

Natality

In 2001, Oregon recorded **45,318 resident births**. There were 468 fewer resident births than in 2000 and the **crude birth rate** (the number of babies born divided by the total state population) decreased slightly, from 13.3 to 13.1 per 1,000 population. [Table 1-2]. Oregon's crude birth rate peaked in 1947 at 25.4 per 1,000 population. For the past thirty years however, Oregon's rates have held in the mid-teens, ranging from a high of 16.4 in 1980 to the current low of 13.1. Except for the period between 1976 and 1981, Oregon's crude birth rate has remained lower than the national rate. In 2001, Oregon's rate was 9.7 percent lower than the nation's (13.1 vs. 14.5). [Figure 2-1].

Oregon's **fertility rate** decreased to 61.6 per 1,000 women age 15-44. [See sidebar page 2-3, Table 2-2]. The fertility rate is based on the number of births per 1,000 women age 15-44. The fertility rate is a more precise measurement of changes in behavioral patterns because it consists only of women who are of childbearing age while the crude rate is based on the entire population. Age-specific **birth rates** increased for women age 30 to 34 and decreased for women age 15-29 and 35-39. The birth rate for women age 40-44 was unchanged. The largest percentage decrease was among women age 15-19 (6.3%). [Table 2-2, Figure 2-2]. The two youngest mothers in 2001 were 12 years old; the oldest was 49. The median age of mothers for all births was 27 and the mean age was 27.1. The median age at first birth was 24 and the mean age was 24.9. The **first birth rate** was 24.6 first births per 1,000 women age 15-44, slightly lower than the national rate of 26.7 and a decrease from 2000 (25.2). The

Oregon's crude birth rate and fertility rate both remain below the national rates.

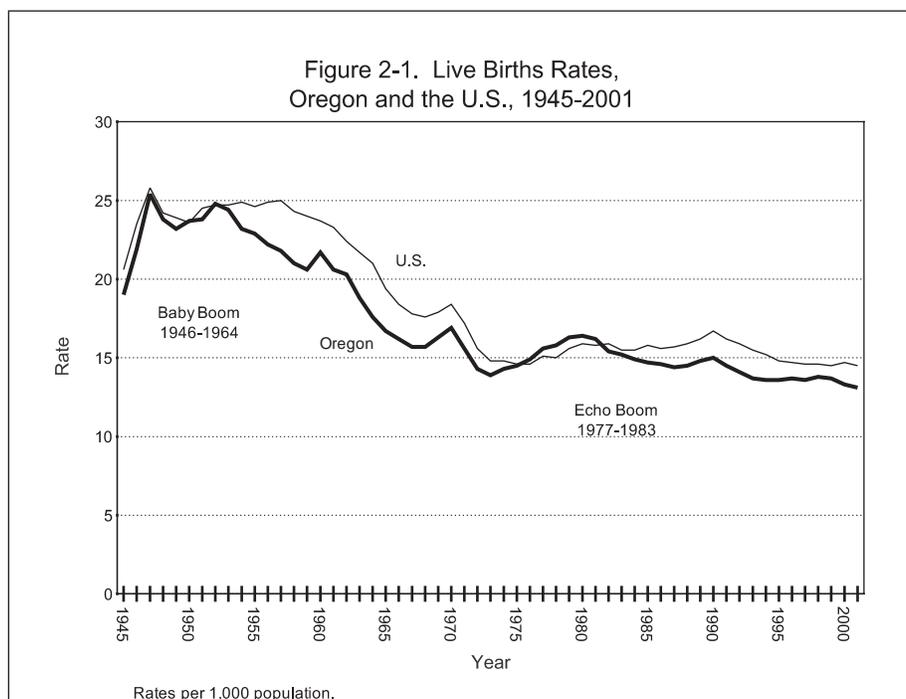
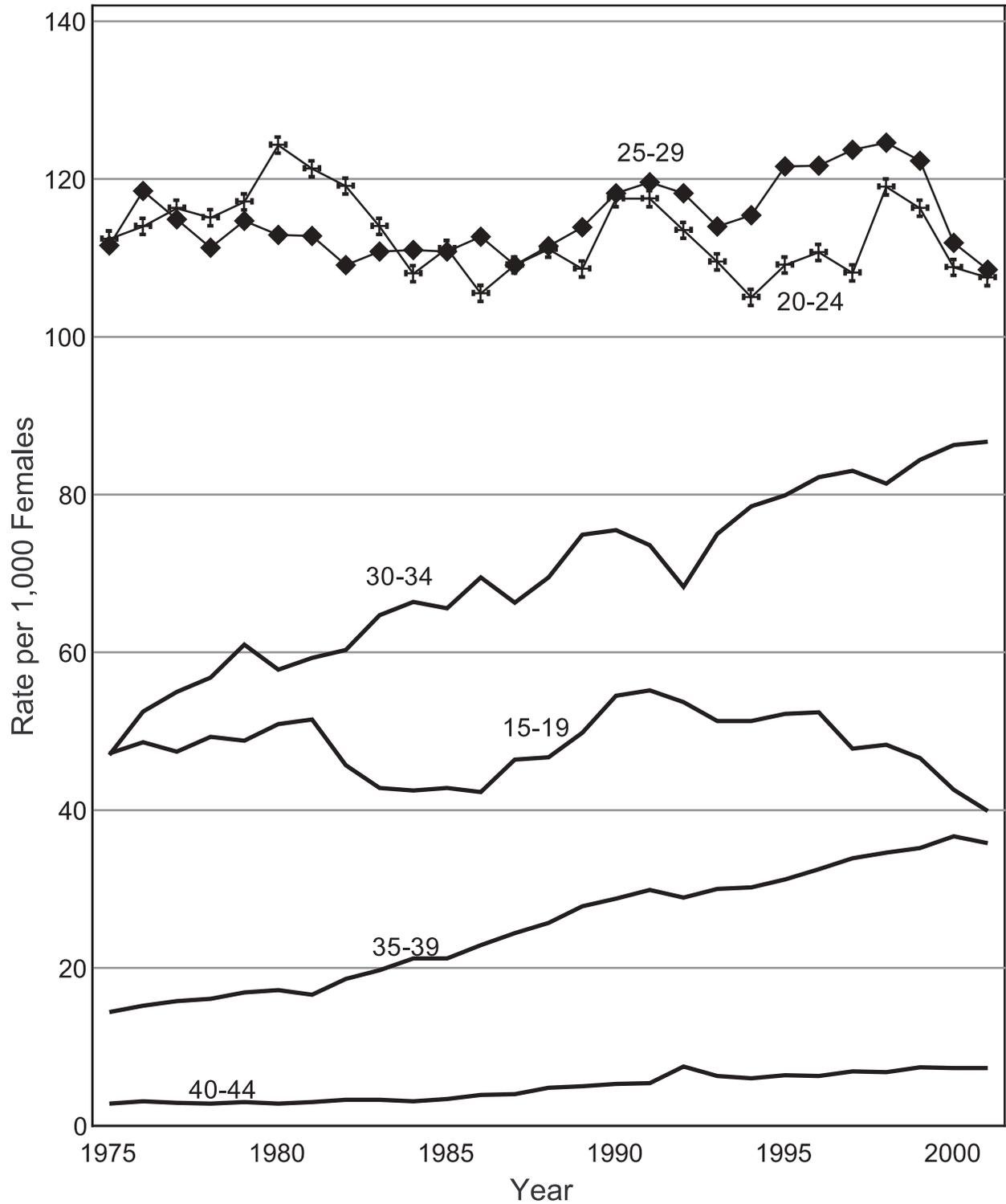


