STATISTICAL NEWS

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According to the Centers for Disease Control and Prevention (CDC) approximately 90 percent of Americans aged 2 years and older consume too much salt, which causes an increased risk in chronic diseases such as high blood pressure, stroke, heart failure, osteoporosis, stomach cancer, and kidney disease. On average, Americans consume about 3,300 mg of sodium (equivalent to about 11 packets of salt, or ½ tablespoon) per day.

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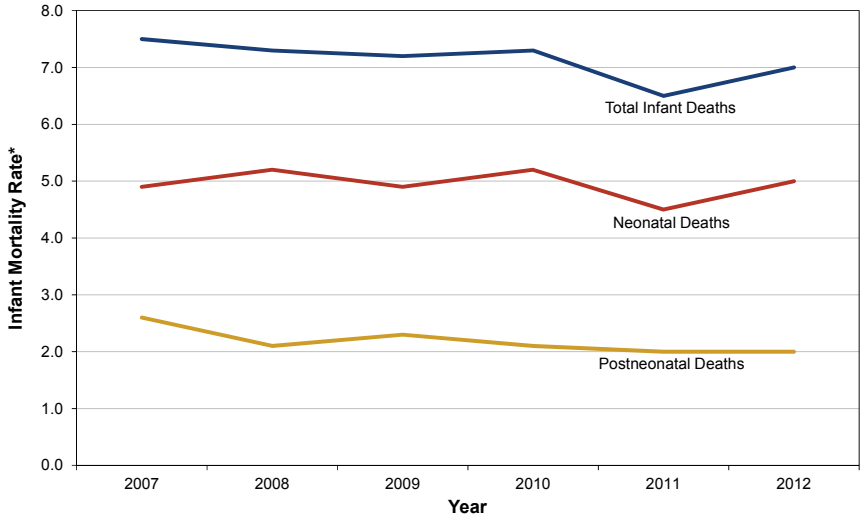
Infant Mortality: An Important Health Indicator

Pa. Infant Deaths Rise in 2012 but Great Progress Being Made

Infant mortality is often used as an indicator of the health and well-being of a nation. According to the Centers for Disease Control and Prevention (CDC), an infant death is defined as the death of a baby before his or her first birthday. Infant deaths are commonly divided into two age categories. The first age category is named "neonatal" and represents deaths that occur before the age of 28 days. The second age group is for deaths occurring between 28 and 364 days and is referred to as "postneonatal." Some common causes for infant deaths include serious birth defects, preterm births (births before 37 weeks gestation), Sudden Infant Death Syndrome (SIDS), maternal complications of pregnancy, and injuries such as suffocation.

To help prevent infant deaths, the CDC recommends some healthy and safe behaviors for women of reproductive age both before they become pregnant and during pregnancy. These include, but are not limited to, taking folic acid, maintaining a healthy weight and diet, quitting tobacco use, not drinking excessive amounts of alcohol, visiting a health care provider at the time periods recommended and discussing your medications with your health care provider, and preventing injuries by wearing seat belts, taking CPR, and installing/testing smoke alarms. It is also a recommendation to create and maintain a safe sleep environment for the infant. If someone you know has experienced the loss of an infant, the following organizations may provide needed support: CJ Foundation for SIDS, Compassionate Friends, First Candle, and March of Dimes.

Chart 1
Pennsylvania Resident Infant Mortality Rates*
by Age Group and Year, 2007-2012



*per 1,000 resident live births

This article will review statistics on infant deaths for Pennsylvania residents by various demographic groups, trends, and causes. Please note that the rates used in this article are called infant mortality rates, i.e., the number of infant deaths per 1,000 live births. These rates differ from infant death rates, which are the number of infant deaths per 1,000 (or 100,000) population of those under one year of age.

Trends

The infant mortality rate for Pa. residents rose in 2012, increasing to 7.0 per 1,000 resident live births compared to 6.5 in 2011. During that time the number of infant deaths rose from 903 in 2011 to 987 in 2012. Most of the increase occurred among neonatal deaths, the rate for which rose from 4.5 to 5.0 (with a count of 699 in 2012), while the postneonatal mortality rate remained at 2.0 (with a count of 288 in 2012). However, it is important to note that since the year 2007, the infant mortality rate has declined by more than 6 percent from 7.5 to 7.0 (see Chart 1). It is also important to note that enormous progress has been made in the reduction of infant deaths since the early 1900's. The infant mortality rate in 1915 (the first year Pennsylvania collected these data) was a staggering 109.8. That means that one in every ten babies born that year died in the first year of life. The rate then decreased in each decade thereafter until the new millennium (see Chart 2, page 3).

Pa. and National Comparison

The infant mortality rate for the United States in 2012 was 6.0. The corresponding Pennsylvania rate (7.0) was more than 16 percent higher than this latest U.S. figure. Of the 50 states, Pennsylvania had the 14th highest infant mortality rate in 2012. The neonatal mortality rate showed a similar result, as the United States

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Infant Mortality: An Important Health Indicator

had a rate of 4.0, compared to 5.0 for Pennsylvania residents. However the postneonatal rate for Pennsylvania (2.0) and the U. S. were the same.

