%; range: 9.1% [Louisiana]–14.7% [New Mexico]) and women of other races (mean: 10.1%; range: 2.8% [Maryland]–20.6% [New York City]). Prevalence did not vary by pregnancy intention or health insurance status (Table 14).

Obesity. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy obesity was 21.9% (range: 15.7% [Utah]–26.6% [Arkansas]) (Table 3). Prevalence was higher among women aged 20–34 years (mean: 26.2%; range 17.4% [Utah]–33.4% [Mississippi]) and women aged ≥35 years (mean: 27.2%; range: 15.0% [Vermont]–44.3% [Arkansas]) than among women aged <20 years (mean: 15.5%; range: 8.0% [Maine]–25.9% [North Carolina]). Prevalence was higher among black women (mean: 37.9%; range: 29.4% [Oklahoma]–46.9% [Michigan]) than among all other racial/ethnic populations except Hispanic women. Prevalence was highest among women whose most recent delivery was unintended pregnancy (mean: 26.7%; range: 19.5% [Minnesota]–31.5% [Michigan]) and women with Medicaid coverage before pregnancy (mean: 32.7%; range: 15.3% [Utah]–44.4% [Michigan]) (Table 15).

Diabetes

Respondents were considered to have prepregnancy diabetes if they reported having had high blood sugar or diabetes that started before their most recent pregnancy. In 2004, for all 26 reporting areas combined, mean prevalence of prepregnancy diabetes was 1.8% (range: 0.9% [Washington]–5.7% [West Virginia]) (Table 3).

Prevalence was higher among women aged ≥35 years (mean: 3.0%; range: 1.0% [Maine]–9.1% [West Virginia]) than among women aged 20–34 years (mean: 1.6%; range: 0.8% [Washington]–5.9% [West Virginia]). Prevalence was higher among black women (mean: 3.3%; range: 0.6% [Nebraska] to 13.1% [West Virginia]) than among all other racial/ethnic populations except Hispanic women (mean: 2.6%; range: 0

[Minnesota]–9.7% [Michigan]). Prevalence did not vary by pregnancy intention. Prevalence was higher among women with Medicaid coverage before pregnancy (mean: 2.9%; range: 0.2% [Maryland and Vermont]–7.8% [Georgia]) and women with no health insurance before pregnancy (mean: 2.2%; range: 0.2% [Maine]–8.4% [West Virginia]) than among women with private health insurance before pregnancy (mean: 1.4%; range: 0.7% [Colorado and Illinois]–3.3% [North Carolina and West Virginia]) (Table 16).

Asthma

Respondents were considered to have prepregnancy asthma if they reported that they had asthma during the 3 months before they became pregnant with their new infant. Information was available in four reporting areas (Florida, Maryland, Minnesota, and West Virginia). In 2004, for all four reporting areas combined, mean prevalence of prepregnancy asthma was 6.9% (range: 6.1% [Florida]–10.8% [West Virginia]) (Table 3).

Prevalence was higher among white women (mean: 7.7%; range: 7.2% [Florida]–10.8% [West Virginia]) and black women (mean: 7.7%; range: 6.1% [Florida]–12.2% [Minnesota]) than among Hispanic women (mean: 4.3%; range: 3.3% [Maryland]–5.8% [Minnesota]). Prevalence was highest among women with Medicaid coverage before pregnancy (mean: 10.7%; range: 8.6% [Florida]–26.5% [West Virginia]). Prevalence did not vary by age group or pregnancy intention (Table 17).

Hypertension

Respondents were considered to have prepregnancy hypertension if they reported that they had high blood pressure (hypertension) during the 3 months before they became pregnant with their new infant. Information was available in four reporting areas (Florida, Maryland, Minnesota, and West Virginia). In 2004, for all four reporting areas combined, mean prevalence of prepregnancy hypertension was 2.2% (range: 1.7% [Minnesota]–4.0% [West Virginia]) (Table 3).

Prevalence was higher among women aged ≥ 35 years (mean: 4.1%; range: 1.5% [West Virginia]–5.4% [Maryland]) than among women aged 20–34 years (mean: 1.8%; range: 1.1% [Minnesota]–4.6% [West Virginia]). Prevalence was highest among black women (mean: 3.8%; range: 3.5% [Maryland]–11.1% [West Virginia]) (Table 18). Prevalence did not vary by pregnancy intention or health insurance status.

Heart Problems

Respondents were considered to have prepregnancy heart problems if they reported that they had heart problems during the 3 months before they became pregnant with their new

infant. Information was available in four reporting areas (Florida, Maryland, Minnesota, and West Virginia). In 2004, for all four reporting areas combined, mean prevalence of prepregnancy heart problems was 1.2% (range: 0.4% [Minnesota]–3.0% [West Virginia]) (Table 3). Prevalence did not vary among any demographic subgroups (Table 19).

Anemia

Respondents were considered to have prepregnancy anemia if they reported that they had anemia (i.e., poor blood or low iron) during the 3 months before they became pregnant with their new infant. Information was available in four reporting areas (Florida, Maryland, Minnesota, and West Virginia). In 2004, for all four reporting areas combined, mean prevalence of prepregnancy anemia was 10.2% (range: 5.2% [Minnesota]–12.3% [Maryland]) (Table 3).

Prevalence was higher among women aged < 20 years (mean: 14.1%; range: 10.7% [Minnesota]–23.9% [Maryland]) than among women aged ≥ 35 years (mean: 7.6%; range: 3.9% [Minnesota]–9.3% [Maryland]). Prevalence was highest among black women (mean: 21.4%; range: 14.8% [West Virginia]–23.4% [Maryland]), women whose most recent delivery was an unintended pregnancy (mean: 15.6%; range: 7.2% [Minnesota]–21.1% [Maryland]), and women with Medicaid coverage before pregnancy (mean: 19.5%; range: 11.7% [Minnesota]–27.9% [Maryland]) (Table 20).

Previous Low Birth Weight Infant

Birth of a previous low birth weight infant was determined from respondents' reporting that they had a previous live birth and that the infant born just before their most recent infant had weighed < 5 lbs. 8 oz. (2,500 g) at birth. In 2004, for all 26 reporting areas combined, mean prevalence of having a previous low birth weight infant was 11.6% (range: 5.7% [Maine]–15.0% [Georgia]) (Table 3).

Prevalence was higher for women aged < 20 years (mean: 15.5%; range: 1.2% [Minnesota]–38.9% [South Carolina]) than women aged ≥ 35 years (mean: 10.8%; range: 4.1% [Oklahoma and Vermont]–27.9% [Mississippi]). Prevalence was higher among black women (mean: 18.7%; range: 5.3% [Maine]–19.5% [Georgia]) and Hispanic women (mean: 16.3%; range: 5.8% [Rhode Island]–34.7% [Oklahoma]) than among white women (mean: 7.9%; range: 4.5% [Minnesota]–13.2% [West Virginia]) and women of other races (mean: 12.4%; range: 2.1% [Minnesota]–23.6% [New York City]). Prevalence was highest among women whose most recent delivery was an unintended pregnancy (mean: 12.9%; range: 5.0% [Alaska]–27.4% [Arkansas]) and women who had Medicaid coverage before pregnancy (mean: 15.6%; range: 5.0% [Minnesota]–26.7% [Oklahoma]) or no health insurance

before pregnancy (mean: 15.0%; range: 6.0% [Maine]–22.2% [Georgia]) (Table 21).

Previous Preterm Infant

Birth of a previous preterm infant was determined from respondents' reporting that they had a previous live birth and that the infant born just before their most recent infant had been born ≥ 3 weeks before the due date. In 2004, for all 26 reporting areas combined, mean prevalence of having a previous preterm infant was 11.9% (range: 7.7% [Minnesota]–16.7% [Mississippi]) (Table 3).

Prevalence was highest for women aged <20 years (mean: 16.4%; range: 3.3% [Minnesota]–35.5% [Illinois]). Prevalence was highest among black women (mean: 16.2%; range: 6.1% [Rhode Island]–41.5% [Oklahoma]), and women whose most recent delivery was an unintended pregnancy (mean: 13.1%; range: 7.6% [Minnesota]–18.2% [Mississippi]). Prevalence was higher among women who had Medicaid coverage before pregnancy (mean: 13.7%; range: 4.5% [Minnesota]–30.4% [West Virginia]) than among women with private health insurance (mean: 11.1%; range: 8.0% [Maine and Utah]–14.6% [Arkansas]) (Table 22).

Interconception (Postpartum) Behaviors and Experiences

Tobacco Use

Respondents were considered to be using tobacco postpartum if they reported that they had smoked ≥ 100 cigarettes in the past 2 years and that they smoked "now" at the time of answering the survey (2–9 months postpartum). In 2004, for all 26 reporting areas combined, mean prevalence of postpartum tobacco use was 17.9% (range: 8.7% [Utah]–33.5% [West Virginia]) (Table 4).

Prevalence was highest for women aged <20 years (mean: 26.7%; range: 14.5% [New York City]–55.9% [Vermont]), white women (mean: 22.2%; range: 8.8% [Utah]–34.6% [Arkansas]), women whose most recent delivery was an unintended pregnancy (mean: 24.7%; range: 14.0% [New York City]–38.9% [West Virginia]), and women who had Medicaid coverage at delivery (mean: 26.8%; range: 10.0% [New York City]–49.0% [West Virginia]) (Table 23).

Contraceptive Use

Postpartum contraceptive use was assessed from respondents' reporting that they were taking action to keep from becoming pregnant at the time of survey (2–9 months postpartum). In 2004, for all 26 reporting areas combined, mean prevalence of postpartum contraceptive use was 85.1% (range: 76.4% [New York City]–89.5% [Mississippi]) (Table 4).

Prevalence was higher among women aged <20 years (mean: 86.0%; range: 75.6% [Hawaii]–91.4% [North Carolina]) and women aged 20–34 years (mean: 85.8%; range: 77.5% [New York City]–90.6% [Vermont]) than among women aged ≥ 35 years (mean: 80.6%; range: 70.6% [New York City]–95.6% [Mississippi]). Prevalence also was higher among white women (mean: 85.6%; range: 67.3% [New York City]–91.1% [South Carolina]), black women (mean: 85.3%; range: 78.9% [Minnesota]–97.1% [Colorado]), and Hispanic women (mean: 85.4%; range: 78.6% [Alaska]–90.5% [Washington]) than among women of other races (mean: 77.8%; range: 65.5% [South Carolina]–95.4% [Colorado]). Prevalence was highest among women whose most recent delivery was an unintended pregnancy (mean: 87.4%; range: 79.2% [Hawaii]–93.4% [Maine]). Prevalence was higher among women with private health insurance (mean: 85.5%; range: 79.3% [New Jersey]–92.5% [Arkansas]) and Medicaid coverage at delivery (mean: 85.1%; range: 72.7% [New York City]–90.1% [South Carolina]) than among women with other health insurance status at delivery (mean: 80.7%; range: 64.0% [Illinois]–91.4% [Colorado]) (Table 24).

Symptoms of Depression

Respondents were considered to have symptoms of depression if they reported at 2–9 months postpartum that they often or always were feeling down, depressed, or hopeless or had little interest or little pleasure in normal activities since the birth of their new infant. Information was available in 16 reporting areas (Alaska, Colorado, Georgia, Hawaii, Maine, Maryland, Minnesota, Nebraska, New Mexico, North Carolina, Oregon, Rhode Island, South Carolina, Utah, Vermont, and Washington). In 2004, for all 16 reporting areas combined, mean prevalence of postpartum symptoms of depression was 15.7% (range: 11.1% [Maine]–19.6% [South Carolina]) (Table 4).

Prevalence was highest among women aged <20 years (mean: 26.2%; range: 15.2% [Oregon]–30.9% [South Carolina]). Prevalence was higher among black women (mean: 23.3%; range: 17.3% [Washington]–42.4% [Colorado]) than among all other groups except women of other races (mean: 21.0%; range: 8.6% [South Carolina]–29.8% [Minnesota]). Prevalence was highest among women whose most recent delivery was an unintended pregnancy (mean: 20.8%; range: 15.3% [Vermont]–25.7% [South Carolina]) and among women with Medicaid coverage at delivery (mean: 22.5%; range: 18.7% [Washington]–28.1% [South Carolina]) (Table 25).

Social Support

Postpartum social support was assessed on the basis of respondents indicating that they had at least three of a list of

five possible sources of help since the birth of their new infant at 2–9 months postpartum. Information was available in three reporting areas (North Carolina, Oklahoma, and Rhode Island). In 2004, for all three reporting areas combined, mean prevalence of postpartum social support was 84.8% (range: 84.1% [Oklahoma]–86.0% [Rhode Island]) (Table 4).

Prevalence was highest among white women (mean: 90.2%; range: 88.0% [Oklahoma]–92.9% [Rhode Island]) and women who had private health insurance at delivery (mean: 91.1%; range: 90.1% [Oklahoma]–93.5% [Rhode Island]). Prevalence did not vary by age group or pregnancy intention (Table 26).

Recent Low Birth Weight Infant

Low birth weight of the most recent infant was defined as weight <2,500 g at birth according to birth certificate data. In 2004, for all 26 reporting areas combined, mean prevalence of having a recent low birth weight infant was 7.5% (range: 4.8% [Washington]–10.7% [Louisiana]) (Table 4). Among multiparous women who had a recent low birth weight infant, 1.2% also had given birth to a low birth weight infant before the birth of their most recent infant (CDC, unpublished data, 2006).

Prevalence was highest among women aged <20 years (mean: 10.5%; range: 0.9% [New Jersey]–16.2% [Louisiana]), black women (mean: 13.3%; range: 5.4% [Minnesota]–15.7% [New Jersey]), women whose most recent delivery was an unintended pregnancy (mean: 8.3%; range: 2.7% [Washington]–12.1% [Mississippi]), and women with Medicaid coverage at delivery (mean: 8.8%; range: 4.9% [Washington]–12.1% [Louisiana and Mississippi]) (Table 27).

Recent Preterm Infant

The most recent infant was considered to be preterm if the birth occurred at <37 weeks gestation according to birth certificate data. In 2004, for all 26 reporting areas combined, mean prevalence of having a recent preterm infant was 10.4% (range: 7.9% [Minnesota and Vermont]–13.4% [Mississippi]) (Table 4). Among multiparous women who had a recent preterm infant, 1.8% also had given birth to a preterm infant before the birth of their most recent infant (CDC, unpublished data, 2006).