Figure 2-2.
Age-Specific Birth Rates,
Oregon Residents, 1975-2001



proportion of first births among total births has been stable for the past decade. In 1990, 39.6 percent of births were first births; in 2001, 40.0 percent were first births.

The mean age for fathers was 30 years and the median age was 29. The **birth rate per 1,000 men** age 15-54 was 44.4 in 2001 for Oregon resident births. Information on the father was missing from almost ten percent of birth certificates. For statistical analysis, unknown father age was distributed in the same manner as national data. (See Technical Notes for details, Appendix B.) Nationally, the mean age of fathers was 29.8 years in 2000 (the last data available) while the national birth rate for men was 51.6 per 1,000 men.

DEMOGRAPHICS

Maternal Race/Ethnicity

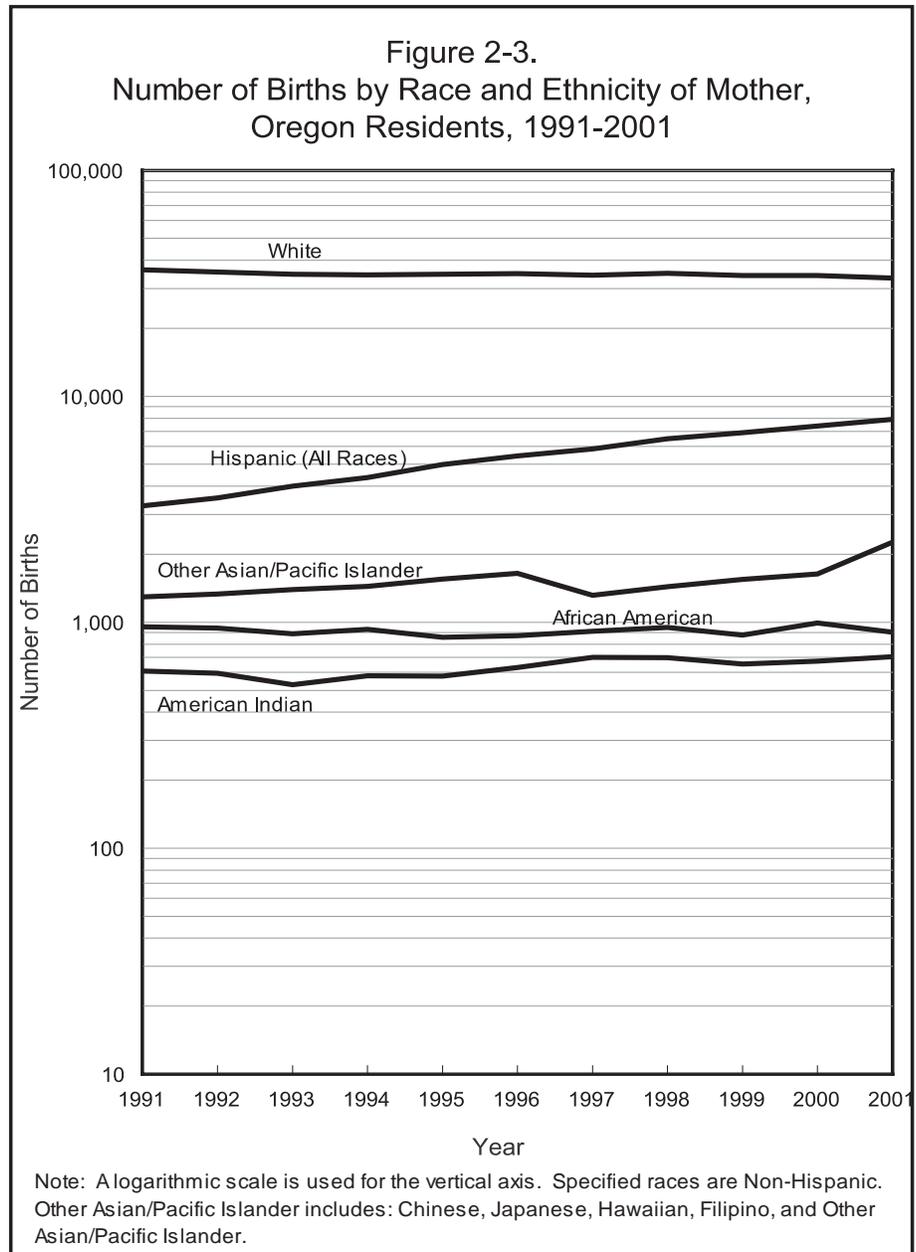
Birth rates for racial and ethnic groups are not calculated in this report because precise population data by racial and ethnic groups are available only for census years. Instead this report focuses on the race and ethnicity of women who gave birth as a proportion of total births. Since 1989, the number of births to women of Hispanic ethnicity has more than tripled to 17.4 percent of total births. [Table 2-6]. From 1981 to 1988, 'Hispanic' was a race category on the birth certificate. Since 1989, information regarding Hispanic ethnicity is reported separately from race. This change addressed the complexity of race and ethnicity and increased the accuracy when self-reporting. Births to Hispanic women, Non-Hispanic American Indian, and Other Asian and Pacific Islander women increased slightly in 2001. [Figure 2-3]. Non-Hispanic American Indians and White Hispanics were far more likely to receive inadequate prenatal care than other groups. Japanese women (2.0%) and Hawaiian women (1.8%) were least likely to receive inadequate care. [Table 2-17].

Marital Status of Mother

Historically, unmarried women as a group have had poorer birth outcomes than married women. They generally have a greater proportion of babies with low birthweight and low Apgar scores than do their married counterparts. Their infants are also more likely to require neonatal intensive care, to have congenital anomalies, or to die before age one. Between 1973 and 1993, the ratio of births to unmarried mothers more than tripled in Oregon. Since the mid-1990s, this ratio has stabilized. [Table 1-2, Figure 2-4]. While there hasn't been a matching increase in low birthweight rates and other indicators of poor health, the disparity in birth outcomes between married and unmarried women continues.

Fertility Rates Per 1,000 Females 15-44, Oregon vs. U.S.		
Year	Oregon	U.S.
1980	69.3	68.4
1981	68.1	67.4
1982	65.2	67.3
1983	64.1	65.8
1984	62.8	65.4
1985	62.2	66.2
1986	61.8	65.4
1987	60.9	65.7
1988	61.8	67.2
1989	63.3	68.2
1990	65.1	71.1
1991	63.7	69.6
1992	62.5	69.3
1993	61.1	67.6
1994	61.0	65.8
1995	62.3	65.6
1996	63.2	65.3
1997	63.0	65.0
1998	64.2	65.6
1999	64.2	65.9
2000	62.9	67.6
2001	61.6	67.2

Unmarried Mothers by Race/Ethnicity, Oregon Residents, 2001	
Race/Ethnicity	Unmarried (%)
Total	30.4
Non-Hispanic	
African American	64.6
American Indian	57.6
White	27.2
Asian	16.0
Hispanic	41.2



In 2001, 30.4 percent of all Oregon births were to unmarried women, a slight increase from the previous year. [Table 1-2]. Oregon has consistently had a lower percentage of births to unmarried women than the nation; Oregon’s rate in 2001 was 9.0 percent lower. [Figure 2-4].