Race/Ethnicity/Sex

The infant mortality rate for black residents of Pennsylvania was the highest of the race/ethnicity groups reviewed. In 2012, the infant mortality rate for black residents was 14.3 (see Chart 3), nearly three times higher than the rate for white infants (5.2). Asian/Pacific Islanders had an infant mortality rate of only 3.2, which is approximately 38 percent lower than the rate for whites. For Pennsylvania residents of Hispanic ethnicity (can be of any race), the infant mortality rate was 7.9, which is higher than the rates for both whites and Asian/Pacific Islanders but not nearly as high as the figure for blacks. With regards to gender, males (7.4) had a higher infant mortality rate in 2012 than female infants (6.5).

Cause of Death

A major cause of death for Pennsylvania resident infants in 2012 was disorders relating to length of gestation and fetal malnutrition (ICD-10 codes P05-P08). There were 217 of these types of deaths, with most occurring in the neonatal period (the first 27 days of life). Many of these deaths were due to extreme low birth weight or extreme immaturity. Another significant cause of infant death for residents of Pa. was birth defects (ICD-10 codes Q00-Q99), which accounted for 165 deaths in 2012. The most common type of fatal birth defect was congenital malformations of the heart. A third major cause of infant death for Pa. residents was the effects of maternal factors and complications of pregnancy, labor, and delivery (ICD-10 codes P00-P04). This cause accounted for 137 deaths in 2012, and most of these deaths were neonatal deaths.

Perhaps the most well-known type of infant death is SIDS (Sudden Infant Death Syndrome). There were 63 Pa. resident deaths due to SIDS in 2012, with almost all occurring in the postneonatal period (28-364 days old).

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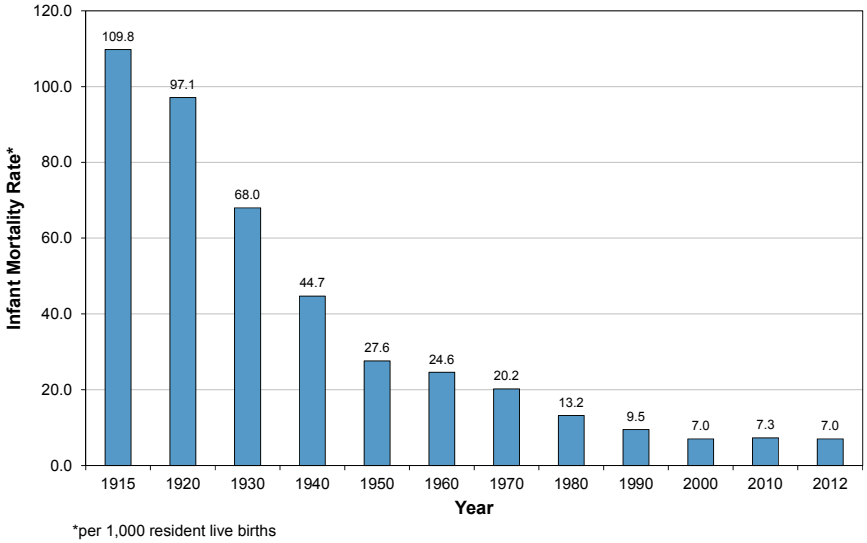

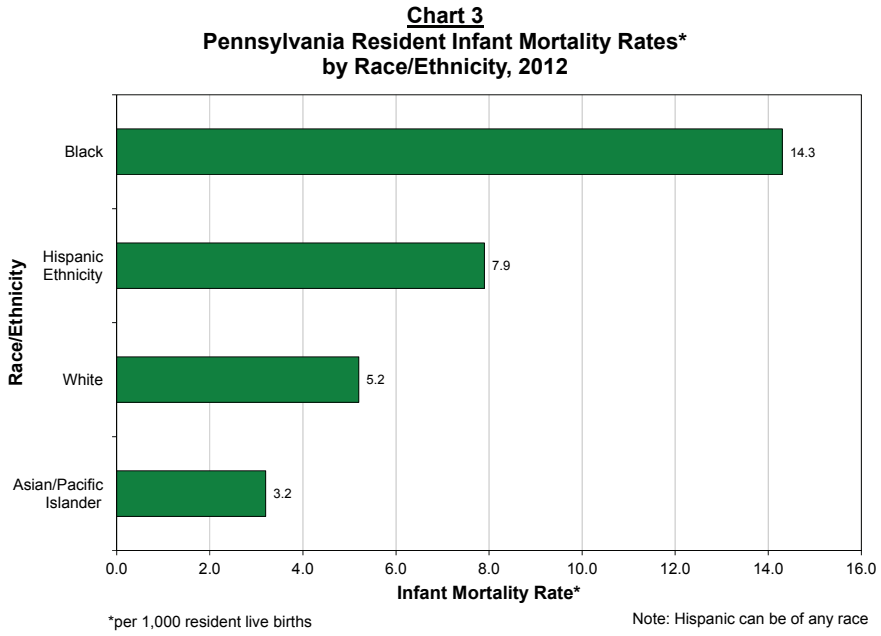

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Infant Mortality: An Important Health Indicator