Prevalence was higher among women aged ≥ 35 years (mean: 12.3%; range: 5.5% [Maine]–21.3% [Louisiana]) than among women aged 20–34 years (mean: 10.0%; range: 7.2% [Minnesota]–12.2% [Georgia and Mississippi]). Prevalence was highest among black women (mean: 14.8%; range: 5.2% [Minnesota]–22.0% [Alaska]), women whose most recent delivery resulted from an unintended pregnancy (mean: 11.1%;

range: 6.8% [Vermont]–15.6% [Mississippi]), and women with Medicaid coverage at delivery (mean: 11.1%; range: 7.2% [New York City]–15.7% [West Virginia]) (Table 28).

Check-Up

Respondents were asked if they had had a postpartum check-up with a health-care provider by the time of survey (2–9 months postpartum). Information was available in 10 reporting areas (Arkansas, Georgia, Hawaii, Minnesota, New Jersey, New York City, Rhode Island, South Carolina, Vermont, and West Virginia). In 2004, for all 10 reporting areas combined, mean prevalence of having a postpartum check-up was 89.3% (range: 84.9% [Arkansas]–93.8% [Rhode Island]) (Table 4).

Prevalence was highest among women aged ≥ 35 years (mean: 92.0%; range: 84.5% [Arkansas]–95.8% [Vermont]). Prevalence was higher among white women (mean: 91.7%; range: 86.5% [West Virginia]–95.1% [Rhode Island]) than among black women (mean: 88.1%; range: 78.9% [Hawaii]–91.1% [South Carolina]) and Hispanic women (mean: 82.5%; range: 72.1% [South Carolina]–94.2% [Rhode Island]). Prevalence was highest among women whose most recent delivery was the result of an intended pregnancy (mean: 91.4%; range: 88.2% [West Virginia]–95.3% [Rhode Island]) and those who had private health insurance at delivery (mean: 93.6%; range: 90.4% [New York City]–97.3% [Rhode Island]) (Table 29).

Contraceptive Use Counseling

Respondents were considered to have had postpartum contraceptive use counseling if they reported that a health-care professional had talked with them about using birth control since the birth of their new infant. Information on postpartum counseling regarding contraceptive use was available in four reporting areas (Colorado, Illinois, New York City, and Utah). In 2004, for all four reporting areas combined, mean prevalence of receiving postpartum counseling regarding contraceptive use was 89.0% (range: 78.5% [New York City]–92.0% [Colorado]) (Table 4).

Prevalence was higher among women aged <20 years (mean: 91.9%; range: 84.5% [New York City]–93.6% [Illinois]) and those aged 20–34 years (mean: 89.5%; range: 79.0% [New York City]–92.1% [Utah]) than among women aged ≥ 35 years (mean: 84.7%; range: 74.1% [New York City]–92.4% [Colorado]). Prevalence was higher among those with private health insurance at delivery (mean: 89.8%; range: 79.2% [New York City]–93.7% [Utah]) and Medicaid at delivery (mean: 88.6%; range: 77.8% [New York City]–92.3% [Colorado]) than among those with other health insurance status at delivery (mean: 79.9%; range: 70.5% [Utah]–87.7% [Colorado]). Prevalence did not vary by race/ethnicity or pregnancy intention (Table 30).

Dental Visit

Respondents were asked if they had had their teeth cleaned by a dentist or dental hygienist since the birth of their new infant by the time of survey (2–9 months postpartum). Information was available for 10 reporting areas (Alaska, Arkansas, Maine, Michigan, Mississippi, Nebraska, South Carolina, Utah, Vermont, and Washington). In 2004, for all 10 reporting areas combined, mean prevalence of having a dental visit was 30.4% (range: 16.2% [Arkansas]–38.4% [Vermont]) (Table 4).

Prevalence was highest among women aged ≥ 35 years (mean: 41.1%; range: 26.6% [Mississippi]–53.0% [Vermont]) and among white women (mean: 33.2%; range: 19.3% [Arkansas]–40.8% [Michigan]). Prevalence also was highest among women whose pregnancy was intended (mean: 35.2%; range: 21.3% [Arkansas]–43.3% [Vermont]), and women with private health insurance at delivery (mean: 41.5%; range: 27.2% [Alaska]–48.8% [Michigan]) (Table 31).

Enrollment in WIC

Respondents were asked if they had used WIC services for their new infant by the time the survey was conducted (2–9 months postpartum). Information was available for four reporting areas (Illinois, Maine, Michigan, and West Virginia). In 2004, for all four reporting areas combined, mean prevalence of women using WIC services for their new infants was 48.6% (range: 42.7% [Maine]–63.0% [West Virginia]) (Table 4).

Prevalence was highest among women aged < 20 years (mean: 90.7%; range: 79.9% [Maine]–92.6% [West Virginia]). Prevalence was higher among black women (mean: 82.0%; range: 79.5% [Michigan]–83.7% [Illinois]) and Hispanic women (mean: 78.7%; range: 71.1% [Michigan]–80.2% [Illinois]) than among white women (mean: 35.0%; range: 26.3% [Illinois]–63.0% [West Virginia]) and women of other races (mean: 30.4%; range: 24.1% [Illinois]–38.1% [Michigan]). Prevalence was highest among women whose most recent delivery resulted from an unintended pregnancy (mean: 68.1%; range: 75.2% [West Virginia]–64.8% [Maine]) and among women who had Medicaid coverage at delivery (mean: 88.5%; range: 84.0% [Maine]–90.9% [West Virginia]) (Table 32).

Discussion

The indicators discussed in this report reflect the goals and recommendations outlined in CDC's 2006 recommendations to improve preconception health and health care in the United States (1). The results presented in this report can serve as a baseline for monitoring changes in preconception and interconception behaviors, health, and health care following implementation of the 2006 recommendations. PRAMS data

also are useful in measuring progress toward meeting *Healthy People 2010* objectives (48). In addition, certain reporting areas have used these data to report on Title V core and state-negotiated performance measures regarding preconception care (56); 23 reporting areas (14 of which were PRAMS reporting areas in 2004) have identified Title V Priority Needs focused on preconception health (57).

The findings outlined in this report indicate that a substantial proportion of women are not engaging in healthy behaviors during the preconception period. Healthier living in the preconception period can lead to better women's health and improved pregnancy outcomes. With respect to the postpartum period, results were encouraging; a smaller proportion of women were engaging in risk behaviors, and a greater percentage were using health services postpartum than were doing so preconception. However, disparities evident in the preconception period persisted into the postpartum period.

Preconception Behaviors and Experiences

Risk Behaviors and Experiences

Tobacco and alcohol use continue to be priority areas for intervention. Maternal tobacco use before pregnancy was prevalent. In the majority of reporting areas, tobacco use was highest among teenagers, white women, women whose pregnancies were unintended, and women with Medicaid coverage. Findings of high prepregnancy tobacco use among teens and white women are consistent with another population-based study that examined prenatal tobacco use utilizing birth certificate data (58).

Current medical guidelines advise against any alcohol use around the time of conception and throughout pregnancy; no amount of alcohol consumption is known to be safe, and any alcohol use puts a woman at elevated risk for having a FAS infant (59). The results outlined in this report indicate that alcohol use in the 3 months before pregnancy is common. This finding is consistent with data cited previously (60–62). Additional interventions are needed to make women aware of the potential harm to the fetus that can be caused by alcohol use during early gestation, before a woman might be aware that she is pregnant. Preconception care should include counseling strategies that emphasize these risks and the provision and use of effective contraception.

Physical abuse can result not only in trauma to a woman and to a fetus if she is pregnant but also in high levels of stress and other risk behaviors that could adversely affect maternal health and pregnancy outcomes (e.g., tobacco, alcohol and drug use; late entry into prenatal care; and preterm labor and low birth weight) (63–66). This report indicates a low overall

prevalence of physical abuse before pregnancy, similar to other studies (67). Women most likely to report abuse and high levels of stress were those aged <20 years, black women, women with unintended pregnancies, and women who were Medicaid recipients before pregnancy. Preconception care counseling should include screening to identify women who might have experienced abuse and provide referrals and access to other resources.

Adequate folic acid consumption has been proven to be an effective preventative measure that reduces the occurrence of NTDs (18). However, only 35.1% of women took a multivitamin or prenatal vitamin four or more times a week in the month prior to pregnancy. The findings provided in this report are consistent with a state study and a national study that reported a higher prevalence of multivitamin use among older women and white women (68,69).

The consistent and correct use of effective contraception is central to all of these interventions. Providing women the ability to plan pregnancies so health promotion interventions can be implemented contributes to positive outcomes. Planned pregnancies have been demonstrated to result in better outcomes for women and their infants (70). However, only half of women who were not trying to become pregnant were using contraception.

CDC recommends that risk assessment and health education be a part of primary care visits for women of reproductive age and that a prepregnancy check-up be incorporated as a component of maternity care that is covered by insurance (1). Results from this report indicate that few women are benefiting from such preventive services; less than one third of women reported that they had talked to a health-care provider about preparing for a healthy pregnancy. Expanding access to preconception counseling by a health-care provider is critical to achieve the goal of allowing all women to enter pregnancy in optimal health.

Another important indicator of access to preventive services is the use of oral health-care services. Good oral health and dental visits before pregnancy might help reduce the number of preterm births and low birth weight infants (37–39). More than three fourths of women in PRAMS reporting areas that assessed prepregnancy dental visits had been to a dentist at some point before their most recent pregnancy. Similar to other health-care service indicators, prevalence varied by maternal characteristics, with high-risk groups having the lowest level of service utilization.

Preconception Health Conditions

In addition to addressing risk behaviors, an aim of preconception care is to identify and provide appropriate manage-

ment of chronic diseases that might affect women's health during and after pregnancy and have a lifetime impact on infants. The results of this analysis confirm that a substantial proportion of women have medical conditions in the preconception period that could have an adverse effect on pregnancy outcomes. Among prepregnancy medical conditions studied, the highest prevalence was for being overweight and underweight, followed by having anemia, asthma, hypertension, and diabetes. Prevalence of these chronic conditions varied by maternal characteristics. Similar findings have been reported among the general population, with higher rates among minority women and those with low incomes (71). Although PRAMS data cannot be used to assess whether these factors are being medically managed in the preconception period, they highlight the importance of women receiving quality care before pregnancy and the need for proper management of chronic diseases before pregnancy occurs.

Postpartum Behaviors and Experiences

The interconception period provides an opportunity to identify and address known risk factors from prior pregnancies (e.g., a previous infant death, fetal loss, low birth weight, or preterm birth) and to implement interventions to reduce the risk for women experiencing the same adverse pregnancy outcome again. Interventions can be targeted to women with a previous adverse outcome and those with risk factors such as tobacco use, low folic acid intake, alcohol use, obesity, and diabetes. The findings in this report underscore the importance of interconception care, especially for women with previous adverse outcomes.

Risk Behaviors and Experiences

The same risk behaviors (e.g., smoking and not using contraception) and protective behaviors (e.g., visiting a health-care provider) often continue (or resume) in the postpartum period. In general, this report demonstrates that negative behaviors are less prevalent in the postpartum period than in the prepregnancy period. Even so, postpartum health-care visits offer another opportunity to address medical risk factors, promote behavioral change, provide prevention services, and link women with appropriate clinical and public health programs.

For example, preventing tobacco use in the postpartum period might improve future reproductive outcomes; tobacco use during pregnancy is a risk factor for multiple complications, including placenta previa, abruption placentae, preterm birth, and low birth weight (3,4,72). Women who smoke could benefit from interconception clinical and public health services on tobacco use cessation to reduce risks to them, their infants, and to future children should they become pregnant again.

Similarly, use of effective contraception is an important determinant of unintended pregnancy, and offering contraception services to women postpartum is important for planning future pregnancies. Birth spacing has been demonstrated repeatedly to reduce adverse events for women and infants (73), and almost 90% of women reported using some form of contraception in the 2–9 months after delivery.

Postpartum depression threatens a woman's health and the social, emotional, and cognitive development of her child (74). Thus, identifying and treating postpartum depression in the interconception period is important for the mother and her family. The data presented in this report indicate that 15.7% of women with recent deliveries reported experiencing symptoms of postpartum depression; this percentage is slightly higher than other estimates of postpartum depression (75). If women are screened for postpartum depression at a postpartum health-care visit, numerous treatment options that are available can be offered (76).

More than three fourths of women reported using postpartum health services. At least 85% of women in 10 reporting areas attended a postpartum check up, and over three fourths of women in four reporting areas received postpartum contraceptive counseling. This represents an important opportunity for health-care providers to reach women during the interconception period.

Poor Birth Outcomes

The data presented in this report indicate that as many as one in 10 women have had a poor birth outcome and are candidates for interventions to improve maternal health during the interconception period. These findings are similar to national estimates published by the National Center for Health Statistics (77). Certain subgroups of women (i.e., black women, women whose most recent pregnancy was unintended, and those who had Medicaid coverage before pregnancy or at delivery) displayed higher rates of previous low birth weight and preterm deliveries. This finding underscores the need for preconception clinical and public health services and programs targeted towards subpopulations of women who are identified to be at risk for poor birth outcomes.

Disparities

The data presented in this report indicate the existence of disparities by maternal characteristics, particularly differences in behaviors, health conditions, and utilization of care. For each indicator studied, results varied by age group, race/ethnicity, pregnancy intention, and health insurance status; no one group was consistently at highest risk.

For example, white women reported the highest prevalence of prepregnancy and postpartum tobacco use and prepregnancy alcohol use. Women aged <20 years had the highest prevalence of many risk behaviors and health conditions (e.g., tobacco use before and after pregnancy, experiencing abuse and high levels of stress before pregnancy, being underweight, being anemic, and experiencing postpartum symptoms of depression) examined in this report. Conversely, these women were more likely to have postpartum contraceptive use counseling and use contraceptives postpartum. Women aged 20–34 years and women aged ≥ 35 years had higher prevalence of being overweight and obese than women aged <20 years. Older women, particularly those aged ≥ 35 years, also had the highest prevalence of protective behaviors such as taking a multivitamin before pregnancy and utilizing health services (e.g., dental visits, preconception health counseling, and postpartum visits). These findings are similar to those reported previously (69,78).