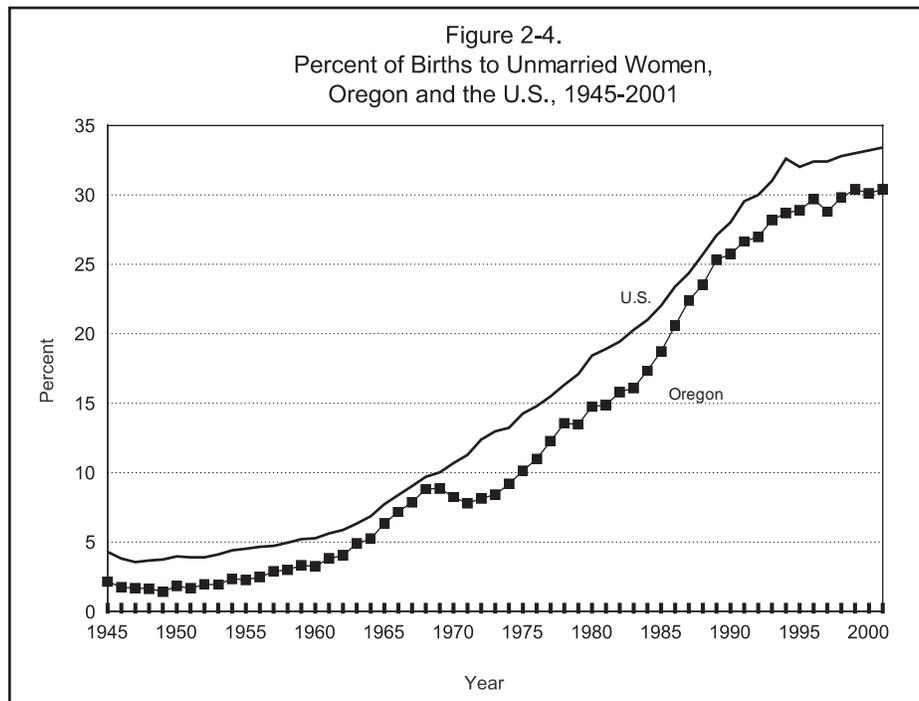
Among women giving birth in 2001, the percentage of women who were unmarried varied widely by ethnic and racial group (see sidebar). Non-Hispanic African American women had the highest rate of non-marital births (64.6%), followed by Non-Hispanic American Indian women (57.6%), and Hispanic women (41.2%). Non-Hispanic Asian women were least likely to be unmarried (16.0%). [Table 2-11].

Young mothers were also likely to be unmarried since persons younger than age 17 cannot get married in Oregon. More than three-fourths of the teens age 15-19 who gave birth in 2001 were unmarried (76.2%). This percentage decreased to 43.5 percent for women age 20-24 and to 20.9 percent for women age 25-29. Mothers age 30-34 (13.0%) and 35-39 (13.1%) were least likely to be unmarried, while 16.5 percent of mothers age 40-44 were unmarried. [Table 2-3]. Twelve of Oregon's 36 counties had proportions of non-marital births that were statistically significantly higher than the state average. [Table 2-8]. Among counties with statistically significant differences, Jefferson had the highest percentage difference (49.8%) followed by Lincoln (44.5%) and Klamath (38.1%). [See Appendix B: Technical Notes for information on statistical significance.] Six Oregon counties had percentages of non-marital births that were statistically significantly lower than the state average. Harney County had the lowest percentage of non-marital births (15.7%). A county's non-marital birth proportion should be viewed in part as a function of its own specific population mix, especially age and race. Variations in population composition among counties will likely result in significant differences in non-marital births.

Years of Education	No First Trimester Care (%)
< 12	33.7
12	21.1
> 12	9.6

Educational Attainment

Mother's level of education was closely related to prenatal care patterns. Women with less than a high school education were least likely to obtain first trimester prenatal care, while those who had college degrees or higher were most likely to have obtained first trimester care. [See sidebar and Table 2-18].



Women who smoked had a low birthweight rate of 81.3 per 1,000.

More than three-fourths of women who gave birth in 2001 had 12 or more years of schooling (79.1%) and 23.6 percent had 16 or more years of formal schooling. Non-Hispanic Asian (90.8%) and Non-Hispanic White (87.8%) mothers were most likely to have completed 12 or more years of education. Hispanic mothers of Mexican origin were least likely to have completed at least 12 years of formal schooling (37.6%). [Table 2-11].

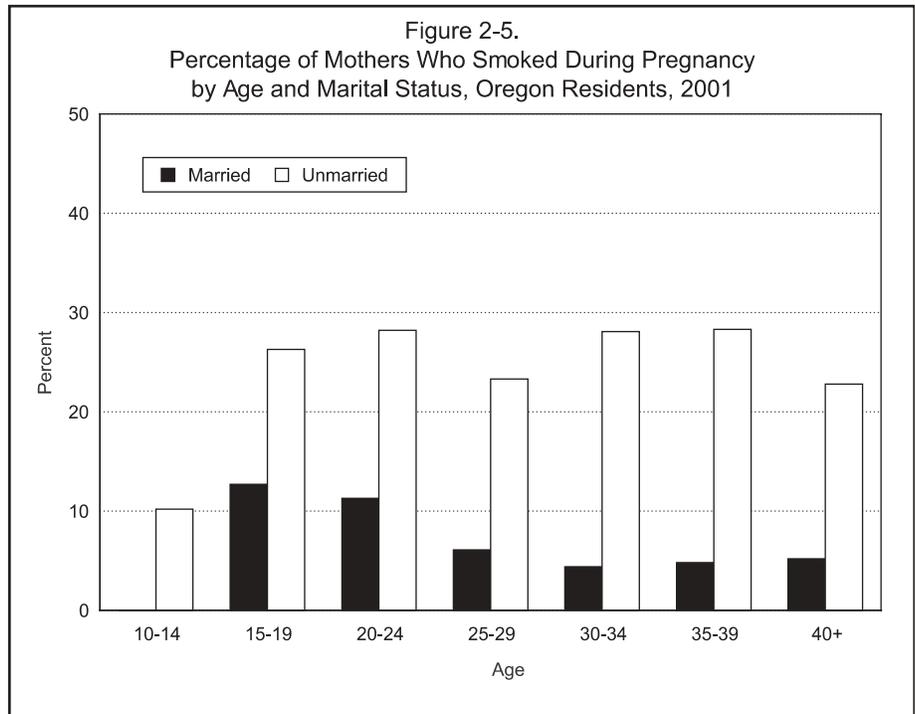
**MATERNAL LIFESTYLE AND HEALTH CHARACTERISTICS
Tobacco**

Oregon Benchmark for the Year 2010

Percentage of infants whose mothers did not use tobacco during pregnancy (self-reported).