According to the CDC, SIDS is the sudden death of an infant that cannot be explained even after a thorough investigation is conducted. This investigation includes a complete autopsy, examination of the death scene, and review of the clinical history. Although the cause for this type of death cannot be explained, it is important to note that most SIDS deaths occur while the infant is sleeping in an unsafe sleeping environment. For information on resources and activities relating to SIDS, CDC is a good source. One other significant cause of infant death worth mentioning is accidental suffocation and strangulation. There were 25 Pennsylvania resident infant deaths for this cause in 2012, and most occurred in the postneonatal period.

County

The Pennsylvania county with the highest resident infant mortality rate during the three-year period of 2010-2012 was Montour County (21.1 infant deaths per 1,000 resident live births). The second highest infant mortality rate was for residents of Mifflin County (11.9), the third highest rate was Lawrence County at 11.0, and the fourth highest was Philadelphia County (10.1). These counties all had significantly higher rates (at the 95% confidence level) than the state.

Cumberland County residents had the lowest infant mortality rate (3.9) during the three-year period of 2010-2012. The next lowest rate was for residents of Butler County (4.5). The third lowest was Montgomery County (5.0), followed by Centre County (5.1). Of these four counties all but Centre County had significantly lower rates when compared to the state. Please note that only counties that had at least 10 infant deaths during the three-year period were included in these rankings, since rates based on less than 10 events are considered statistically unreliable.

For additional information on infant deaths visit our Death Statistics webpage or EpiQMS, our online data dissemination tool. For questions regarding the statistics presented in this article, please contact the Division of Health Informatics via the Contact Us page on our website at www.statistics.health.pa.gov.

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2012 Popular Baby Names in Pennsylvania

Mason and Emma Take First in 2012

Baby names are always a popular topic of conversation. Common subjects include the most popular choices for first and middle names and the most unique names for boys and girls. The year 2012 was no exception, as there were some very popular choices as well as some rather unique individual choices.

Starting with boys, 2012 saw Mason take the most popular spot for the second straight year. For the first time since 1959, when the Pennsylvania Department of Health began tracking these statistics, Michael fell outside of the top two, dropping to the fourth most popular male first name in 2012. For girls, 2012 saw Emma become the most popular name for the first time. Girls' names have seen much more change in recent years, with traditional names like Mary and Nicole being replaced with more contemporary names like Madison and Abigail. The full list of the top ten boys' and girls' names are shown in Table 1.

When comparing the state list of most popular baby names to the national list, both Mason and Emma fell from their top spots within the state to second place nationally. The most popular national boy's first name in 2012 was Jacob, which ranked third in Pennsylvania. The most popular national girl's first name in 2012 was Sophia, which ranked second in the state.

In addition to the popular names, 2012 offered a variety of unique names as well. For the purposes of this article, unique names are defined as a name with only one occurrence per gender. For boys there were names such as Electron, Brick, Ole, Pharaoh, Everest, Victory, and Freedom. For girls there were names such as Sparrow, Orange, Majesty, Bliss, Apricot, Pinkie, and Nautica. These were just a few of the many unique names that were given to babies born in 2012. For a full listing of baby first names by gender, check the Birth First Name Occurrences page on the department website.

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Table 1
Top Ten Most Popular Baby First Names by Gender
Pennsylvania Resident Births, 2012

Boys	Count	Rank	Girls	Count
MASON	855	1	EMMA	875
LIAM	782	2	SOPHIA	866
JACOB	763	3	OLIVIA	771
MICHAEL	720	4	AVA	762
NOAH	702	5	ISABELLA	702
RYAN	617	6	MADISON	532
ETHAN	601	7	ABIGAIL	498
LOGAN	598	8	EMILY	487
BENJAMIN	579	9	MIA	412
JOHN	564	10	AUBREY	408

Table 2
Top Ten Boys First Names and Middle Names
Pennsylvania Resident Births, 2012

Boy First Name	Count	Rank	Boy Middle Name	Count
MASON	855	1	JAMES	3,596
LIAM	782	2	MICHAEL	3,283
JACOB	763	3	JOSEPH	2,032
MICHAEL	720	4	ANTHONY	1,373
NOAH	702	5	THOMAS	1,369
RYAN	617	6	LEE	1,286
ETHAN	601	7	ROBERT	1,253
LOGAN	598	8	WILLIAM	1,242
BENJAMIN	579	9	DAVID	1,191
JOHN	564	10	JOHN	1,161

Table 3
Top Ten Girls First Names and Middle Names
Pennsylvania Resident Births, 2012