Black women reported the highest prevalence of prepregnancy stress, overweight, hypertension, anemia, and giving birth to recent low birth weight infants and preterm infants. Black and Hispanic women were more likely than white women and women of other races to experience prepregnancy physical abuse, prepregnancy diabetes, and the birth of a previous low birth weight infant. Such differences have been reported previously (79–81). Culturally appropriate interventions to improve preconception and interconception health care among minority women should be explored as a mechanism to reduce persistent disparities in maternal and infant health (82,83).

Women with an unintended pregnancy had consistently higher prevalences for negative behaviors, experiences, and conditions. These findings are consistent with the results from other studies on unintended pregnancy (70,84). Because women who have received preconception health promotion interventions are more likely to have intended pregnancies (85), women should be encouraged to work with their partners, health-care providers, and public health programs to implement a reproductive life plan to ensure optimal timing and health for pregnancy (1).

Women with private health insurance were more likely to report positive behaviors and experiences, including multivitamin use, postpartum social support, and access to services (e.g., prepregnancy and postpartum dental visits, prepregnancy health counseling, postpartum check-up, and postpartum contraceptive counseling). Medicaid and other funding programs can play an important role in addressing the access gap and providing continuity of care. A lack of financial coverage for the health-care component of preconception care is a major barrier to implementation. Women with Medicaid

coverage before the current pregnancy might constitute a high-risk population that can be targeted for preconception care services such as screening and counseling (86).

Limitations

The findings presented in this report are subject to a number of limitations. First, because PRAMS does not have data on all reproductive-age women, only on women who recently gave birth to a live infant in the selected PRAMS reporting areas, the prevalence estimates for indicators in this report cannot be generalized to the entire population of reproductive-age women. Second, the data reflect only certain behaviors and risks shortly before, during, and after pregnancy; the 28 indicators discussed in this report do not represent the universe of measures related to preconception and interconception care. Preconception indicators focus only on the 1–12 months before pregnancy, and interconception indicators are based on postpartum behaviors and experiences 2–9 months after the birth of a live infant. This is a period when behaviors might change because of pregnancy intention and heightened concerns about health. The value of the data for monitoring the impact of interventions might be limited by the short timeframe of data collection; however observing changes in risk factors in the time surrounding pregnancy might provide information about the impact of population-based interventions. Third, PRAMS does not collect data on men, who are important contributors to reproductive health. Fourth, PRAMS survey data are self-reported, so negative behaviors might be underestimated and positive behaviors overestimated; variables such as height, weight, or reported medical conditions cannot be confirmed. Finally, limitations exist with respect to certain indicators. For example, the prepregnancy dental question does not specify during what period before pregnancy a woman might have visited the dentist. For the diabetes indicator, preliminary results from a PRAMS questionnaire evaluation have demonstrated that women do not differentiate well between the two questions on the PRAMS survey related to prepregnancy diabetes and gestational diabetes, resulting in ambiguity as to whether women had prepregnancy or gestational diabetes (Research Triangle Institute, unpublished data, 2007). This is important to note because recommendations for care of women with prepregnancy and gestational diabetes differ (25). Regarding WIC enrollment, what percentage of women were actually eligible for these services is not known. Despite these limitations, PRAMS data are a valuable source of information regarding maternal and infant health indicators, many of which are not collected elsewhere.

Conclusions

Targeted and accessible public health and clinical services are needed to improve women's health and the health of their infants. The findings discussed in this report document the need for clinical and public health preconception and interconception services to ensure that all women have access to health care and are able to enjoy the potential benefits of evidence-based interventions.

PRAMS data have been used previously to gain support for a wide range of programs and initiatives aimed at improving the health of women and infants around the time of pregnancy, not only in the preconception and interconception periods (87). The data presented in this report can be used to track progress in implementing CDC's 2006 recommendations to improve preconception health and health care and to identify areas in need of policy and programmatic improvements. Further analyses are needed to better understand the impact of specific indicators on health outcomes for women and their infants.

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TABLE 1. Preconception and interconception health indicators — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas,* 2004

Period	Definition	Table No.	No. areas
Preconception behavior and experience			
Tobacco use	Reported cigarette smoking during the 3 months before pregnancy, among women who reported smoking at least 100 cigarettes during the previous 2 years	2, 5	26
Alcohol use	Reported drinking during the 3 months before pregnancy, among women who reported consuming alcohol during the previous 2 years	2, 6	26
Multivitamin use	Reported taking a multivitamin ≥ 4 times per week during the month before pregnancy	2, 7	26
Nonuse of contraception	Reported not using contraception at time of conception, among women reporting that they were not trying to become pregnant	2, 8	26
Dental visit	Reported having teeth cleaned by a dentist or dental hygienist sometime before most recent pregnancy	2, 9	10 [†]
Health counseling	Reported talking to a health-care worker to prepare for a healthy pregnancy and baby	2, 10	5 [§]
Physical abuse	Reported having been pushed, hit, slapped, kicked, choked, or physically hurt in any way by a husband or partner during the 12 months before pregnancy	2, 11	26
Stress	Reported experiencing at least four stresses during the 12 months before birth of new baby	2, 12	26
Preconception health condition			
Underweight	Prepregnancy body mass index (BMI) <19.8 calculated from self-reported prepregnancy height and weight	3, 13	26
Overweight	Prepregnancy BMI of 26.0–29.0 calculated from self-reported prepregnancy height and weight	3, 14	26
Obesity	Prepregnancy BMI >29.0 calculated from self-reported prepregnancy height and weight	3, 15	26
Diabetes	Reported high blood sugar or diabetes that started before most recent pregnancy	3, 16	26
Asthma	Reported asthma before pregnancy	3, 17	4 [¶]
Hypertension	Reported hypertension before pregnancy	3, 18	4 [¶]
Heart problem	Reported heart problem before pregnancy	3, 19	4 [¶]
Anemia	Reported anemia before pregnancy	3, 20	4 [¶]
Previous low birth weight infant	Reported birth to a baby weighing <2.5 kilos or <5 lbs 8 oz before most recent birth	3, 21	26
Previous preterm infant	Reported birth of baby >3 weeks earlier than due date before most recent birth	3, 22	26
Interconception behavior and experience			
Tobacco use	Reported cigarette smoking at time of survey (2–9 months postpartum), among women who reported smoking at least 100 cigarettes during the previous 2 years	4, 23	26
Contraceptive use	Reported doing something to keep from becoming pregnant at time of survey (2–9 months postpartum)	4, 24	26
Depression	Reported “always or often” feeling down, depressed, or hopeless, or “always or often” having little interest in doing things since birth of new baby	4, 25	16 ^{**}
Social support	Reported having at least three kinds of help available since birth of new baby	4, 26	3 ^{††}
Recent low birth weight infant	New baby birth weight of <2,500 g according to birth certificate	4, 27	26
Recent preterm infant	New baby born at <37 weeks' gestation according to birth certificate	4, 28	26
Check-up	Reported having had a check-up since birth of new baby	4, 29	10 ^{§§}
Contraceptive use counseling	Reported talking with a health-care worker about birth control since birth of new baby	4, 30	4 ^{¶¶}
Dental visit	Reported having teeth cleaned by a dentist or dental hygienist since birth of a new baby	4, 31	10 [†]
WIC ^{***}	Reported receiving WIC for new baby	4, 32	4 ^{†††}

* Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, New York City, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Washington, and West Virginia.

† Alaska, Arkansas, Maine, Michigan, Mississippi, Nebraska, South Carolina, Utah, Vermont, and Washington.

§ Louisiana, Maine, New Jersey, Utah, and Vermont.

¶ Florida, Maryland, Minnesota, and West Virginia.

** Alaska, Colorado, Georgia, Hawaii, Maine, Maryland, Minnesota, Nebraska, North Carolina, New Mexico, Oregon, Rhode Island, South Carolina, Utah, Vermont, and Washington.

†† North Carolina, Oklahoma, and Rhode Island.

§§ Arkansas, Georgia, Hawaii, Minnesota, New Jersey, New York City, Rhode Island, South Carolina, Vermont, and West Virginia.

¶¶ Colorado, Illinois, New York City, and Utah.

*** Special Supplemental Nutrition Program for Women, Infants, and Children.

††† Illinois, Maine, Michigan, and West Virginia.

TABLE 2. Prevalence of maternal prepregnancy behaviors and experiences — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Tobacco use		Alcohol use		Multivitamin use		Contraceptive nonuse*		Dental visit		Health counseling		Physical abuse		Stress	
	%	(CI) [†]	%	(CI)	%	(CI)	%	(CI)	%	(CI)	%	(CI)	%	(CI)	%	(CI)
Alaska	30.9	(±3.0)	53.3	(±3.4)	34.3	(±3.2)	54.2	(±4.7)	74.1	(±2.8)	— [§]		4.3	(±1.2)	17.9	(±2.5)
Arkansas	34.5	(±2.8)	48.4	(±2.9)	26.7	(±2.6)	53.2	(±3.9)	68.3	(±2.8)	—		7.3	(±1.6)	29.0	(±2.7)
Colorado	21.3	(±2.6)	61.8	(±3.1)	37.5	(±3.0)	53.8	(±4.7)	—	—	—		2.8	(±1.1)	17.0	(±2.4)
Florida	22.1	(±2.7)	48.2	(±3.0)	31.6	(±2.9)	55.4	(±3.9)	—	—	—		3.1	(±1.0)	19.4	(±2.4)
Georgia [¶]	19.4	(±2.9)	41.2	(±3.4)	37.1	(±3.3)	47.5	(±4.6)	—	—	—		3.4	(±1.2)	18.7	(±2.6)
Hawaii	20.6	(±1.8)	42.1	(±2.1)	39.3	(±2.1)	54.0	(±3.1)	—	—	—		3.1	(±0.8)	14.0	(±1.6)
Illinois	22.3	(±2.0)	54.6	(±2.4)	35.9	(±2.3)	50.5	(±3.6)	—	—	—		4.0	(±1.0)	19.0	(±1.9)
Louisiana	28.2	(±2.5)	54.4	(±2.8)	28.5	(±2.5)	55.7	(±3.6)	—	—	24.1	(±2.3)	4.5	(±1.2)	23.8	(±2.4)
Maine	31.0	(±3.1)	62.4	(±3.2)	40.8	(±3.2)	52.5	(±5.0)	79.6	(±2.8)	34.8	(±3.1)	2.2	(±1.0)	18.4	(±2.6)
Maryland	20.3	(±3.2)	50.9	(±3.8)	39.0	(±3.6)	58.6	(±5.5)	—	—	—		4.6	(±1.7)	14.9	(±2.8)
Michigan	31.7	(±3.0)	57.9	(±3.1)	36.5	(±3.0)	52.0	(±4.6)	81.0	(±2.6)	—		2.5	(±0.9)	19.0	(±2.5)
Minnesota	27.6	(±2.9)	65.7	(±3.1)	41.4	(±3.2)	56.1	(±5.0)	—	—	—		3.4	(±1.2)	13.1	(±2.2)
Mississippi	21.4	(±2.7)	37.4	(±3.2)	32.7	(±3.1)	47.4	(±4.2)	74.7	(±3.0)	—		4.8	(±1.4)	23.9	(±2.8)
Nebraska	26.1	(±2.5)	60.1	(±2.6)	37.0	(±2.6)	54.7	(±3.8)	76.5	(±2.3)	—		3.9	(±1.0)	18.4	(±2.1)
New Jersey	16.7	(±1.5)	48.8	(±2.2)	40.0	(±2.3)	56.4	(±3.4)	—	—	34.7	(±2.2)	3.4	(±0.8)	13.8	(±1.5)
New Mexico	20.7	(±2.2)	48.9	(±2.7)	32.1	(±2.5)	53.6	(±3.6)	—	—	—		5.8	(±1.2)	20.6	(±2.1)
New York City ^{**}	14.2	(±3.1)	36.1	(±4.3)	33.5	(±4.2)	56.4	(±6.2)	—	—	—		3.7	(±1.7)	13.6	(±3.1)
North Carolina	26.7	(±2.8)	47.6	(±3.1)	31.5	(±2.8)	52.6	(±4.4)	—	—	—		4.7	(±1.4)	18.2	(±2.4)
Oklahoma	31.8	(±3.5)	51.7	(±3.7)	29.0	(±3.3)	55.2	(±5.0)	—	—	—		5.1	(±1.7)	26.7	(±3.4)
Oregon	23.6	(±3.3)	51.4	(±3.5)	37.4	(±3.5)	50.2	(±5.4)	—	—	—		2.7	(±1.2)	20.1	(±2.9)
Rhode Island	22.2	(±2.6)	59.1	(±2.9)	43.6	(±3.0)	52.4	(±4.5)	—	—	—		2.9	(±1.0)	15.5	(±2.2)
South Carolina	24.7	(±3.6)	44.9	(±4.1)	31.6	(±3.7)	48.9	(±5.7)	78.8	(±3.5)	—		3.4	(±1.5)	22.5	(±3.5)
Utah	12.3	(±1.5)	25.3	(±2.2)	40.1	(±2.5)	50.4	(±4.0)	79.5	(±1.9)	26.9	(±2.3)	2.8	(±0.8)	13.7	(±1.6)
Vermont	29.8	(±2.8)	66.8	(±2.9)	41.3	(±2.9)	51.6	(±4.8)	84.2	(±2.3)	33.2	(±2.8)	3.4	(±1.2)	18.2	(±2.4)
Washington	19.8	(±2.9)	54.6	(±3.3)	36.3	(±3.3)	54.9	(±5.1)	77.1	(±2.7)	—		2.5	(±0.8)	15.5	(±2.5)
West Virginia ^{**}	39.5	(±4.7)	42.4	(±4.8)	28.2	(±4.4)	55.3	(±6.4)	—	—	—		4.7	(±2.0)	20.6	(±3.8)
Total	23.2	(±0.7)	50.1	(±0.8)	35.1	(±0.7)	53.1	(±1.1)	77.8	(±1.1)	30.3	(±1.3)	3.6	(±0.3)	18.5	(±0.6)

* Among women who were not trying to become pregnant.