Year 2010 Target:	98 percent
2001:	87 percent

Women who smoke when pregnant have a far higher incidence of low birthweight babies than nonsmokers. Low birthweight infants are more likely to experience serious health problems, including increased rates of infant mortality. In 2000, the Oregon infant mortality rate during the first 27 days of life (neonatal) was 43.6 per 1,000 live births for low birthweight (less than 2,500 grams) infants compared to 1.2 per 1,000 for infants with birthweights of 2,500 grams or



more. In 2001, women who smoked had a low birthweight rate of 81.3 per 1,000 live births, compared to 51.2 per 1,000 among women who did not smoke. Less than one out of seven mothers (12.8%) reported using tobacco during pregnancy, a proportion that has declined 27.7 percent since 1996 and 5.2 percent since 2000. Unmarried women were over three times more likely to smoke than married women (26.6% vs. 6.8%). For unmarried women, the smoking rate was highest among women age 35-39 (28.3%), 20-24 (28.2%) and 30-34 (28.1%) while for married women the lowest smoking prevalence rates were for women age 30-34 (4.4%) and age 35-39 (4.8%). [Figure 2-5].

Smoking prevalence as reported on birth certificates also varied among racial and ethnic groups. In 2001, Non-Hispanic American Indian women (24.8%) and Non-Hispanic African American women (17.3%) had the highest reported proportions for smoking during pregnancy, while Hispanic women (3.5%) and Non-Hispanic Asian women (3.2%) reported the lowest. [Table 2-23].

Alcohol and Illicit Drugs

Oregon Benchmark for the Year 2010

Percentage of infants whose mothers did not use alcohol during pregnancy (self-reported).

<i>Year 2010 Target:</i>	<i>98 percent</i>
<i>2001:</i>	<i>99 percent</i>

Used during pregnancy, alcohol can cause deformity, mental retardation, and other severe developmental problems. Based on birth certificate data, 1.0 percent of Oregon mothers (436 women) drank alcohol during pregnancy in 2001. This represents an 80.1 percent decline from 1990, when 5.2 percent of mothers reported alcohol use. Hispanic women not from Mexico, Central or South America (2.0%) and Non-Hispanic American Indian women (1.6%) were most likely to have reported using alcohol during pregnancy. Non-Hispanic Asian women (0.4%) and Hispanic women of Mexican descent (0.4%) reported the lowest alcohol use during pregnancy. [Table 2-23]. Oregon also records information on the use of illicit drugs during pregnancy including heroin, cocaine, marijuana and methamphetamine. In 2001, illicit drugs were mentioned in less than 1 percent of resident births (0.9%). [Table 2-14].

Weight Gain

Maternal weight gain has been shown to have a positive correlation with the birthweight of the infant. The median weight gain during pregnancy was 30 pounds in 2001. The amount of weight gained by mothers varied by period of gestation, race and ethnicity. For all births, Hispanic women

(49.4%) and Non-Hispanic African American women (45.5%) were least likely to gain more than 25 pounds during pregnancy. [Table 2-32]. Non-Hispanic African American women had the highest percent of low birthweight infants (9.9%). Hispanic women, despite the lower weight gain, had the second lowest percentage of low birthweight infants (5.6%). [Table 2-33]. Non-Hispanic Whites were both most likely to gain more than 25 pounds during pregnancy and least likely to have a low birthweight infant. Although the standard recommendation is 25 to 35 pounds for women of normal weight, pre-pregnancy weight isn't collected on the birth certificate so percentages of mothers who had appropriate weight gains cannot be calculated.

Medical Risk Factors

Maternal medical risk factors influence pregnancy complications and infant health and vary greatly with the age, race and ethnicity of the mother. In 2001, the most frequently reported medical risk factors were anemia (5.7%) and pregnancy-associated hypertension (4.7%). [Tables 2-24 and 2-25].

MEDICAL SERVICES UTILIZATION

Prenatal Care

Oregon Benchmark for the Year 2001

Percentage of infants whose mothers received prenatal care beginning in the first trimester.