Girl First Name	Count	Rank	Girl Middle Name	Count
EMMA	875	1	MARIE	4,868
SOPHIA	866	2	ROSE	2,880
OLIVIA	771	3	GRACE	2,872
AVA	762	4	ELIZABETH	2,722
ISABELLA	702	5	LYNN	1,692
MADISON	532	6	ANN	1,680
ABIGAIL	498	7	NICOLE	1,228
EMILY	487	8	MAE	1,102
MIA	412	9	JANE	739
AUBREY	408	10	RAE	725

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2012 Popular Baby Names in Pennsylvania

Another interesting topic is the comparison of first names versus middle names for babies. There was a lot of overlap in popularity for boys' first and middle names in 2012. Michael, Joseph, James, Matthew, Anthony, William, and John were all in both the top 20 for first names and middle names for boys. The overlap for girls was much smaller with only Grace and Elizabeth cracking the top 20 for both first names and middle names. Mason (the most popular boys' first name) was the 70th most popular boys' middle name, while Emma (the most popular girls' first name) was the 86th most popular girls' middle name. Inversely, Marie, the most popular middle name selection for girls, was just the 417th most popular girls' first name. For boys, the difference was not as large. James was the choice for most popular baby middle name and also checked in at the 16th most popular first name. Comparisons for baby boys' names can be found in Table 2 and for baby girls' names in Table 3 (see page 5).

One other interesting fact is that the middle name selections for both boys and girls are concentrated more among a smaller group of names in contrast to first names, where you see more diverse choices and spellings of names. For boys, there were about 500 more first name choices selected versus middle name choices. For girls, there were about 3,000 more first name choices compared to middle name choices. Overall, girls had more first name and middle name selections compared to boys. There were 10,810 different first names given to boys versus 10,320 middle name selections. Girls had 14,567 different first names given versus 11,160 different middle names assigned in 2012. One of the main reasons for this could be that spelling differences amongst similar names is more common for girls (Sara and Sarah, for example) than what is commonly seen for boys' names.

For additional birth data, please visit the Health Statistics webpages on the Pennsylvania Department of Health website. Birth data among Pennsylvania residents are also available on EpiQMS, the department's interactive data dissemination tool. If you have any questions about the data presented in this article, please contact the Division of Health Informatics by sending us a message using our Contact Us page.

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Smoking During Pregnancy Declining Among Pa. Mothers

Younger White Mothers Have Highest Rate of Smoking During Pregnancy

It is commonly known that smoking during pregnancy can increase the risk for pregnancy complications. Women who smoke during pregnancy are more likely to have preterm deliveries (less than 37 weeks gestation) and low birth weight babies (under 2,500 grams) than women who do not smoke during their pregnancy. According to data collected by the Pa. Department of Health on certificates of live births, younger white mothers were more likely to smoke during pregnancy than young black and Hispanic mothers, while Asian/Pacific Islander (A/PI) mothers were consistently the least likely to smoke during pregnancy. Data for A/PI mothers are not included in this article's charts due to small counts.

According to the Centers for Disease Control and Prevention (CDC), smoking during pregnancy, regardless of when or how often, can result in the baby being born too small or early (premature birth). Premature babies often have health problems like low birth weight and are at risk for other serious health problems or death. The best time to quit smoking is before a woman gets pregnant, but quitting any time during pregnancy can help improve the baby's start on life. The longer a mother smokes during pregnancy, the greater the effect on the infant's birth weight. Both the birth weight and the length of pregnancy are prime indicators of infant health. Low birth weight and preterm births are major contributors to higher infant mortality, according to the CDC.

The percentages of live births to Pennsylvania mothers who smoked in the three months prior to pregnancy, and the first, second, and third trimester of pregnancy for 2003-2012 are shown on Chart 1. Aside from a few slight increases, the percent of live births to women smoking before and during each trimester has been decreasing each year during this decade. In addition, the smoking percentage during each trimester of the pregnancy was consistently lower than in the preceding three-month period. In 2003, the percent of live births to mothers who smoked in the three months prior to pregnancy was

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Chart 1
Percent of Live Births to Mothers Who Smoked Before and During Pregnancy, Pennsylvania Residents, 2003-2012