[†] 95% confidence interval.[§] Data not collected.[¶] Represents births during February–December 2004.^{**} Represents births during July–December 2004.

TABLE 3. Prevalence of prepregnancy health conditions and previous poor birth outcomes — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Underweight		Overweight		Obesity		Diabetes		Asthma	Hypertension	Heart problem	Anemia	Previous birth							
	%	(CI) [†]	%	(CI)	%	(CI)	%	(CI)					LBW* infant	Preterm infant						
													% (CI)	% (CI)						
Alaska	11.1	(±2.3)	13.3	(±2.3)	22.6	(±2.8)	2.0	(±0.9)	— [§]	—	—	—	8.0	(±2.2)	13.2	(±2.9)				
Arkansas	17.0	(±2.3)	13.4	(±2.0)	26.6	(±2.7)	3.0	(±1.0)	—	—	—	—	12.8	(±2.5)	14.0	(±2.6)				
Colorado	15.3	(±2.3)	12.4	(±2.2)	17.4	(±2.6)	1.2	(±0.8)	—	—	—	—	11.6	(±2.8)	11.9	(±2.7)				
Florida	15.4	(±2.3)	13.8	(±2.3)	19.6	(±2.4)	1.4	(±0.7)	6.1	(±1.5)	2.2	(±0.8)	1.4	(±0.7)	11.1	(±1.8)				
Georgia [¶]	11.5	(±2.2)	11.9	(±2.3)	24.4	(±3.0)	2.7	(±1.2)	—	—	—	—	15.0	(±3.1)	12.3	(±2.9)				
Hawaii	16.6	(±1.6)	11.3	(±1.4)	18.6	(±1.7)	2.1	(±0.6)	—	—	—	—	10.2	(±1.8)	11.5	(±1.9)				
Illinois	12.6	(±1.7)	14.1	(±1.8)	20.5	(±2.0)	1.5	(±0.6)	—	—	—	—	11.8	(±2.0)	13.3	(±2.2)				
Louisiana	15.0	(±2.0)	11.3	(±1.7)	26.4	(±2.5)	1.9	(±0.7)	—	—	—	—	13.1	(±2.5)	12.9	(±2.5)				
Maine	11.0	(±2.1)	12.7	(±2.2)	22.5	(±2.8)	1.0	(±0.6)	—	—	—	—	5.7	(±1.9)	9.1	(±2.4)				
Maryland	14.2	(±2.8)	12.3	(±2.5)	23.7	(±3.3)	1.9	(±1.0)	8.2	(±2.1)	2.2	(±0.9)	1.0	(±0.7)	12.3	(±2.5)				
Michigan	11.6	(±2.0)	13.3	(±2.2)	26.5	(±2.8)	2.0	(±0.9)	—	—	—	—	9.7	(±2.5)	10.1	(±2.5)				
Minnesota	12.8	(±2.2)	12.5	(±2.2)	19.9	(±2.6)	1.6	(±0.9)	7.6	(±1.7)	1.7	(±0.9)	0.4	(±0.4)	5.2	(±1.4)				
Mississippi	13.3	(±2.2)	14.3	(±2.4)	25.3	(±2.9)	2.8	(±1.0)	—	—	—	—	14.9	(±3.1)	16.7	(±3.2)				
Nebraska	12.6	(±1.9)	12.0	(±1.8)	21.7	(±2.3)	1.7	(±0.7)	—	—	—	—	8.9	(±1.9)	11.4	(±2.3)				
New Jersey	11.7	(±1.6)	12.6	(±1.6)	18.7	(±1.9)	1.5	(±0.5)	—	—	—	—	11.5	(±2.0)	13.5	(±2.1)				
New Mexico	12.6	(±1.9)	13.8	(±1.9)	22.9	(±2.3)	2.0	(±0.7)	—	—	—	—	10.6	(±2.1)	11.0	(±2.1)				
New York City ^{**}	12.7	(±3.0)	15.0	(±3.3)	18.5	(±3.7)	2.5	(±1.3)	—	—	—	—	14.2	(±4.3)	10.1	(±3.6)				
North Carolina	14.2	(±2.2)	13.0	(±2.2)	23.9	(±2.8)	2.9	(±1.0)	—	—	—	—	14.1	(±2.9)	11.1	(±2.5)				
Oklahoma	13.6	(±2.7)	11.4	(±2.3)	23.2	(±3.2)	1.3	(±0.7)	—	—	—	—	9.8	(±2.9)	12.0	(±3.1)				
Oregon	11.0	(±2.3)	14.2	(±2.7)	22.1	(±3.2)	1.3	(±0.7)	—	—	—	—	8.3	(±2.5)	11.4	(±3.1)				
Rhode Island	11.3	(±2.0)	14.6	(±2.2)	20.0	(±2.5)	1.2	(±0.6)	—	—	—	—	9.4	(±2.2)	10.9	(±2.4)				
South Carolina	10.8	(±2.5)	14.2	(±3.0)	24.4	(±3.6)	1.8	(±1.0)	—	—	—	—	10.9	(±3.3)	12.3	(±3.6)				
Utah	15.7	(±1.9)	11.0	(±1.6)	15.7	(±1.9)	1.3	(±0.6)	—	—	—	—	9.3	(±1.7)	8.9	(±1.7)				
Vermont	11.2	(±1.9)	11.8	(±1.9)	20.5	(±2.5)	1.2	(±0.6)	—	—	—	—	7.0	(±2.1)	9.0	(±2.3)				
Washington	11.1	(±2.2)	13.5	(±2.4)	22.3	(±3.1)	0.9	(±0.5)	—	—	—	—	10.7	(±2.8)	11.1	(±2.9)				
West Virginia ^{**}	14.6	(±3.2)	12.0	(±3.2)	25.9	(±4.3)	5.7	(±2.4)	10.8	(±2.9)	4.0	(±1.9)	3.0	(±1.6)	9.3	(±2.8)				
Total	13.2	(±0.5)	13.1	(±0.5)	21.9	(±0.7)	1.8	(±0.2)	6.9	(±1.0)	2.2	(±0.5)	1.2	(±0.4)	10.2	(±1.2)	11.6	(±0.7)	11.9	(±0.6)

* Low birth weight.

† 95% confidence interval.

§ Data not collected.

¶ Represents births during February–December 2004.

** Represents births during July–December 2004.

TABLE 4. Prevalence of postpartum maternal behaviors and experiences — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Tobacco use		Contraceptive use		Depression		Social support		Recent birth		Check-up		Contraceptive use counseling		Dental visit		WIC†			
	%	(CI)§	%	(CI)	%	(CI)	%	(CI)	LBW* infant	Preterm infant	%	(CI)	%	(CI)	%	(CI)	%	(CI)		
Alaska	23.6	(±2.7)	84.0	(±2.4)	16.6	(±2.5)	— [¶]	—	5.3	(±0.1)	9.0	(±1.5)	—	—	19.9	(±2.7)	—	—		
Arkansas	28.6	(±2.6)	88.7	(±1.9)	—	—	—	—	8.2	(±0.1)	10.7	(±1.3)	84.9	(±2.1)	16.2	(±2.2)	—	—		
Colorado	15.3	(±2.2)	87.1	(±2.2)	15.0	(±2.3)	—	—	8.2	(±0.2)	9.1	(±1.3)	—	92.0	(±1.7)	—	—	—		
Florida	16.1	(±2.4)	84.1	(±2.3)	—	—	—	—	7.7	(±0.1)	11.5	(±1.6)	—	—	—	—	—	—		
Georgia**	14.8	(±2.6)	85.0	(±2.5)	17.2	(±2.6)	—	—	8.4	(±0.6)	12.2	(±1.8)	88.8	(±2.2)	—	—	—	—		
Hawaii	13.1	(±1.5)	78.4	(±1.8)	16.8	(±1.6)	—	—	6.3	(±1.0)	10.0	(±1.3)	88.3	(±1.5)	—	—	—	—		
Illinois	17.1	(±1.8)	86.0	(±1.7)	—	—	—	—	7.3	(±0.1)	10.9	(±1.2)	—	90.6	(±1.4)	—	—	48.7	(±2.5)	
Louisiana	23.4	(±2.4)	87.3	(±1.9)	—	—	—	—	10.7	(±1.6)	13.3	(±1.8)	—	—	—	—	—	—		
Maine	24.5	(±2.9)	89.2	(±2.0)	11.1	(±2.1)	—	—	5.6	(±0.1)	9.2	(±1.5)	—	—	27.1	(±3.1)	42.7	(±3.3)		
Maryland	16.3	(±2.9)	80.5	(±3.0)	15.2	(±2.8)	—	—	8.1	(±0.2)	11.0	(±1.8)	—	—	—	—	—	—		
Michigan	25.6	(±2.8)	85.4	(±2.3)	—	—	—	—	7.3	(±0.2)	9.1	(±1.4)	—	—	36.7	(±3.2)	48.1	(±3.1)		
Minnesota	21.4	(±2.7)	85.0	(±2.4)	12.7	(±2.2)	—	—	5.0	(±1.4)	7.9	(±1.7)	90.1	(±2.0)	—	—	—	—		
Mississippi	17.7	(±2.5)	89.5	(±2.1)	—	—	—	—	10.5	(±0.2)	13.4	(±1.7)	—	—	24.8	(±3.0)	—	—		
Nebraska	20.8	(±2.3)	87.3	(±1.8)	14.3	(±1.8)	—	—	5.7	(±1.3)	8.4	(±1.5)	—	—	30.4	(±2.7)	—	—		
New Jersey	12.0	(±1.2)	78.7	(±1.9)	—	—	—	—	7.5	(±1.2)	10.2	(±1.4)	89.6	(±1.4)	—	—	—	—		
New Mexico	14.5	(±1.9)	84.5	(±2.0)	19.5	(±2.1)	—	—	8.0	(±1.5)	9.1	(±1.5)	—	—	—	—	—	—		
New York City††	11.7	(±2.9)	76.4	(±3.7)	—	—	—	—	7.9	(±0.2)	10.2	(±2.0)	89.5	(±2.7)	78.5	(±3.6)	—	—		
North Carolina	20.7	(±2.6)	87.1	(±2.1)	17.7	(±2.4)	85.0	(±2.2)	8.1	(±0.1)	10.6	(±1.4)	—	—	—	—	—	—		
Oklahoma	26.3	(±3.3)	87.9	(±2.4)	—	—	84.1	(±2.7)	7.2	(±0.1)	9.4	(±1.6)	—	—	—	—	—	—		
Oregon	17.8	(±3.0)	87.3	(±2.4)	13.2	(±2.3)	—	—	5.2	(±0.4)	8.3	(±1.6)	—	—	—	—	—	—		
Rhode Island	16.6	(±2.3)	85.9	(±2.1)	13.4	(±2.0)	86.0	(±2.0)	7.4	(±0.1)	9.6	(±1.3)	93.8	(±1.5)	—	—	—	—		
South Carolina	19.2	(±3.3)	89.3	(±2.6)	19.6	(±3.4)	—	—	9.3	(±0.2)	10.6	(±1.8)	90.5	(±2.5)	—	30.1	(±3.9)	—		
Utah	8.7	(±1.3)	89.2	(±1.6)	14.8	(±1.7)	—	—	5.8	(±0.1)	8.7	(±1.1)	—	91.9	(±1.4)	31.4	(±2.6)	—		
Vermont	22.8	(±2.6)	88.6	(±1.9)	12.2	(±2.0)	—	—	5.6	(±0.1)	7.9	(±1.3)	92.7	(±1.6)	—	38.4	(±3.1)	—		
Washington	14.6	(±2.6)	86.2	(±2.3)	13.5	(±2.3)	—	—	4.8	(±1.5)	8.7	(±2.0)	—	—	31.7	(±3.5)	—	—		
West Virginia††	33.5	(±4.5)	81.4	(±3.8)	—	—	—	—	8.9	(±0.1)	12.4	(±2.4)	86.8	(±3.2)	—	—	—	63.0	(±4.7)	
Total	17.9	(±0.6)	85.1	(±0.6)	15.7	(±0.8)	84.8	(±1.7)	7.5	(±0.1)	10.4	(±0.4)	89.3	(±0.8)	89.0	(±1.0)	30.4	(±1.3)	48.6	(±1.8)

* Low birth weight.

† Special Supplemental Nutrition Program for Women, Infants, and Children.

§ 95% confidence interval.

¶ Data not collected.

** Represents births during February–December 2004.

†† Represents births during July–December 2004.