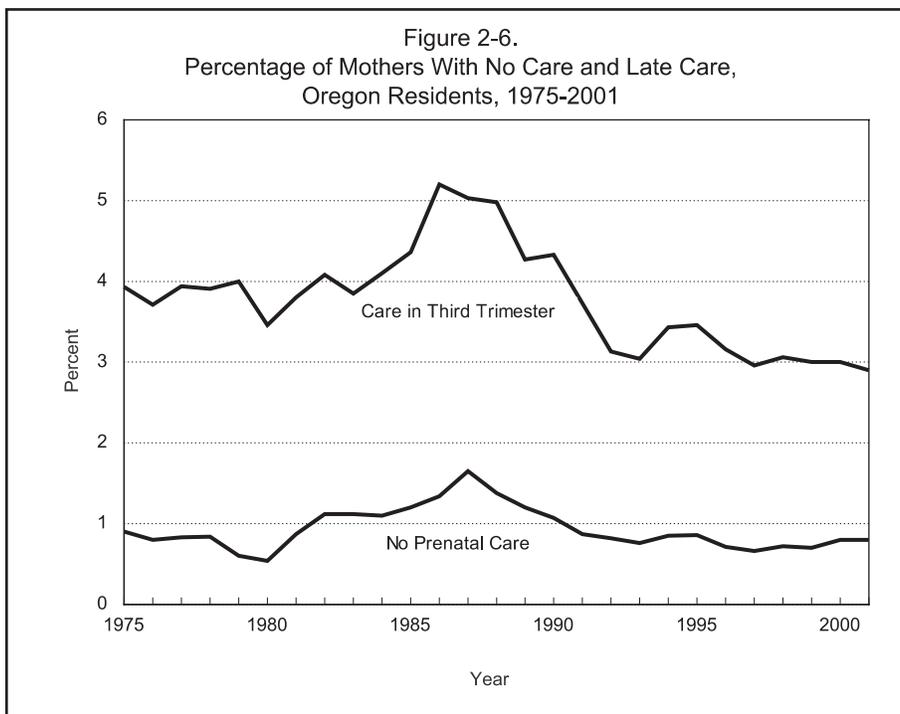
<i>Year 2010 Target:</i>	<i>90 percent</i>
<i>2001:</i>	<i>82 percent</i>

Public health services and private care providers seek to minimize the risk of death and disability, and to reduce costs associated with low birthweight infants by providing comprehensive prenatal care. Two ways to measure prenatal care are: 1) "inadequate prenatal care," defined as no care until the third trimester or fewer than five total prenatal visits; or 2) "first trimester care," defined as care beginning during the first three months of pregnancy, regardless of the number of total prenatal visits. First trimester care has been adopted as an Oregon Benchmark with a goal to ensure that at least 90 percent of women begin prenatal care within the first three months of their pregnancy. Overall, 81.5 percent of women who gave birth during 2001 received early prenatal care, slightly lower than the national number of 83.4. [Table 2-16; Table 1-5]. This is slightly higher than the 2000 rate and maintains the positive trend in Oregon. [Table 1-6].

In 2001, five percent of women giving birth received inadequate prenatal care and eighteen percent received no first trimester care. Women who received inadequate prenatal care were twice as likely to give birth to a low birthweight child as those who received adequate prenatal care, 10.8 percent compared to 5.2 percent. [Figure 2-6]. The proportion that received no prenatal care or third trimester care only remained about the same as previous years (0.8% and 2.9% respectively). Inadequate or no prenatal care is frequently associated with other risk factors including tobacco use, alcohol use, ethnic or racial minority, and age less than 18 or age 35 or older. Women who received inadequate prenatal care were more than six times as likely to have three or more risk factors indicated in their pregnancy than women who received adequate prenatal care (44.5% vs. 6.4%). Age, marital status, education and race/ethnicity continue to show important differences in accessing prenatal care. [Tables 2-16, 2-17, 2-18, 2-13]. Women with less than a high school education were least likely to obtain first trimester prenatal care, while those who had college degrees or higher were most likely to have first trimester care. [See sidebar, p. 2-5 and Table 2-18].

Five of Oregon’s 36 counties had first trimester care rates significantly lower than the statewide rate: Coos, Jefferson, Malheur, Marion, and Umatilla. Three counties had rates significantly higher than the statewide rate: Benton, Deschutes and Washington. [Table 2-19].

The **Adequacy of Prenatal Care Utilization Index** is an alternative measure that is also based on the month prenatal began and the number of prenatal visits, adjusting for



gestational age. Care is determined to be intensive (exceeding recommended care by a ratio of expected visits to actual by at least 110 percent), adequate, intermediate and inadequate. [See table, this page.] As with other measures of prenatal care, women under the age of 20 were least likely to receive adequate care, while women age 40 and over were

Adequacy of Prenatal Care Utilization Index Oregon 1996-2001				
	Intensive	Adequate	Intermediate	Inadequate
1996	26.6	47.6	14.2	11.6
1997	27.3	47.9	13.7	11.0
1998	28.0	46.3	14.0	11.7
1999	28.6	45.7	14.3	11.3
2000	30.0	45.3	13.8	10.9
2001	30.2	46.1	12.8	11.0

most likely to receive intensive prenatal care. Women with medical risk factors such as diabetes and hypertension, were also more likely to receive intensive prenatal care. For 2000, (last available data for U.S.), Oregon's proportion of 10.9 percent of births with inadequate care was lower than the national proportion of 11.9 percent.

Birth Attendant and Place of Delivery

Hospital Births A major shift over the past few years has been the increasing prevalence of births attended by Certified Nurse Midwives (CNM). In 2001, 14.9 percent of hospital deliveries were CNM-attended, a 3.5 percent increase from 2000 and almost three times the proportion in 1988 (5.3%). This is more than twice the national proportion of births attended by CNM (2000= 7.2%). Most in-hospital births (80.5%) were delivered by MDs, the same proportion as 2000. [Table 2-27].