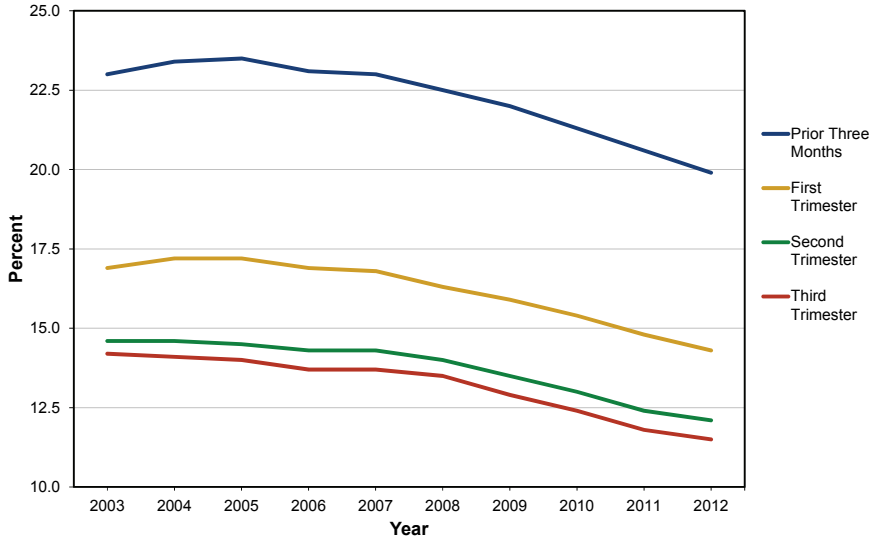
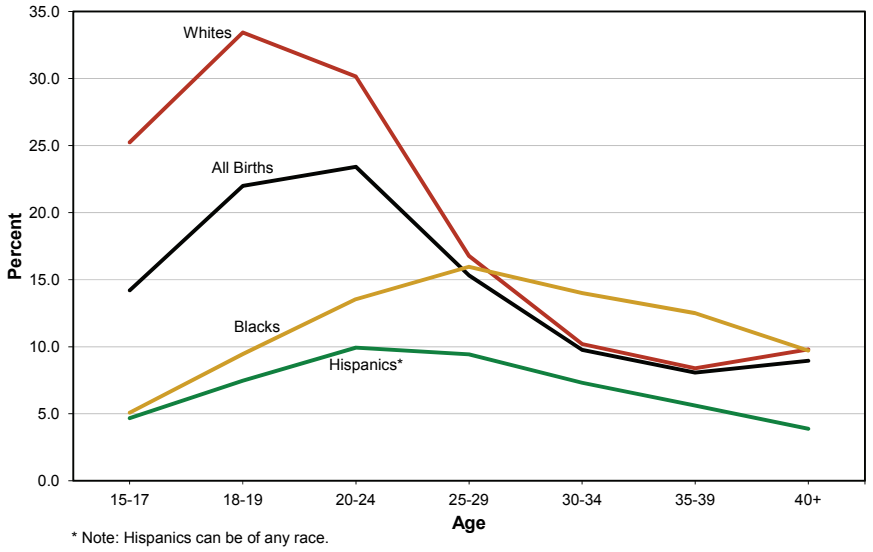


Chart 2
Percent of Live Births to Mothers Who Smoked During Pregnancy by Age, Race and Hispanic Origin of Mother, Pennsylvania Residents, 2012



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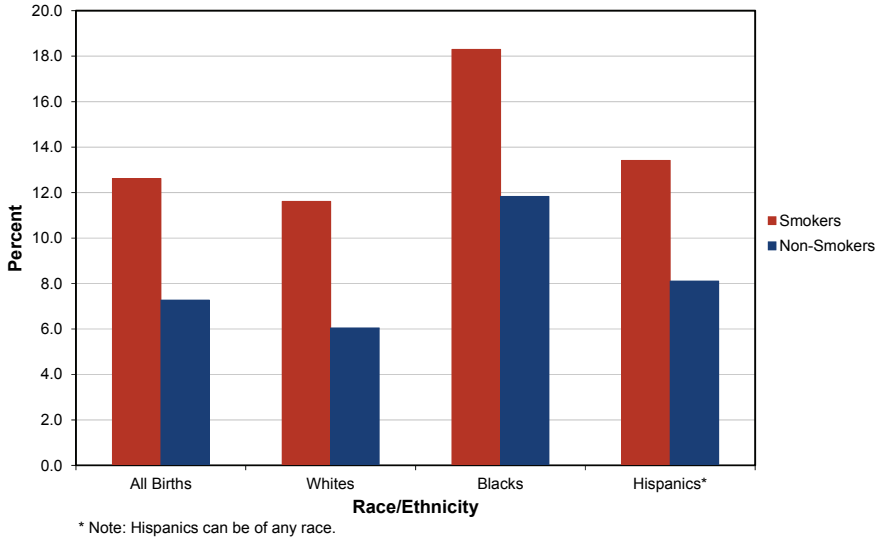
Smoking During Pregnancy Declining Among Pa. Mothers

23.0 percent; it was 16.9 percent during the first trimester, 14.6 percent during the second trimester, and 14.2 percent during the last trimester. In 2012, the percent of mothers who smoked during the three months prior to pregnancy dropped to 19.9 percent, to 14.3 percent in the first trimester, 12.1 percent in the second trimester, and 11.5 percent in the third trimester.

When comparing mothers that smoked during the third trimester to those that smoked during the first trimester, some mothers stopped smoking while, conversely, some smoked more as their pregnancies progressed. In 2003, 1.6 percent of mothers smoked more cigarettes in the last trimester compared to the first trimester. Interestingly, of those that smoked more, 40 percent of those mothers had not smoked at all during the first trimester. In 2012, 0.9 percent of mothers smoked more in the last three months of their pregnancy; of those mothers, 43 percent had not smoked in the first three months of pregnancy. Alternatively, when looking at mothers who smoked less or stopped smoking during the last three months of pregnancy versus the first three months, 8.6 percent of mothers in both 2003 and 2012 either stopped smoking or smoked less by the third trimester when compared to the first trimester. Of those, 39.1 percent in 2003 and 37.3 percent in 2012 smoked in the first three months of pregnancy and later reported no cigarettes by the last three months.