TABLE 9. Prevalence of prepregnancy dental visit, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 10 reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity [†]				Pregnancy intention		Prepregnancy insurance status											
	<20		20–34		≥35		White		Black		Hispanic		Intended	Unintended	Private	Medicaid	None							
	%	(±CI) [§]	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)						
Alaska	75.7	(8.4)	74.5	(3.2)	70.3	(8.3)	81.8	(3.7)	82.6 [¶]	(15.2)	57.9	(4.6)	78.1	(10.7)	79.4	(3.4)	67.9	(4.7)	81.4	(3.6)	51.7	(9.3)	68.7	(5.0)
Arkansas	72.0	(6.9)	67.0	(3.1)	76.2	(10.0)	74.3	(3.0)	61.6	(7.5)	55.2 ^{¶¶}	(23.0)	41.9	(9.7)	73.1	(3.7)	63.9	(4.0)	77.7	(3.7)	64.1	(8.7)	59.7	(4.4)
Maine	72.1	(11.9)	78.5	(3.2)	90.7	(5.2)	80.7	(2.8)	—	—	—	—	—	83.6	(3.2)	72.8	(5.2)	84.9	(3.0)	64.7	(7.3)	78.5	(7.6)	
Michigan	74.9	(9.1)	80.4	(3.0)	88.9	(5.1)	82.9	(2.8)	77.3	(7.9)	68.7 ^{¶¶}	(15.8)	73.0	(13.1)	83.0	(3.2)	77.9	(4.3)	86.3	(2.8)	75.0	(8.2)	67.8	(6.8)
Mississippi	76.5	(6.8)	75.1	(3.4)	65.2	(11.6)	82.3	(3.5)	67.4	(4.8)	—	—	—	79.2	(4.1)	71.7	(4.1)	78.7	(4.0)	72.2	(7.3)	71.0	(5.2)	
Nebraska	75.9	(7.3)	75.4	(2.6)	84.4	(5.7)	82.1	(2.7)	72.0	(5.2)	56.8	(4.9)	50.5	(5.6)	80.1	(2.8)	72.0	(3.7)	85.0	(2.5)	71.8	(7.0)	57.3	(5.3)
South Carolina	76.9	(10.4)	78.6	(4.0)	81.9	(9.7)	86.3	(3.7)	72.2	(7.1)	69.2 ^{¶¶}	(23.6)	46.7	(17.1)	82.6	(4.4)	73.8	(5.7)	85.4	(4.0)	80.5	(8.9)	66.2	(7.5)
Utah	68.5	(7.7)	79.8	(2.1)	83.8	(6.3)	85.9	(2.0)	—	—	57.7	(12.8)	48.9	(6.0)	82.9	(2.3)	72.8	(3.8)	86.7	(2.1)	67.2	(10.4)	62.1	(4.4)
Vermont	80.1	(10.3)	83.3	(2.7)	90.6	(4.5)	84.8	(2.3)	—	—	—	—	—	86.4	(2.7)	79.2	(4.6)	86.0	(2.7)	79.3	(7.1)	80.4	(6.2)	
Washington	72.1	(10.2)	76.8	(3.2)	82.3	(6.3)	87.3	(3.5)	69.5	(6.7)	70.9	(5.6)	47.3	(6.2)	80.5	(3.1)	71.1	(5.2)	86.0	(3.1)	73.9	(9.4)	58.8	(5.9)
Total	74.4	(3.5)	77.4	(1.2)	83.7	(2.7)	83.4	(1.2)	71.3	(3.4)	66.0	(4.2)	52.4	(3.9)	81.3	(1.3)	72.9	(1.8)	84.9	(1.2)	73.1	(3.5)	64.4	(2.3)

* Data on this question were not collected by 15 states (Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Minnesota, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, and West Virginia) and New York City.

† White = non-Hispanic white; Black = non-Hispanic black; and Other = non-Hispanic Other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

¶¶ Represents <30 respondents; data not reported.

TABLE 10. Prevalence of prepregnancy health counseling, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, five reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity [†]				Pregnancy intention		Prepregnancy insurance status											
	<20		20–34		≥35		White		Black		Hispanic		Intended	Unintended	Private	Medicaid	None							
	%	(±CI) [§]	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)						
Louisiana	14.6	(5.6)	24.1	(2.6)	37.0	(8.0)	29.5	(3.1)	16.2	(3.4)	20.3 ^{¶¶}	(14.6)	20.6 ^{¶¶}	(12.6)	41.4	(3.8)	8.8	(2.2)	38.0	(3.7)	15.7	(6.0)	9.8	(2.6)
Maine	11.9	(8.1)	35.6	(3.5)	43.7	(8.7)	34.9	(3.1)	—	—	—	—	—	46.6	(4.0)	12.8	(3.8)	43.9	(4.0)	19.1	(5.7)	18.8	(6.8)	
New Jersey	20.7	(7.4)	33.2	(2.6)	44.8	(5.4)	41.6	(3.7)	33.2	(4.9)	39.3	(5.4)	19.6	(3.6)	46.9	(3.1)	15.9	(2.8)	42.5	(2.9)	27.4	(6.6)	14.0	(3.2)
Utah	7.4	(3.7)	27.2	(2.6)	35.8	(8.6)	28.6	(2.7)	—	—	23.6	(10.4)	18.4	(4.8)	35.6	(3.2)	8.4	(2.4)	32.8	(3.1)	21.1	(9.6)	12.4	(3.1)
Vermont	12.1	(8.2)	32.4	(3.2)	46.4	(7.2)	33.5	(2.9)	—	—	—	—	—	—	46.2	(3.6)	7.3	(2.7)	42.6	(3.5)	7.3	(4.4)	13.0	(5.0)
Total	15.5	(3.6)	29.5	(1.4)	42.2	(3.8)	34.2	(1.7)	23.3	(2.8)	34.6	(4.5)	19.4	(2.9)	43.0	(1.8)	11.9	(1.5)	39.5	(1.8)	20.9	(3.6)	12.2	(1.7)

* Data not reported by 19 states (Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Washington, and West Virginia) and New York City.

† White = non-Hispanic white; Black = non-Hispanic black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

¶¶ Represents <30 respondents; data not reported.

TABLE 11. Prevalence of prepregnancy physical abuse, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Age group (yrs)						Race/Ethnicity*						Pregnancy intention		Prepregnancy insurance status				
	<20		20–34		≥35		White		Black		Other		Hispanic		Intended	Unintended	Private	Medicaid	None
	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†	% (±CI)†
Alaska	4.0 (2.3)	4.8 (1.4)	1.3 (1.3)	2.1 (1.4)	0§ (0)	8.8 (2.3)	4.4 (5.0)	2.8 (1.2)	6.3 (2.2)	1.7 (1.0)	9.9 (4.9)	6.9 (2.6)							
Arkansas	10.2 (4.3)	7.0 (1.8)	2.1 (2.1)	7.2 (1.8)	7.3 (3.6)	10.3§ (13.9)	6.9 (5.1)	5.0 (1.9)	9.4 (2.4)	4.0 (1.8)	10.5 (5.1)	9.9 (2.7)							
Colorado	6.6 (4.7)	2.7 (1.4)	0.9 (1.3)	2.3 (1.1)	0§ (0)	0.5 (1.0)	4.4 (2.8)	1.3 (0.9)	4.9 (2.5)	1.3 (0.7)	9.2 (8.7)	4.4 (2.7)							
Florida	5.7 (3.4)	2.5 (1.0)	3.8 (3.5)	2.7 (1.5)	6.3 (2.2)	2.7 (3.3)	1.4 (1.6)	1.2 (0.9)	5.2 (1.8)	1.8 (0.9)	5.6 (4.3)	4.1 (1.9)							
Georgia¶	6.1 (4.7)	3.3 (1.3)	1.7 (2.2)	1.1 (0.9)	5.7 (2.1)	0.7§ (1.3)	6.8 (5.8)	2.8 (1.5)	4.1 (1.8)	2.0 (1.1)	9.8 (5.5)	3.6 (2.3)							
Hawaii	5.0 (3.8)	3.5 (1.0)	0.9 (0.9)	1.2 (1.1)	7.9§ (8.2)	3.2 (1.0)	4.1 (2.3)	1.8 (0.8)	4.7 (1.5)	2.6 (0.8)	6.4 (4.4)	4.1 (2.4)							
Illinois	5.8 (4.4)	4.4 (1.2)	1.0 (1.2)	2.5 (1.0)	7.7 (3.5)	5.3 (5.2)	4.5 (2.1)	1.9 (0.8)	7.1 (2.1)	1.3 (0.7)	11.8 (5.2)	6.4 (2.3)							
Louisiana	5.8 (3.6)	4.5 (1.4)	2.8 (2.9)	3.2 (1.3)	6.5 (2.4)	8.4† (11.0)	2.9† (5.5)	2.7 (1.3)	6.3 (2.0)	2.1 (1.1)	10.3 (5.0)	5.7 (2.1)							
Maine	2.2 (4.1)	2.5 (1.2)	0.1 (0.1)	2.3 (1.0)	—**	—	—	0.7 (0.6)	4.9 (2.5)	1.5 (1.0)	3.6 (2.7)	3.2 (3.2)							
Maryland	7.7 (8.1)	4.8 (2.1)	2.3 (1.2)	3.7 (2.1)	3.6 (3.0)	4.3 (7.1)	11.4 (7.8)	1.7 (1.3)	9.5 (4.0)	2.3 (1.4)	15.8§ (19.3)	9.3 (4.7)							
Michigan	3.2 (3.4)	2.8 (1.0)	0.7 (0.9)	2.7 (1.1)	1.0 (1.1)	3.3§ (4.7)	4.6 (4.8)	1.4 (0.8)	4.3 (1.9)	1.5 (0.8)	6.1 (3.9)	3.8 (2.3)							
Minnesota	4.3 (4.3)	3.6 (1.4)	2.0 (2.5)	2.4 (1.2)	4.1 (1.6)	13.0 (9.1)	5.0 (6.2)	2.3 (1.3)	4.5 (2.2)	1.6 (0.9)	5.0 (3.8)	11.1 (5.7)							
Mississippi	6.9 (3.9)	4.6 (1.6)	1.8 (3.1)	3.5 (1.6)	6.4 (2.5)	†	†	4.0 (2.0)	5.6 (2.0)	2.0 (1.4)	6.6 (4.0)	7.6 (2.9)							
Nebraska	8.0 (4.9)	3.6 (1.1)	2.7 (2.7)	3.2 (1.3)	6.6 (2.8)	5.6 (2.0)	6.9 (2.7)	2.2 (1.1)	5.8 (1.9)	1.8 (1.0)	8.3 (4.1)	7.3 (2.7)							
New Jersey	7.1 (4.8)	3.3 (0.9)	2.4 (1.6)	2.0 (1.0)	3.9 (2.0)	0.5 (0.6)	6.9 (2.3)	2.1 (0.9)	5.7 (1.7)	1.8 (0.7)	6.7 (3.7)	7.0 (2.6)							
New Mexico	10.2 (4.2)	5.3 (1.3)	2.3 (2.7)	4.2 (1.7)	—	10.9 (4.9)	5.6 (1.7)	3.9 (1.4)	8.4 (2.1)	2.3 (1.3)	9.4 (3.3)	7.9 (2.3)							
New York City††	7.5† (8.9)	3.6 (2.0)	2.5 (3.3)	0.7 (1.2)	6.0 (4.4)	0.2 (0.5)	5.3 (3.4)	1.7 (1.5)	6.5 (3.6)	2.8 (2.0)	8.2 (6.8)	3.1 (2.7)							
North Carolina	6.6 (5.1)	4.9 (1.6)	1.3 (2.4)	3.6 (1.6)	5.4 (3.1)	0.3 (0.6)	9.2 (5.1)	3.0 (1.5)	6.7 (2.5)	1.7 (1.1)	9.3 (5.8)	7.7 (3.0)							
Oklahoma	10.9 (7.1)	4.3 (1.7)	3.1 (4.2)	5.5 (2.2)	3.5 (4.4)	7.2 (6.8)	2.4 (3.3)	2.2 (1.6)	7.7 (3.0)	3.8 (2.2)	19.1 (11.4)	4.0 (2.2)							
Oregon	—	3.0 (1.4)	0.9 (0.6)	2.3 (1.5)	10.9 (3.7)	3.2 (1.1)	3.0 (1.8)	0.6 (0.3)	5.9 (3.1)	0.6 (0.6)	5.8 (5.3)	5.8 (3.3)							
Rhode Island	3.2 (3.5)	3.4 (1.3)	1.1 (1.4)	2.2 (1.1)	4.3 (4.1)	2.0 (3.3)	5.9 (3.2)	1.6 (1.0)	5.1 (2.1)	1.3 (0.8)	7.9 (4.1)	5.1 (3.1)							
South Carolina	1.8 (2.5)	3.5 (1.7)	5.4 (5.6)	2.7 (1.7)	4.1 (2.9)	6.3§ (11.7)	5.8 (6.8)	2.0 (1.5)	5.3 (2.7)	1.8 (1.4)	5.5 (4.8)	5.4 (3.4)							
Utah	7.8 (4.1)	2.6 (0.9)	1.6 (2.2)	2.6 (0.9)	—	2.1 (2.4)	3.9 (2.3)	1.1 (0.7)	6.5 (2.2)	2.1 (0.9)	8.2 (6.3)	3.7 (1.7)							
Vermont	—	4.0 (1.5)	0	3.2 (1.2)	—	—	—	1.5 (1.0)	7.1 (3.3)	1.6 (1.0)	13.1 (6.6)	3.8 (3.3)							
Washington	2.4 (2.4)	2.8 (1.0)	0.3 (0.4)	1.2 (1.0)	6.7 (3.5)	5.9 (2.8)	3.5 (2.1)	0.9 (0.6)	5.6 (2.2)	1.6 (0.9)	3.5 (2.8)	4.0 (1.9)							
West Virginia††	8.6 (3.2)	4.5 (2.5)	0	4.5 (2.0)	11.2§ (19.9)	—	—	4.2 (2.6)	5.4 (3.2)	2.4 (2.0)	5.0 (5.3)	7.5 (4.2)							
Total	6.1 (1.1)	3.6 (0.3)	1.9 (0.6)	2.7 (0.3)	5.4 (0.8)	4.1 (0.9)	4.8 (0.8)	1.9 (0.3)	5.9 (0.5)	1.8 (0.2)	8.0 (1.3)	5.6 (0.6)							

* White = non-Hispanic white; Black = non-Hispanic black; and Other = non-Hispanic other.

† 95% confidence interval.

§ Represents <60 respondents; data might not be reliable.

¶ Represents births during February–December 2004.

** Represents <30 respondents; data not reported.

†† Represents births during July–December 2004.