Out-of-Hospital Births In 2001, 2.2 percent of Oregon births occurred out-of-hospital. Oregon generally has a higher proportion of out-of-hospital births than the U.S. as a whole. In 2000 (last U.S. data available), Oregon's proportion of out-of-hospital births was double that of the U.S. (2.2% vs. 0.9%). As in past years, the majority of out-of-hospital births occurred in the mother's home (69%). Free-standing birthing centers accounted for 227 births, almost one-fourth of the births occurring out-of-hospital. Outcomes

Out-of-Hospital Births Oregon Occurrence		
Year	Deliveries	Rate
1982	2,069	49.2
1983	2,060	50.2
1984	1,786	43.7
1985	1,772	43.5
1986	1,520	37.9
1987	1,361	34.0
1988	1,217	29.4
1989	1,117	26.2
1990	1,077	24.2
1991	979	22.2
1992	996	22.8
1993	936	21.6
1994	979	22.5
1995	967	21.7
1996	979	21.4
1997	970	21.5
1998	914	19.8
1999	948	20.6
2000	1,047	22.4
2001	1,007	21.7

Rates per 1,000 births.

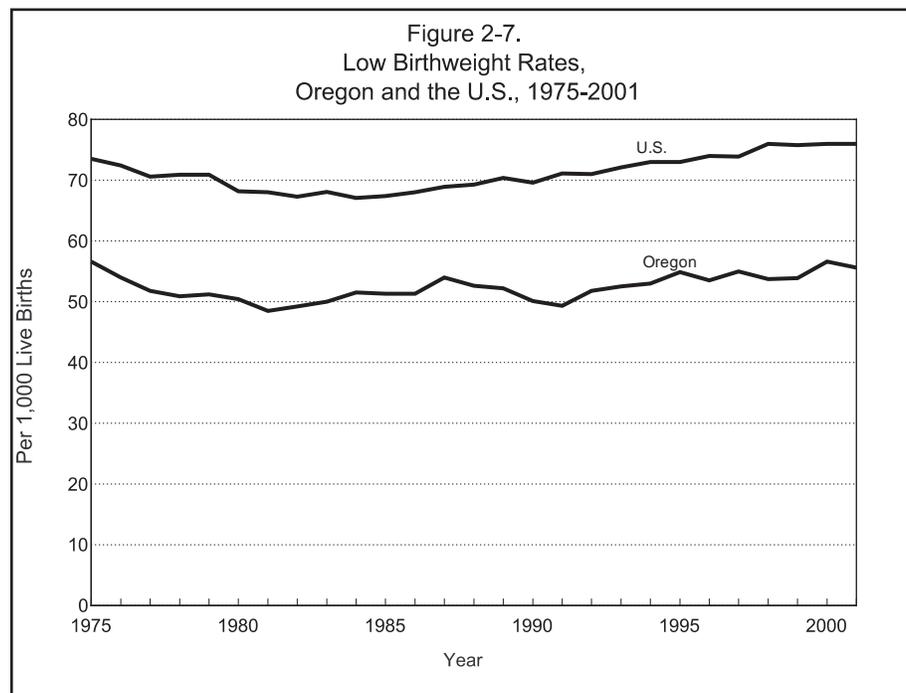
have generally been positive for out-of-hospital births. In 2001, only 19 infants born out-of-hospital in Oregon had low birthweights (1.9%). Ten infants (1.0%) were reported to have a congenital anomaly, which is slightly lower than the percentage for in-hospital births (1.3%).

The type of attendant varied by birth setting. Licensed Direct Entry Midwives (LDEM) were predominant in out-of-hospital births, delivering one-fifth (20.4%) of those births in 2001. LDEMs are lay midwives who have volunteered for state licensure to provide natality care for Oregon women. In addition, Certified Nurse Midwives delivered one in seven out-of-hospital births (12.6%). Naturopathic physicians delivered one in nine out-of-hospital births (11.1%). Non-medical attendants, including non-licensed lay midwives, delivered 543 babies, 53.9 percent of the out-of-hospital births. [Table 2-27].

Method of Delivery

In 2001, the rate of cesarean delivery was 21.4 per 100 births, an increase of 8.1% from 2000 (19.8 per 100 births) but well below the national rate of 24.4 per 100 births. The rate for vaginal delivery after a previous cesarean was only 2.1 while repeat cesarean was 8.1 per 100 births. The majority of births (76.5 per 100) continue to be vaginal deliveries (without prior cesarean). [Table 2-26]. During the past ten years, the rate of vaginal deliveries without prior cesarean has remained within a narrow range, 76.5 to 79.4 per 100 births.

Certified Nurse Midwife Deliveries, Oregon Occurrence			
Year	Deliveries		
	Total	In-Hospital	Out-of-Hospital
1984	1,912	1,567	374
1985	2,022	1,661	390
1986	1,984	1,607	400
1987	1,843	1,483	385
1988	2,345	2,133	259
1989	2,886	2,706	244
1990	3,660	3,539	226
1991	4,262	4,096	166
1992	4,498	4,319	179
1993	4,784	4,618	173
1994	4,931	4,772	159
1995	5,601	5,441	160
1996	6,019	5,871	148
1997	5,853	5,734	119
1998	6,152	6,004	148
1999	6,357	6,193	164
2000	6,740	6,591	149
2001	6,848	6,721	127



INFANT HEALTH CHARACTERISTICS

Period of Gestation

***There were 2,518
low birthweight
babies born to
Oregon mothers
in 2001.***

Preterm births, (born prior to completion of 37 weeks), comprised 7.6 percent of total births in 2001, almost half that of the U.S. in 2000 (11.6%). (Table 2-22) Similar to national trends, proportions of preterm births are higher for Non-Hispanic African Americans (11.5%) and Non-Hispanic American Indians (10.0%). [Table 2-23].