Among white mothers in 2012, over 16 percent smoked during pregnancy, the highest percentage among the race/ethnicity groups analyzed here. Among black mothers, 13.3 percent of live births involved mothers who smoked during pregnancy. Live births to Asian/Pacific Islander mothers who smoked during pregnancy showed the lowest percent (1.5 percent). Slightly over 8 percent of the live births to Hispanics involved mothers who had smoked during pregnancy.

Chart 3
Percent Low Birth Weight Live Births by Smoking Status, Race and Hispanic Origin of Mother, Pennsylvania Residents, 2012



* Note: Hispanics can be of any race.

When looking at the percent of live births to mothers who smoked by age and race (Chart 2, page 7), it becomes evident that differences exist between the races by age. In 2012, young white mothers were the most likely to smoke during pregnancy. In fact, it is more common for younger mothers to smoke during pregnancy, compared to older mothers. For example, 33.4 percent of live births were to white mothers ages 18-19 who smoked during pregnancy, compared to just 9.5 percent of black mothers ages 18-19. Hispanic mothers ages 18-19 had 7.5 percent of live births to mothers who smoked during pregnancy. However, among mothers ages 40 and over, 9.8 percent of white births were to mothers who smoked during pregnancy, 9.7 percent were to black mothers, and 3.9 percent were to Hispanic mothers who smoked during pregnancy. To contrast that, in 2003, the percentage of black mothers ages 40 and over that smoked during pregnancy was 20.9, compared to 10.5 percent of white mothers and 12.1 percent of Hispanic mothers.

The percent of low birth weight babies among Pa. residents was considerably higher for smoking mothers (12.6 percent) than non-smoking mothers (7.3 percent) in 2012. The percent of low birth weight babies among white, black, and Hispanic mothers is considerably higher among smokers (see Chart 3). Among whites, 6.0 percent of live births to non-smoking mothers were low birth weight, compared to 11.6 percent for mothers who smoked

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Smoking During Pregnancy Declining Among Pa. Mothers

during pregnancy. Similarly, with Hispanic mothers, 8.1 percent of live births to non-smoking mothers were low birth weight, compared to 13.4 percent for mothers who smoked during pregnancy. Over 18 percent of live births to black mothers who smoked during pregnancy were low birth weight, versus the 11.8 percent of low birth weight babies among non-smoking black mothers.

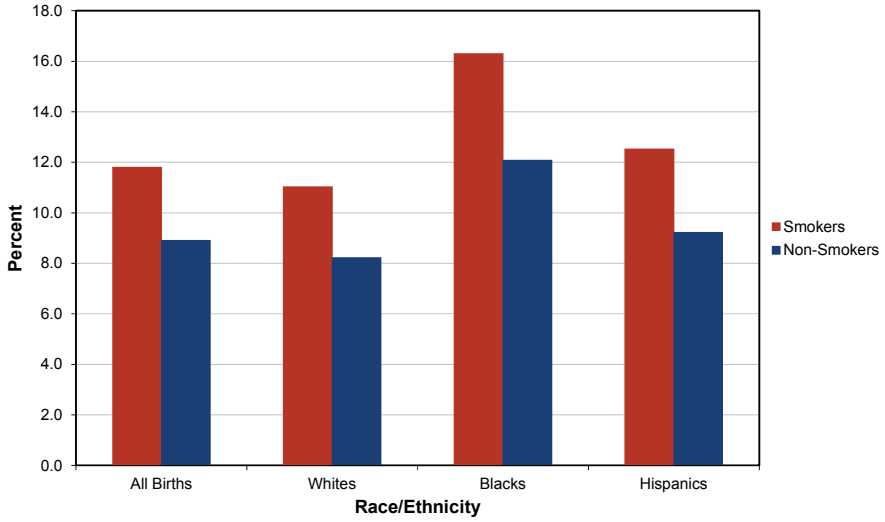
The percent of preterm births was higher among smoking mothers (11.8 percent), compared to non-smoking mothers (8.9 percent). A review of the percent of preterm births for the race/ethnicity groups follows the same pattern as the percent of low birth weight babies (see Chart 4). White mothers who did not smoke had 8.2 percent of preterm live births compared to 11.0 percent of preterm live births to white mothers who did smoke. The percent of preterm live births to Hispanic mothers who did not smoke was 9.2 percent versus 12.5 percent to those mothers that did smoke. Black mothers had the highest percentage of preterm live births at 12.1 percent and 16.3 percent, to those who did not smoke and those who did, respectively.