TABLE 16. Prevalence of prepregnancy diabetes, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Age group (yrs)			Race/Ethnicity*				Pregnancy intention		Prepregnancy insurance status		
	<20	20–34	≥35	White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	None
	% (±CI) [†]	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)
Alaska	0	1.9 (1.1)	4.2 (3.3)	1.4 (1.0)	5.4 [§] (9.3)	3.3 (2.0)	0.2 (0.2)	2.6 (1.4)	0.6 (0.5)	1.4 (1.1)	2.0 (1.6)	2.9 (1.9)
Arkansas	3.4 (2.6)	2.9 (1.1)	3.8 (3.2)	2.1 (1.0)	6.4 (3.3)	0 [§]	4.6 (3.8)	3.0 (1.3)	3.1 (1.5)	1.8 (1.1)	4.0 (2.9)	4.1 (1.8)
Colorado	0.6 (1.0)	1.2 (1.0)	1.4 (1.2)	0.7 (0.4)	1.6 [§] (2.2)	1.1 (1.3)	2.0 (2.3)	0.4 (0.3)	2.2 (1.9)	0.7 (0.4)	4.5 (7.4)	1.3 (1.6)
Florida	1.2 (1.6)	1.4 (0.7)	2.1 (2.3)	1.4 (1.1)	3.1 (1.6)	0.1 (0.2)	0.6 (0.4)	1.3 (0.9)	1.7 (0.9)	1.3 (0.9)	1.7 (2.2)	1.6 (1.1)
Georgia [¶]	3.4 (4.1)	2.1 (1.2)	5.2 (4.2)	1.6 (1.4)	3.1 (1.4)	0.9 [§] (1.2)	6.5 (5.7)	2.5 (1.5)	2.6 (1.6)	0.9 (0.7)	7.8 (5.8)	4.0 (2.6)
Hawaii	2.7 (2.5)	1.8 (0.7)	3.2 (1.7)	0.9 (0.9)	2.6 [§] (4.8)	2.6 (0.8)	1.4 (1.3)	2.3 (0.9)	2.0 (0.9)	2.2 (0.7)	0.9 (1.3)	2.6 (2.0)
Illinois	2.3 (2.5)	1.3 (0.7)	1.7 (1.5)	0.7 (0.5)	2.0 (1.9)	0.3 (0.6)	3.2 (1.7)	1.1 (0.6)	2.0 (1.1)	0.7 (0.5)	1.0 (1.5)	3.4 (1.8)
Louisiana	2.7 (2.6)	1.8 (0.8)	1.8 (2.2)	1.4 (0.8)	3.0 (1.6)	0 [§]	0 [§]	1.7 (0.9)	1.9 (1.1)	1.8 (1.0)	4.7 (3.6)	1.2 (0.9)
Maine	0	1.2 (0.8)	1.0 (1.9)	1.0 (0.6)	— ^{**}	—	—	1.2 (0.9)	0.8 (0.9)	1.4 (0.9)	0.7 (1.0)	0.2 (0.2)
Maryland	2.5 (4.8)	1.7 (1.2)	2.7 (1.3)	1.3 (1.1)	1.9 (1.6)	3.7 (7.1)	4.3 (3.9)	1.6 (1.1)	2.6 (1.9)	1.5 (1.1)	0.2 [†] (0.4)	3.3 (2.3)
Michigan	5.3 (5.0)	1.0 (0.7)	5.0 (4.4)	0.7 (0.5)	5.5 (4.3)	0 [§]	9.7 (8.5)	2.1 (1.3)	1.7 (1.3)	1.7 (1.0)	5.6 (5.0)	0.8 (0.8)
Minnesota	2.2 (4.2)	1.2 (0.8)	3.2 (3.0)	1.3 (0.9)	3.4 (4.3)	4.8 (6.1)	0	1.1 (0.9)	2.5 (1.9)	1.4 (0.9)	2.1 (3.1)	1.0 (1.6)
Mississippi	1.1 (1.5)	3.2 (1.3)	3.3 (3.0)	2.8 (1.4)	2.4 (1.3)	—	—	3.7 (1.8)	1.9 (1.1)	2.3 (1.3)	4.0 (2.8)	3.0 (1.8)
Nebraska	0.4 (0.4)	1.6 (0.7)	3.3 (2.7)	1.2 (0.8)	0.6 (1.0)	2.8 (1.5)	4.7 (2.3)	1.7 (0.9)	1.7 (1.0)	1.3 (0.8)	2.2 (1.9)	2.5 (1.4)
New Jersey	0.9 (1.2)	1.6 (0.6)	1.4 (1.0)	0.5 (0.5)	3.4 (1.8)	2.3 (1.6)	2.2 (1.3)	1.4 (0.7)	1.8 (0.8)	1.3 (0.6)	2.0 (1.8)	2.1 (1.3)
New Mexico	0.7 (1.0)	1.8 (0.8)	5.8 (4.1)	1.2 (1.0)	—	3.4 (2.6)	2.1 (1.0)	2.0 (0.9)	2.1 (1.2)	1.5 (1.0)	1.5 (1.2)	3.0 (1.5)
New York City ^{††}	0.8 [§] (1.2)	2.1 (1.5)	4.4 (4.2)	0.8 (1.3)	4.1 (3.5)	0.4 (0.7)	3.1 (2.5)	3.0 (2.0)	1.8 (1.8)	2.7 (2.0)	2.1 (3.0)	2.3 (2.2)
North Carolina	3.8 (3.8)	2.2 (1.0)	7.4 (4.8)	2.2 (1.2)	5.1 (2.9)	5.0 (6.5)	2.3 (2.6)	3.0 (1.4)	2.7 (1.5)	3.3 (1.4)	4.8 (4.2)	1.8 (1.4)
Oklahoma	1.8 (3.0)	1.0 (0.7)	3.0 (4.1)	1.2 (0.9)	3.6 (4.4)	0.7 (0.7)	0.7 (0.7)	1.1 (1.0)	1.4 (1.1)	0.9 (0.8)	0.5 (0.7)	1.9 (1.4)
Oregon	0.8 (1.1)	1.3 (0.8)	1.4 (1.0)	0.7 (0.8)	2.4 (1.6)	2.4 (1.3)	2.7 (1.5)	1.5 (1.0)	0.8 (0.5)	1.2 (1.0)	1.3 (1.3)	1.4 (0.8)
Rhode Island	1.1 (1.9)	1.0 (0.7)	1.8 (1.7)	0.4 (0.4)	2.3 (2.9)	1.7 (3.2)	3.6 (2.5)	1.3 (0.8)	1.0 (0.9)	1.2 (0.8)	1.7 (1.7)	0.7 (1.1)
South Carolina	0	1.8 (1.2)	4.2 (5.2)	1.6 (1.3)	2.0 (1.8)	0 [†]	4.0 (7.0)	1.5 (1.3)	2.3 (1.8)	1.5 (1.3)	1.6 (3.0)	2.5 (2.2)
Utah	0.9 (1.1)	1.3 (0.6)	1.2 (2.1)	1.2 (0.7)	—	0	1.8 (1.3)	1.4 (0.8)	0.9 (0.8)	1.0 (0.6)	1.0 (1.1)	1.9 (1.3)
Vermont	0.6 (0.4)	1.2 (0.7)	1.4 (1.6)	1.1 (0.6)	—	—	—	1.4 (0.9)	0.9 (0.8)	1.4 (0.8)	0.2 (0.2)	1.0 (1.9)
Washington	0.2 (0.3)	0.8 (0.6)	1.5 (1.3)	0.4 (0.6)	2.2 (2.1)	1.1 (0.8)	2.2 (1.6)	0.7 (0.6)	1.3 (0.9)	0.8 (0.7)	1.6 (1.7)	0.8 (0.6)
West Virginia ^{††}	2.2 (1.6)	5.9 (2.8)	9.1 (10.4)	5.3 (2.4)	13.1 [§] (20.1)	—	—	5.6 (3.2)	5.9 (3.7)	3.3 (2.4)	7.3 (7.7)	8.4 (4.8)
Total	2.0 (0.7)	1.6 (0.2)	3.0 (0.7)	1.2 (0.2)	3.3 (0.6)	1.8 (0.6)	2.6 (0.6)	1.7 (0.3)	2.0 (0.3)	1.4 (0.2)	2.9 (0.9)	2.2 (0.4)

* White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

† 95% confidence interval.

§ Represents <60 respondents; data might not be reliable.

¶ Represents births during February–December 2004.

** Represents <30 respondents; data not reported.

†† Represents births during July–December 2004.

TABLE 17. Prevalence of prepregnancy asthma, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, four reporting areas,* 2004

Area	Age group (yrs)			Race/Ethnicity [†]				Pregnancy intention		Prepregnancy insurance status		
	<20	20–34	≥35	White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	None
	% (±CI) [§]	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)
Florida	6.5 (3.4)	6.4 (1.8)	4.3 (3.4)	7.2 (2.5)	6.1 (2.1)	5.0 (5.9)	4.3 (2.4)	5.2 (1.9)	7.3 (2.4)	5.5 (1.9)	8.6 (4.6)	6.2 (2.7)
Maryland	11.5 (8.8)	8.2 (2.6)	6.6 (2.0)	8.7 (3.0)	9.9 (4.1)	4.9 (7.2)	3.3 (3.7)	6.6 (2.4)	10.7 (4.0)	7.2 (2.3)	15.0 [¶] (15.6)	10 (4.7)
Minnesota	12.3 (7.7)	7.3 (1.8)	6.9 (4.2)	7.3 (1.9)	12.2 (4.8)	7.8 (7.0)	5.8 (6.6)	7.8 (2.2)	7.6 (2.7)	7.7 (2.0)	15.0 (6.9)	1.9 (1.6)
West Virginia ^{¶¶}	16.3 (4.2)	10.2 (3.4)	7.7 (9.4)	10.8 (3.0)	6.4 ^{**} (6.4)	— ^{††}	—	10.4 (3.9)	10.5 (4.2)	8.0 (3.6)	26.5 (11.6)	9.9 (4.6)
Total	8.5 (2.9)	7.0 (1.2)	5.4 (2.1)	7.7 (1.5)	7.7 (1.8)	5.6 (4.0)	4.3 (2.1)	6.2 (1.3)	8.0 (1.7)	6.5 (1.2)	10.7 (3.7)	6.6 (2.1)

* Data not collected in 21 states (Alaska, Arkansas, Colorado, Georgia, Hawaii, Illinois, Louisiana, Maine, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, and Washington) and New York City.

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents births during July–December 2004.

** Represents <60 respondents; data might not be reliable.

†† Represents <30 respondents; data not reported.

TABLE 18. Prevalence of prepregnancy hypertension, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, four states,* 2004

Area	Age group (yrs)			Race/Ethnicity [†]				Pregnancy intention		Prepregnancy insurance status		
	<20	20–34	≥35	White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	None
	% (±CI) [§]	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)
Florida	2.5 (2.3)	1.9 (0.9)	3.5 (2.4)	2.0 (1.4)	3.9 (1.5)	0.7 (0.7)	1.6 (1.4)	2.6 (1.3)	1.8 (0.9)	2.2 (1.3)	2.8 (1.9)	2.0 (1.1)
Maryland	2.7 (4.6)	1.4 (1.0)	5.4 (1.8)	1.5 (0.9)	3.5 (1.8)	2.8 (5.3)	2.4 (3.7)	1.6 (0.8)	3.5 (2.0)	2.2 (0.9)	0.4 [¶] (0.5)	2.6 (2.3)
Minnesota	2.3 (4.2)	1.1 (0.7)	4.5 (3.7)	1.6 (0.9)	4.0 (4.3)	2.8 (5.0)	0.1 (0.1)	1.5 (1.0)	2.2 (1.8)	2.0 (1.1)	0.6 (0.5)	0 (0)
West Virginia ^{**}	2.2 (1.5)	4.6 (2.4)	1.5 (1.1)	3.9 (1.9)	11.1 ^{¶¶} (19.8)	— ^{††}	—	3.9 (2.5)	4.2 (2.9)	3.8 (2.5)	6.8 (7.6)	3.6 (2.9)
Total	2.5 (1.8)	1.8 (0.6)	4.1 (1.6)	1.9 (0.8)	3.8 (1.1)	1.6 (1.6)	1.6 (1.2)	2.2 (0.8)	2.2 (0.7)	2.2 (0.8)	2.4 (1.4)	2.0 (0.9)

* Data not collected in 21 states (Alaska, Arkansas, Colorado, Georgia, Hawaii, Illinois, Louisiana, Maine, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, and Washington) and New York City.

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

** Represents births during July–December 2004.

†† Represents <30 respondents; data not reported.

TABLE 26. Prevalence of postpartum social support, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, three reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity†				Pregnancy intention		Insurance status at delivery		
	<20		20–34		≥35		White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	Other
	% (±CI)§	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	
North Carolina	84.6 (7.3)	85.2 (2.5)	84.1 (6.4)	91.0 (2.2)	87.8 (4.1)	80.1 (11.3)	59.5 (8.6)	86.1 (3.0)	83.7 (3.5)	91.2 (2.4)	80.3 (3.7)	65.2 [¶] (19.3)			
Oklahoma	82.8 (8.2)	84.2 (3.1)	85.6 (8.5)	88.0 (2.8)	75.6 (11.5)	78.1 (10.4)	70.4 (10.4)	84.5 (3.8)	83.6 (3.9)	90.1 (3.3)	78.4 (4.5)	89.7 (6.8)			
Rhode Island	74.3 (7.9)	85.8 (2.4)	92.4 (3.4)	92.9 (1.8)	75.9 (9.4)	77.9 (10.2)	65.6 (6.3)	89.0 (2.3)	81.8 (3.6)	93.5 (1.8)	67.9 (9.9)	78.0 (4.3)			
Total	83.4 (5.3)	85.0 (1.9)	85.4 (4.7)	90.2 (1.6)	85.8 (3.8)	79.0 (7.2)	62.4 (6.4)	86.0 (2.2)	83.6 (2.5)	91.1 (1.8)	79.7 (2.9)	79.5 (5.8)			

* Data not reported by 22 states (Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Utah, Vermont, Washington, and West Virginia) and New York City.