Low Birthweight

National Healthy People 2010 Objective

Reduce low birthweight to an incidence of no more than 5.0 percent of live births.

Percentage of Oregon low birthweight births, 2001: 5.6

Of the thousands of infants born each year, not all thrive and become healthy adults. Low birthweight is the major predictor of infant death, which in turn is a fundamental measure of the health of a population. Infants with low birthweight are more likely to need extensive medical treatment and to have lifelong disabling conditions. (For more information, see the Fetal and Infant Mortality section published in Volume 2 of the Oregon Vital Statistics Annual Report). The low birthweight rate is the proportion of infants who weigh less than 2,500 grams (5.5 pounds) at birth. In 2001, there were 2,518 low birthweight babies born to Oregon mothers. [Table 2-21]. One of the National Healthy People 2010 Objectives is to reduce the percentage of low birthweight infants nationwide to 5.0 percent. In 2001, the percentage of low birthweight births in Oregon remained slightly above this objective at 5.6 percent, or 55.6 per 1,000 live births. This rate is a decrease from the 2000 figure of 56.6. While annual changes have been slight over the last twenty years, there has been an upward trend in low birthweight infants and this year's rate is Oregon's second highest in twenty-five years. [Table 1-6; Figure 2-7]. Nevertheless, Oregon's low birthweight rates are typically 25 percent lower than the national rate and in 2001, Oregon's rate was 26.8 percent lower than the national rate (55.6 vs. 76.0 per 1,000 births).

Major factors contributing to the risk of having a low birthweight baby are multiple births, tobacco use and chronic hypertension. Other factors include: non-white race of mother, mother's age (younger than 18 or older than 34), lack of prenatal care, low income, single marital status, a previous fetal or infant death, low education, and short spacing between births. As an example of risk factors, women age 40 and over have the fourth-highest rate of first trimester care (83.1%) as well as the fourth lowest rate of

inadequate prenatal care (5.0%). [Table 2-16]. Nevertheless, women over age 40 continue to have a higher percentage of low birthweight babies. [Table 2-22]. In 2001, most women (64.9%) had at least one risk factor for their pregnancy. Statewide 8.4 percent of the women had three or more risk factors.

Apgar Scores

The Apgar score is composed of measurements of five characteristics of the infant: heart rate, respiratory effort, muscle tone, reflex irritability, and color. Each characteristic is rated 0-2 and the score totaled. Scores below 7, five minutes after birth, indicate poor to intermediate health at birth. In Oregon during 2001, 1.6 percent of infants had Apgar scores below 7, slightly higher than the 2000 national figure of 1.4 percent. [Table 2-22, Table 2-23].

Abnormal Conditions and Congenital Anomalies

The most frequently reported conditions on birth certificates were birth injury, assisted ventilation of less than 30 minutes and assisted ventilation of more than 30 minutes. [Table 2-34, Table 2-35]. Congenital anomalies reported on birth certificates are shown in Table 2-36. Although Oregon occurrences are somewhat higher than national rates for some anomalies, congenital anomalies are believed to be under reported nationally due to factors such as recognizability and severity. Even at the national level, data users are advised to use caution in comparing annual occurrences for relatively small numbers.

Multiple Births

Although slightly less than three percent of births in Oregon during 2001 were multiple births, the proportion varied widely by age, race and ethnicity. During 2001 the older the mother, the more likely she was to have multiple births. The percentage of multiple births for each age group increased progressively from none for mothers younger than 15 to 22.4% of births to mothers age 45 and older [Table 2-22]. Non-Hispanic African Americans and Non-Hispanic Whites were most likely to have multiple births (3.2% and 3.1% respectively). [Table 2-23].

Primary Source of Payment for Delivery, Oregon Residents			
Year	Private Insurance	Self Pay	Medicaid/OHP
	%	%	%
1989	60.7	9.5	27.5
1990	60.4	8.7	28.7
1991	58.2	6.5	33.2
1992	57.2	5.8	35.2
1993	56.2	5.9	36.2
1994	57.5	5.6	34.9
1995	57.9	4.9	35.5
1996	58.3	5.7	35.0
1997	60.8	6.3	31.9
1998	62.2	6.3	30.7
1999	61.1	5.9	32.4
2000	61.6	5.4	32.8
2001	61.2	4.3	34.3

NOTE: Denominator excludes births with unknown payor source and multiple payor source.

SOURCE OF PAYMENT

Primary source of payment for delivery is noted on Oregon birth certificates under four categories: 1) private insurance, 2) self-pay (no insurance), 3) public insurance (Medicaid/Oregon Health Plan), and 4) other public insurance. The specific type of private insurance coverage is not defined. Multiple payment sources can be indicated. Private insurance companies paid for the majority of deliveries in Oregon (61.2%), down slightly from 61.6 percent in 2000 (see sidebar). Medicaid programs (e.g. the Oregon Health Plan) paid for slightly more than one-third of Oregon resident births (34.3%). Delivery costs were more likely to be paid for by public insurance if the woman was under age 18. [Table 2-13].