Additional factors such as education level, marital status, and breastfeeding initiation status differed for mothers who smoked during pregnancy, compared to those who did not smoke. In 2012, over 25 percent of live births to mothers with a high school education or less were to smoking mothers, while only 8.1 percent of mothers with some college education or a college degree smoked during pregnancy. Almost 27 percent of live births in 2012 to unmarried mothers were to women who smoked during pregnancy, compared to just 6.2 percent of married women who smoked during pregnancy. Of the women who initiated breastfeeding following a live birth, only 10.1 percent had smoked during the pregnancy. Among women who did not initiate breastfeeding, 28.0 percent had smoked during the pregnancy.

In addition, mothers living in rural counties were generally more likely to smoke during pregnancy than mothers living in urban counties. The five counties with the highest percent of live births to mothers who smoked during pregnancy were McKean (37.2 percent), Cameron (36.5 percent), Potter (34.5 percent), Fayette (34.2 percent), and Elk (31.4 percent). The counties with the lowest percent of live births to mothers who smoked during pregnancy were Chester (6.5 percent), Montgomery (6.8 percent), Delaware (9.6 percent), Philadelphia (9.9 percent), and Lancaster (10.1 percent).

For additional information on birth statistics or smoking status during pregnancy, visit our website at www.statistics.health.pa.gov and click on the EpiQMS link or visit the Birth, Death, and Other Vital Statistics page. For questions about the data presented in this article, please contact the Division of Health Informatics by sending us a message using our Contact Us page.

Chart 4
Percent Preterm Live Births by Smoking Status, Race and Hispanic Origin of Mother, Pennsylvania Residents, 2012



* Note: Hispanics can be of any race.

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Sodium or Salt-Related Behavior in Pennsylvania

An Analysis of Questions Included in the 2012 BRFSS Survey

According to the Centers for Disease Control and Prevention (CDC) approximately 90 percent of Americans aged 2 years and older consume too much salt, which causes an increased risk in chronic diseases such as high blood pressure, stroke, heart failure, osteoporosis, stomach cancer, and kidney disease. On average, Americans consume about 3,300 mg of sodium (equivalent to about 11 packets of salt, or ½ tablespoon) per day. Current dietary guidelines from the CDC recommend that adults should consume no more than 2,300 mg of sodium, which is approximately seven packets of salt, or one teaspoon per day. It is also recommended that adults who are African-American and have high blood pressure, diabetes, kidney disease or are 51 years of age or older consume less than 1,500 mg of sodium, which is approximately five packets of salt, or half a teaspoon per day. The average American consumes a vast majority of sodium in his or her diet from processed or prepared foods, such as bread, pizza, poultry, cheese, soups, chips, and popcorn. To continue addressing the issue of sodium overconsumption, the Pennsylvania Department of Health included two questions related to sodium or salt-related behavior in the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey.

The BRFSS survey is a telephone survey funded by the CDC that is conducted by state health departments with technical and methodological assistance provided by the CDC. Telephone interviews of adults aged 18 and over are conducted using randomly generated telephone numbers. The questions asked relate to the leading causes of chronic diseases and other health-related behaviors.

In the first question, "Has a doctor or other health professional ever told you to reduce your salt intake?," information was obtained from Pennsylvania adults and then analyzed for various criteria. Results from this question can be found in Chart 1. It is estimated that 55 percent (95% Confidence Interval [CI]: 51-59) of adults who have heart disease indicated they were told by a doctor or other health professional to reduce salt intake, which is significantly higher compared to adults who do not have heart disease (43 percent, CI: 38-48). The estimate for adults with diabetes (66 percent, CI: 60-71) was also significantly higher than all Pennsylvania adults (50 percent, CI: 47-53) and adults who are non-diabetic (44 percent, CI: 40-47). It was also found that estimates for adults who are considered obese (58 percent, CI: 53-63) were significantly higher compared to adults who are considered overweight (46 percent, CI: 41-52) and adults who are neither overweight nor obese (42 percent, CI: 36-48). Adults who are overweight or obese or have heart disease

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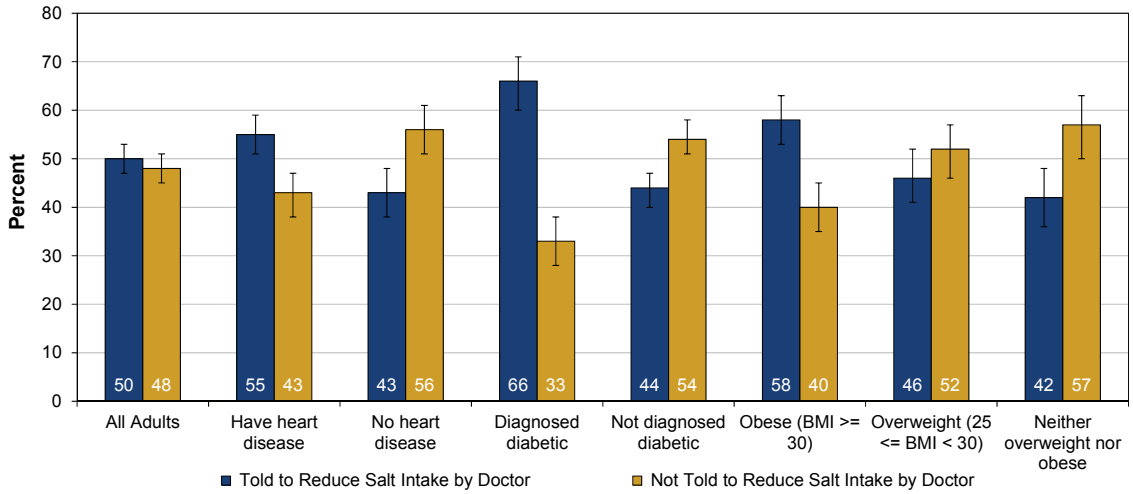
Chart 1
BRFSS Question: Has a doctor or other health professional ever told you to reduce your salt intake?
Pennsylvania Adults Residents, 2012 Survey