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

TABLE 27. Prevalence of recent low-birth-weight infant, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Age group (yrs)						Race/Ethnicity*				Pregnancy intention		Insurance status at delivery		
	<20		20–34		≥35		White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	Other
	% (±CI)†	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	
Alaska	5.8 (1.4)	4.9 (0.2)	7.5 (1.5)	4.8 (0.3)	10.6 [§] (4.6)	5.7 (0.4)	5.5 (1.8)	5.4 (0.4)	5.1 (0.5)	4.9 (0.5)	6.0 (0.6)	4.6 (0.8)			
Arkansas	9.5 (1.7)	7.8 (0.3)	10.8 (3.2)	6.8 (0.4)	15.5 (2.5)	9.7 [§] (5.5)	5.2 (1.5)	8.1 (0.7)	8.3 (0.7)	7.1 (0.7)	9.2 (0.7)	6.0 (1.8)			
Colorado	12.1 (3.3)	7.8 (0.5)	8.0 (1.7)	7.8 (0.6)	15.0 [†] (8.2)	15.9 (6.9)	7.2 (1.2)	7.9 (0.6)	8.6 (1.1)	7.6 (0.6)	9.0 (1.2)	8.8 (3.6)			
Florida	9.8 (0.2)	7.3 (0.3)	8.2 (1.7)	6.3 (0.5)	12.5 (0.9)	5.7 (2.2)	6.8 (1.1)	7.3 (0.6)	8.0 (0.7)	6.5 (0.6)	8.8 (0.7)	7.4 (3.0)			
Georgia [¶]	13.5 (4.7)	7.7 (0.6)	8.1 (2.5)	6.0 (0.8)	12.9 (0.6)	13.5 [§] (7.7)	6.2 (3.2)	6.9 (0.7)	9.8 (1.4)	7.0 (1.0)	9.8 (1.3)	5.7 (2.7)			
Hawaii	6.8 (4.0)	5.9 (1.2)	7.5 (2.4)	5.3 (2.2)	7.9 [§] (8.2)	6.2 (1.3)	7.9 (3.2)	7.3 (1.5)	5.2 (1.5)	6.4 (1.4)	6.2 (2.2)	6.6 (2.6)			
Illinois	11.9 (3.0)	6.6 (0.4)	8.1 (1.7)	5.9 (0.6)	12.3 (2.1)	9.3 (3.6)	6.5 (1.2)	6.9 (0.6)	7.9 (0.9)	6.1 (0.6)	8.5 (0.9)	11.8 [§] (6.5)			
Louisiana	16.2 (5.5)	8.7 (1.6)	19.0 (6.7)	8.4 (1.9)	14.9 (3.1)	5.0 [§] (8.2)	8.6 [§] (8.4)	9.3 (2.1)	11.7 (2.4)	8.9 (2.2)	12.1 (2.3)	7.9 [§] (8.7)			
Maine	7.4 (2.3)	5.3 (0.3)	6.1 (1.3)	5.6 (0.1)	—**	—	—	5.3 (0.4)	6.0 (0.8)	4.8 (0.4)	7.0 (0.8)	2.7 [§] (1.3)			
Maryland	9.7 (3.3)	7.8 (0.4)	8.7 (0.2)	5.8 (0.7)	13.2 (1.9)	8.4 (3.3)	6.7 (2.2)	7.4 (0.7)	9.7 (1.3)	7.2 (0.6)	10.3 (1.7)	9.1 (4.6)			
Michigan	13.3 (4.1)	6.3 (0.6)	8.7 (2.3)	6.2 (0.5)	13.9 (3.1)	7.1 [§] (4.6)	3.6 (2.4)	6.6 (0.7)	8.0 (1.2)	6.5 (0.7)	8.6 (1.4)	8.4 [§] (5.8)			
Minnesota	13.2 (8.5)	4.4 (1.5)	4.3 (3.6)	4.6 (1.6)	5.4 (1.9)	4.9 (4.8)	9.3 (8.5)	4.3 (1.7)	6.8 (2.8)	4.9 (1.7)	5.5 (2.8)	0.9 [§] (1.2)			
Mississippi	12.2 (2.4)	9.9 (0.6)	13.3 (4.2)	7.3 (0.8)	14.5 (1.4)	—	—	8.9 (1.0)	12.1 (1.0)	7.9 (1.2)	12.1 (0.9)	7.9 [§] (4.8)			
Nebraska	6.4 (4.2)	5.6 (1.4)	5.5 (3.9)	5.7 (1.6)	9.1 (3.0)	4.8 (1.8)	3.9 (2.1)	5.2 (1.7)	6.3 (2.0)	5.3 (1.6)	6.6 (2.3)	2.3 (1.9)			
New Jersey	0.9 (1.2)	7.5 (1.4)	9.5 (2.9)	5.4 (1.7)	15.7 (3.7)	9.1 (3.4)	6.1 (2.1)	7.3 (1.5)	7.5 (1.9)	7.1 (1.4)	9.0 (2.4)	6.0 (3.9)			
New Mexico	9.6 (4.1)	7.4 (1.6)	10.6 (5.2)	5.6 (2.0)	—	11.8 (5.2)	8.7 (2.1)	8.0 (2.0)	8.2 (2.2)	7.9 (2.5)	7.6 (1.9)	7.7 (4.9)			
New York City ^{††}	9.5 [§] (4.4)	7.6 (0.6)	8.3 (2.2)	4.9 (1.3)	12.8 (2.5)	7.5 (3.0)	6.7 (1.2)	8.8 (1.0)	6.6 (1.2)	8.5 (1.2)	7.6 (1.1)	4.6 [§] (3.3)			
North Carolina	10.4 (2.7)	7.7 (0.4)	8.9 (2.1)	6.8 (0.6)	13.4 (2.0)	7.6 (3.4)	5.6 (1.5)	6.7 (0.6)	9.9 (1.0)	6.8 (0.6)	9.2 (0.9)	8.3 [§] (5.0)			
Oklahoma	10.1 (2.4)	6.5 (0.3)	10.6 (3.2)	6.8 (0.4)	13.5 (4.0)	5.7 (1.8)	6.5 (1.8)	7.2 (0.7)	7.2 (0.7)	6.4 (0.7)	8.3 (0.8)	6.0 (2.0)			
Oregon	6.5 (2.9)	4.8 (0.5)	6.6 (1.9)	5.1 (0.1)	8.4 (3.0)	7.8 (2.2)	4.0 (1.9)	4.8 (0.6)	5.7 (1.0)	4.8 (0.5)	5.7 (1.1)	8.6 [§] (7.0)			
Rhode Island	9.4 (1.9)	7.3 (0.3)	6.5 (0.9)	6.3 (0.3)	13.9 (3.2)	8.8 (2.5)	8.7 (1.1)	7.3 (0.4)	7.6 (0.7)	6.6 (0.4)	10.9 (2.5)	8.1 (0.8)			
South Carolina	12.9 (3.5)	8.6 (0.6)	9.8 (2.7)	6.9 (0.7)	14.6 (2.2)	6.4 [§] (4.4)	5.9 (2.7)	8.3 (0.9)	10.4 (1.2)	7.5 (0.9)	11.6 (1.2)	4.7 (2.2)			
Utah	10.6 (2.8)	5.6 (0.3)	5.6 (1.6)	5.6 (0.2)	—	6.3 (2.7)	6.7 (1.3)	5.0 (0.4)	7.7 (0.9)	5.3 (0.4)	7.2 (0.8)	5.1 (2.3)			
Vermont	8.9 (2.5)	5.3 (0.2)	5.9 (1.0)	5.5 (0.1)	—	—	—	5.2 (0.3)	6.7 (0.8)	4.2 (0.3)	7.9 (0.8)	6.0 (2.0)			
Washington	3.2 (3.4)	4.6 (1.7)	6.7 (4.8)	5.0 (2.1)	9.6 (4.2)	4.7 (2.9)	3.3 (2.1)	5.9 (2.1)	2.7 (1.5)	4.7 (2.2)	4.9 (2.2)	4.8 (6.1)			
West Virginia ^{††}	11.5 (0.1)	8.4 (0.4)	10.7 (4.2)	9.1 (0.3)	10.3 [§] (6.2)	—	—	8.1 (0.8)	9.8 (1.3)	6.6 (0.9)	11.1 (1.2)	5.0 [§] (2.7)			
Total	10.5 (0.8)	7.0 (0.2)	8.5 (0.6)	6.2 (0.2)	13.3 (0.6)	7.3 (0.8)	6.4 (0.5)	6.9 (0.2)	8.3 (0.3)	6.5 (0.2)	8.8 (0.3)	6.6 (0.9)			

* White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

† 95% confidence interval.

§ Represents <60 respondents; data might not be reliable.

¶ Represents births during February–December 2004.

** Represents <30 respondents; data not reported.

†† Represents births during July–December 2004.

TABLE 28. Prevalence of recent preterm infant, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 26 reporting areas, 2004

Area	Age group (yrs)						Race/Ethnicity*				Pregnancy intention		Insurance status at delivery		
	<20		20–34		≥35		White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	Other
	% (±CI)†	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	
Alaska	7.8 (2.7)	9.3 (1.9)	7.8 (2.3)	7.8 (2.1)	22.0§ (16.0)	10.2 (2.1)	6.8 (4.5)	9.1 (2.1)	9.0 (2.3)	8.0 (2.3)	11.3 (2.7)	6.2 (2.5)			
Arkansas	11.4 (3.8)	10.2 (1.4)	15.8 (6.4)	10.6 (1.6)	12.6 (2.8)	5.7† (3.9)	8.7 (4.1)	9.5 (1.6)	11.9 (2.0)	10.0 (2.0)	11.5 (1.9)	8.0 (4.1)			
Colorado	8.7 (3.3)	8.8 (1.5)	11.2 (4.4)	9.7 (1.8)	7.7† (5.1)	11.0 (6.0)	8.0 (2.6)	8.8 (1.5)	9.7 (2.6)	10.2 (2.0)	8.0 (1.9)	5.6 (3.0)			
Florida	11.4 (3.2)	11.7 (2.0)	10.5 (3.9)	10.2 (2.4)	15.9 (2.4)	5.1 (2.7)	11.9 (3.8)	10.7 (2.2)	12.1 (2.4)	10.4 (2.5)	12.6 (2.3)	10.2 (6.4)			
Georgia¶	10.3 (4.5)	12.2 (2.2)	13.7 (5.2)	12.0 (3.0)	14.7 (2.2)	16.8§ (14.0)	7.3 (4.3)	12.9 (2.8)	11.6 (2.4)	13.0 (3.0)	12.1 (2.5)	7.4 (4.8)			
Hawaii	7.3 (4.2)	10.0 (1.5)	11.0 (3.0)	7.3 (2.6)	13.2§ (10.2)	10.5 (1.6)	10.7 (3.5)	11.3 (1.8)	8.6 (1.9)	9.9 (1.7)	9.5 (2.6)	11.3 (3.4)			
Illinois	13.7 (4.6)	10.0 (1.4)	14.4 (3.8)	9.8 (1.6)	15.7 (3.8)	10.4 (5.2)	10.2 (2.5)	10.4 (1.5)	11.9 (2.1)	10.3 (1.6)	11.7 (2.0)	11.6§ (8.4)			
Louisiana	17.0 (5.9)	11.6 (1.9)	21.3 (7.1)	11.4 (2.2)	16.7 (3.4)	7.6§ (9.5)	11.9§ (10.3)	11.4 (2.4)	14.9 (2.7)	12.6 (2.7)	14.0 (2.6)	4.8§ (7.4)			
Maine	12.8 (7.2)	9.4 (1.7)	5.5 (2.5)	9.4 (1.6)	—**	—	—	9.7 (2.0)	8.4 (2.4)	10.4 (2.3)	8.4 (2.2)	2.5§ (1.3)			
Maryland	7.3 (2.7)	11.4 (2.4)	11.3 (1.9)	10.0 (2.5)	12.5 (3.0)	9.5 (6.0)	13.1 (6.8)	10.6 (2.2)	12.2 (3.3)	10.6 (2.2)	11.5 (3.4)	11.4§ (9.5)			
Michigan	11.1 (4.5)	8.8 (1.7)	9.7 (3.6)	9.0 (1.6)	12.5 (4.3)	9.9§ (8.3)	1.6 (1.6)	7.7 (1.6)	10.9 (2.7)	8.5 (1.7)	10.0 (2.5)	6.7† (5.2)			
Minnesota	14.0 (8.5)	7.2 (1.9)	8.8 (4.7)	8.2 (2.0)	5.2 (1.8)	8.9 (6.7)	7.2 (7.6)	7.0 (2.0)	10.0 (3.3)	8.1 (2.1)	8.2 (3.4)	0.6† (1.1)			
Mississippi	15.7 (4.8)	12.2 (1.9)	19.7 (7.7)	11.2 (2.3)	15.6 (2.7)	—	—	11.0 (2.3)	15.6 (2.6)	13.5 (3.1)	13.6 (2.2)	9.3§ (8.3)			
Nebraska	5.5 (4.1)	8.3 (1.7)	11.4 (5.1)	8.7 (1.9)	8.5 (3.0)	6.1 (2.4)	7.8 (2.9)	7.5 (1.9)	9.7 (2.5)	8.5 (2.0)	8.9 (2.5)	5.4 (4.6)			
New Jersey	9.2 (5.5)	9.8 (1.6)	11.9 (3.3)	8.0 (2.0)	17.5 (3.9)	10.3 (3.5)	10.2 (2.8)	10.0 (1.8)	9.9 (2.2)	9.3 (1.7)	11.9 (2.8)	11.9 (6.0)			
New Mexico	8.8 (3.8)	8.7 (1.8)	12.8 (5.7)	9.2 (2.8)	—	13.8 (5.3)	7.9 (2.0)	9.9 (2.2)	8.1 (2.2)	8.7 (2.5)	9.6 (2.2)	8.9 (5.1)			
New York City††	6.3§ (3.4)	9.4 (2.2)	14.7 (6.1)	8.7 (4.1)	18.8 (5.7)	5.3 (3.7)	6.6 (2.2)	11.4 (2.8)	8.8 (3.0)	13.6 (3.7)	7.2 (2.2)	11.6§ (11.2)			
North Carolina	8.1 (3.1)	10.2 (1.6)	15.6 (5.3)	10.8 (1.9)	14.4 (3.4)	4.9 (2.5)	5.4 (2.7)	10.0 (1.9)	11.1 (2.1)	10.5 (2.0)	10.2 (2.0)	9.7§ (9.3)			
Oklahoma	8.8 (3.4)	8.9 (1.8)	16.9 (8.6)	9.2 (2.0)	11.9 (5.3)	8.0 (5.1)	10.0 (5.7)	9.3 (2.4)	9.5 (2.3)	8.3 (2.1)	10.4 (2.6)	8.4 (6.1)			
Oregon	14.7 (8.9)	7.9 (1.8)	6.2 (1.9)	7.9 (2.2)	10.2 (3.2)	8.2 (2.2)	9.7 (2.8)	7.0 (1.9)	10.7 (3.2)	6.5 (1.9)	10.9 (3.1)	7.9§ (6.9)			
Rhode Island	8.3 (2.9)	9.8 (1.6)	9.8 (3.3)	9.0 (1.7)	12.5 (4.4)	11.8 (6.1)	10.3 (2.9)	9.5 (1.7)	9.9 (2.2)	9.3 (1.7)	12.7 (5.5)	9.5 (2.3)			
South Carolina	18.5 (8.0)	8.9 (1.7)	13.1 (6.4)	9.1 (2.2)	14.3 (3.8)	9.6§ (12.0)	5.9 (4.6)	10.1 (2.4)	11.5 (2.9)	8.9 (2.4)	13.2 (3.1)	3.5 (1.8)			
Utah	10.9 (3.4)	8.3 (1.2)	10.7 (4.6)	8.5 (1.3)	—	7.3 (4.9)	9.7 (2.9)	7.7 (1.4)	9.8 (2.0)	8.4 (1.5)	9.7 (1.9)	6.3 (4.0)			
Vermont	14.1 (7.8)	7.3 (1.4)	7.7 (3.0)	7.8 (1.3)	—	—	—	8.5 (1.7)	6.8 (2.0)	7.6 (1.7)	8.8 (2.3)	5.4 (3.9)			
Washington	2.7 (2.4)	9.0 (2.3)	10.2 (5.5)	9.3 (2.9)	9.9 (4.1)	8.2 (3.2)	6.9 (2.9)	9.2 (2.5)	7.8 (3.1)	8.6 (2.9)	8.6 (2.8)	9.5 (9.2)			
West Virginia††	14.8 (3.5)	11.6 (2.8)	16.3 (10.8)	12.8 (2.6)	9.0§ (7.0)	—	—	12.9 (3.5)	11.7 (3.5)	8.8 (3.2)	15.7 (3.9)	9.8§ (10.1)			
Total	11.1 (1.1)	10.0 (0.5)	12.3 (1.1)	9.7 (0.5)	14.8 (0.9)	8.9 (1.1)	9.0 (1.0)	9.8 (0.5)	11.1 (0.6)	9.9 (0.5)	11.1 (0.6)	8.6 (1.5)			

* White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

† 95% confidence interval.