95% Confidence Interval
Source: 2012 Pennsylvania BRFSS Survey

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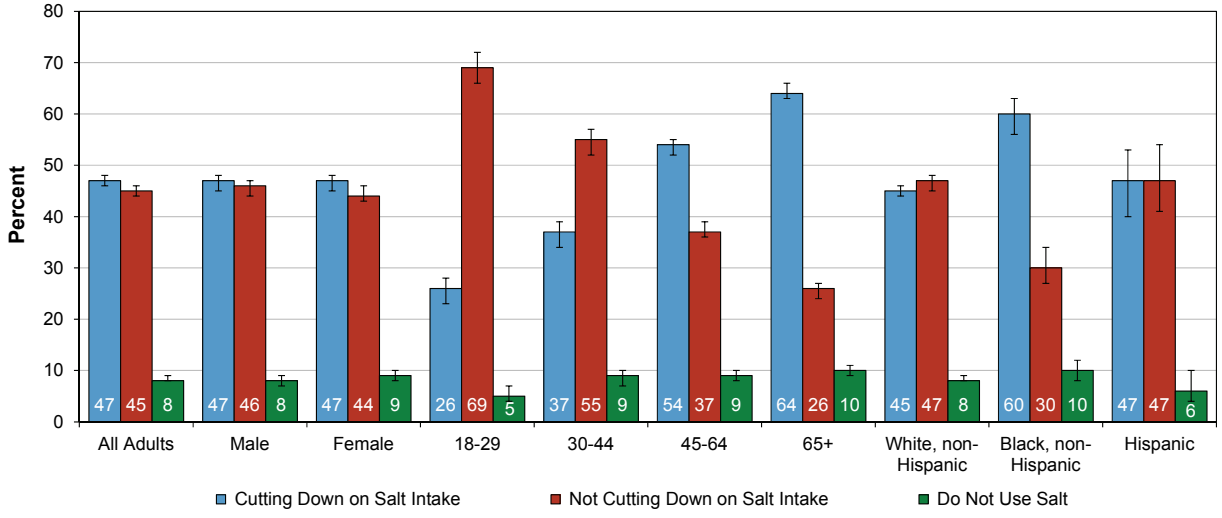
Sodium or Salt-Related Behavior in Pennsylvania

or diabetes are more likely to be told by a doctor or other health professional to reduce their salt intake than those without these risk factors. However, it is still important that all adults be educated on the risks of high sodium consumption, regardless of any health condition.

The second question, "Are you cutting down on salt intake now?," collected information on salt intake among Pennsylvania adults. As indicated on Chart 2, adults aged 65 and older (64 percent, CI: 63-66) had a significantly higher percentage compared to adults aged 18-29 (26 percent, CI: 23-28), adults aged 30-44 (37 percent, CI: 34-39), and adults aged 45-64 (54 percent, CI: 52-55). Black, non-Hispanic adults (60 percent, CI: 56-63) had a significantly higher percentage compared to white, non-Hispanic adults (45 percent, CI: 44-46), and Hispanic adults (47 percent, CI: 40-53). Estimates for adults aged 45-64 (54 percent, CI: 52 -55) and adults aged 65 and older (64 percent, CI: 63-66) were significantly higher compared to Pennsylvania adults overall (47 percent, CI: 46-48). Black, non-Hispanic adults (60 percent, CI: 56-63) also had a significantly higher percentage compared to Pennsylvania adults overall. There were no statistically significant differences between males and females currently cutting down on their salt intake when compared to Pennsylvania adults overall.

Adults and children generally can benefit from reducing the amount of salt in their diet. Purchasing more fresh foods, such as fruits, vegetables, meat and poultry, and eating more home-prepared foods and meals (where you are able to control the amount of salt that is being used) are all helpful ways of reducing your salt intake. It is also important to read the nutritional facts on packaging while shopping.

Reports are created from the results of the annual BRFSS surveys and can be found on the Health Statistics webpages on the Pennsylvania Department of Health website. The data are also posted on the department's interactive Web tool, the Epidemiologic Query and Mapping System (EpiQMS). If you have any questions about BRFSS data or the statistics presented in this article, please contact the Division of Health Informatics by submitting a question or data request through our Division's Contact Us page.



Source: 2012 Pennsylvania BRFSS Survey

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