§ Represents <60 respondents; data might not be reliable.

¶ Represents births during February–December 2004.

** Represents <30 respondents; data not reported.

†† Represents births during July–December 2004.

TABLE 29. Prevalence of postpartum check-up, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 10 reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity†				Pregnancy intention		Insurance status at delivery		
	<20		20–34		≥35		White	Black	Other	Hispanic	Intended	Unintended	Private	Medicaid	Other
	% (±CI)§	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	% (±CI)	
Arkansas	79.1 (6.1)	86.1 (2.3)	84.5 (8.0)	87.1 (2.2)	81.8 (5.7)	81.4¶ (18.4)	75.2 (8.4)	88.0 (2.7)	82.0 (3.1)	94.0 (2.2)	79.2 (3.3)	81.8 (7.9)			
Georgia**	88.8 (6.9)	87.8 (2.7)	94.2 (4.1)	92.2 (2.9)	87.9 (2.9)	92.4§ (12.8)	78.9 (8.9)	90.9 (2.8)	86.7 (3.5)	92.4 (2.8)	86.9 (3.3)	75.3 (14.7)			
Hawaii	79.7 (7.0)	88.5 (1.7)	90.9 (2.9)	88.7 (3.2)	78.9¶ (12.3)	88.9 (1.8)	87.4 (4.1)	91.1 (1.7)	84.9 (2.5)	93.2 (1.5)	80.3 (3.6)	86.5 (3.7)			
Minnesota	85.6 (8.2)	90.5 (2.2)	89.9 (4.9)	90.8 (2.2)	88.9 (4.9)	79.3 (10.7)	92.2 (7.8)	93.3 (2.1)	84.7 (4.0)	93.8 (1.9)	81.2 (5.0)	88.3§ (15.3)			
New Jersey	85.5 (6.2)	89.7 (1.6)	90.5 (3.0)	94.0 (1.7)	85.9 (3.4)	91.6 (3.2)	81.9 (3.5)	92.2 (1.5)	85.4 (2.6)	94.1 (1.3)	80.3 (3.4)	79.8 (7.8)			
New York City††	92.5¶ (7.7)	88.3 (3.3)	93.3 (4.9)	93.3 (4.2)	90.8 (4.9)	90.7 (7.9)	85.5 (5.1)	88.8 (3.7)	89.9 (4.1)	90.4 (3.8)	88.7 (4.0)	89.7¶ (11.1)			
Rhode Island	90.7 (5.6)	93.8 (1.7)	95.5 (2.8)	95.1 (1.6)	83.0 (8.7)	88.4 (8.4)	94.2 (3.0)	95.3 (1.6)	91.8 (2.7)	97.3 (1.3)	89.1 (6.5)	88.9 (3.3)			
South Carolina	89.3 (7.6)	90.3 (2.9)	93.1 (6.2)	91.8 (3.0)	91.1 (4.4)	99.9¶ (0.1)	72.1 (15.3)	92.6 (3.1)	88.7 (4.1)	96.7 (2.3)	87.1 (4.1)	79.7 (14.1)			
Vermont	80.4 (9.9)	93.3 (1.8)	95.8 (3.0)	93.0 (1.6)	—§§	—	—	93.7 (1.9)	91.5 (3.2)	96.3 (1.5)	87.6 (3.6)	87.3 (8.8)			
West Virginia††	80.5 (4.5)	87.4 (3.8)	90.4 (10.4)	86.5 (3.3)	85.2§ (17.2)	—	—	88.2 (4.1)	85.7 (5.0)	94.0 (3.6)	80.3 (5.2)	89.1§ (10.7)			
Total	86.7 (2.8)	89.0 (1.0)	92.0 (1.7)	91.7 (1.0)	88.1 (1.7)	89.5 (2.2)	82.5 (2.8)	91.4 (1.0)	86.5 (1.4)	93.6 (0.9)	84.7 (1.5)	82.6 (4.0)			

* Data not collected by 15 states (Alaska, Colorado, Florida, Illinois, Louisiana, Maine, Maryland, Michigan, Mississippi, Nebraska, New Mexico, North Carolina, Oklahoma, Oregon, Utah, and Washington).

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

** Represents births during February–December 2004.

†† Represents births during July–December 2004.

§§ Represents <30 respondents; data not reported.

TABLE 30. Prevalence of postpartum contraceptive use counseling, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, four reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity†						Pregnancy intention				Insurance status at delivery							
	<20		20–34		≥35		White		Black		Other		Hispanic		Intended		Unintended		Private		Medicaid		Other	
	%	(±CI)§	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)
Colorado	92.7	(6.7)	91.9	(1.9)	92.4	(3.9)	91.3	(2.0)	90.6¶	(13.0)	94.6	(7.2)	93.3	(3.2)	93.0	(1.9)	90.6	(3.1)	92.3	(2.2)	92.3	(2.7)	87.7	(7.4)
Illinois	93.6	(3.8)	91.3	(1.6)	85.2	(4.4)	89.6	(2.0)	93.8	(2.9)	93.2	(5.4)	90.0	(3.0)	91.0	(1.8)	89.9	(2.3)	90.5	(1.9)	91.1	(2.1)	80.8¶	(13.9)
New York City**	84.5¶	(11.4)	79.0	(4.2)	74.1	(8.8)	72.4	(7.4)	83.7	(6.5)	76.5	(11.9)	80.1	(5.9)	75.2	(5.0)	82.6	(5.3)	79.2	(5.2)	77.8	(5.3)	79.3¶	(15.5)
Utah	93.3	(4.3)	92.1	(1.5)	89.4	(4.9)	92.4	(1.6)	—††	—	94.9	(6.1)	88.2	(3.8)	92.5	(1.7)	90.6	(2.5)	93.7	(1.6)	91.2	(2.3)	70.5	(10.5)
Total	91.9	(3.1)	89.5	(1.1)	84.7	(3.0)	89.1	(1.3)	90.5	(2.8)	88.0	(4.9)	88.2	(2.1)	89.1	(1.3)	88.8	(1.7)	89.8	(1.3)	88.6	(1.6)	79.9	(6.4)

* Data not collected by 22 states (Alaska, Arkansas, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Vermont, Washington, and West Virginia).

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

** Represents births during July–December 2004.

†† Represents <30 respondents; data not reported.

TABLE 31. Prevalence of postpartum dental visit, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, 10 reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity†						Pregnancy intention				Insurance status at delivery							
	<20		20–34		≥35		White		Black		Other		Hispanic		Intended		Unintended		Private		Medicaid		Other	
	%	(±CI)§	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)
Alaska	19.1	(8.1)	19.0	(3.0)	26.7	(8.5)	21.6	(4.0)	9.4¶	(11.9)	18.0	(3.7)	18.0	(9.6)	22.6	(3.8)	16.8	(3.9)	27.2	(5.1)	13.8	(3.5)	19.3	(5.7)
Arkansas	11.1	(4.5)	16.5	(2.4)	27.9	(11.3)	19.3	(2.7)	9.2	(3.7)	22.2¶	(18.3)	6.0	(4.4)	21.3	(3.5)	11.4	(2.6)	28.3	(4.3)	8.5	(2.2)	10.0	(6.1)
Maine	27.6	(12.2)	26.9	(3.5)	27.9	(8.4)	27.5	(3.2)	—**	—	—	—	—	—	30.5	(4.0)	21.4	(5.0)	36.4	(4.4)	16.6	(4.4)	8.2¶	(7.9)
Michigan	34.1	(10.9)	34.7	(3.6)	49.8	(8.8)	40.8	(3.6)	23.8	(8.4)	31.2¶	(16.6)	22.6¶	(11.2)	41.6	(4.1)	28.6	(4.9)	48.8	(4.2)	17.1	(4.3)	—	—
Mississippi	21.1	(6.7)	25.6	(3.5)	26.6	(11.3)	25.1	(4.1)	24.9	(4.6)	—	—	—	—	29.7	(4.7)	21.1	(3.9)	36.3	(5.6)	18.6	(3.5)	33.4¶	(20.6)
Nebraska	26.5	(8.5)	30.4	(3.0)	33.9	(8.2)	32.3	(3.3)	21.5	(4.8)	25.3	(4.2)	23.9	(4.9)	35.3	(3.7)	24.5	(3.8)	36.6	(3.7)	22.5	(3.9)	11.0	(8.0)
South Carolina	21.5	(10.3)	30.7	(4.5)	37.2	(12.3)	32.9	(5.1)	29.4	(7.3)	—	—	6.5	(7.6)	38.2	(5.7)	21.6	(5.4)	48.0	(6.3)	17.0	(4.9)	22.7	(13.5)
Utah	21.3	(6.9)	30.4	(2.9)	46.2	(9.7)	33.6	(3.0)	—	—	36.7	(13.2)	16.0	(5.3)	33.9	(3.4)	26.9	(4.3)	36.6	(3.5)	21.4	(4.0)	20.4	(10.3)
Vermont	30.5	(12.2)	36.2	(3.5)	53.0	(7.8)	39.2	(3.2)	—	—	—	—	—	—	43.3	(3.9)	29.4	(5.2)	46.8	(4.1)	27.5	(5.0)	23.1¶	(11.6)
Washington	20.7	(10.0)	31.8	(3.9)	37.9	(9.8)	32.7	(4.9)	18.9	(5.6)	33.2	(6.0)	29.4	(5.7)	33.8	(4.5)	28.0	(5.4)	38.7	(5.3)	23.3	(4.3)	30.8	(14.1)
Total	23.2	(3.7)	29.9	(1.4)	41.1	(4.2)	33.2	(1.6)	23.7	(3.4)	29.8	(4.5)	20.6	(3.1)	35.2	(1.7)	23.8	(1.9)	41.5	(1.9)	18.1	(1.6)	21.5	(4.7)

* Data not collected by 15 states (Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Minnesota, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, and West Virginia) and New York City.

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

** Represents <30 respondents; data not reported.

TABLE 32. Prevalence of postpartum participation in the Special Supplemental Nutrition Program for Women, Infants, and Children, by selected demographic characteristics — Pregnancy Risk Assessment Monitoring System, United States, four reporting areas,* 2004

Area	Age group (yrs)						Race/Ethnicity†						Pregnancy intention				Insurance status at delivery							
	<20		20–34		≥35		White		Black		Other		Hispanic		Intended		Unintended		Private		Medicaid		Other	
	%	(±CI)§	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)	%	(±CI)
Illinois	90.8	(4.7)	50.0	(2.8)	17.6	(4.8)	26.3	(2.9)	83.7	(4.6)	24.1	(9.8)	80.2	(4.0)	35.7	(3.1)	67.4	(3.6)	17.6	(2.5)	89.3	(2.3)	38.7¶	(17.4)
Maine	79.9	(10.7)	43.2	(3.7)	17.7	(6.9)	41.8	(3.3)	—**	—	—	—	—	—	31.0	(3.8)	64.8	(5.4)	15.3	(3.2)	84.0	(4.0)	25.9¶	(12.3)
Michigan	91.4	(5.9)	46.6	(3.6)	26.9	(7.7)	40.3	(3.4)	79.5	(7.3)	38.1¶	(15.5)	71.1	(12.8)	34.7	(3.9)	68.7	(4.7)	23.5	(3.5)	87.6	(3.8)	69.0¶	(16.3)
West Virginia††	92.6	(3.0)	60.5	(5.6)	42.3¶	(17.5)	63.0	(4.9)	75.8¶	(22.8)	—	—	—	—	52.8	(6.6)	75.2	(6.4)	29.9	(7.0)	90.9	(4.1)	71.9¶	(18.8)
Total	90.7	(3.4)	48.7	(2.1)	21.6	(4.1)	35.0	(2.0)	82.0	(4.0)	30.4	(8.3)	78.7	(3.9)	35.5	(2.3)	68.1	(2.7)	20.3	(2.0)	88.5	(1.9)	53.6	(11.3)

* Data not collected by 21 states (Alaska, Arkansas, Colorado, Florida, Georgia, Hawaii, Louisiana, Maryland, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, and Washington) and New York City.

† White = non-Hispanic white; Black = non-Hispanic Black; and Other = non-Hispanic other.

§ 95% confidence interval.

¶ Represents <60 respondents; data might not be reliable.

** Represents <30 respondents; data not reported.

†† Represents births during July–December 2004.

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