

KIDS COUNT IN DELAWARE FAMILIES COUNT IN DELAWARE

Fact Book 2005

*Funded by The Annie E. Casey Foundation
the University of Delaware
and the State of Delaware*



Imena and Almonta 2003



Imena and Almonta 2005

KIDS COUNT in Delaware

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The photographs in this book do not necessarily represent the situations described.



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- Delaware Department of Services for Children, Youth and Their Families
- Center for Applied Demography and Survey Research
- Center for Drug and Alcohol Studies
- Delaware Health Statistics Center
- Delaware Population Consortium
- Delaware State Housing Authority
- Domestic Violence Coordinating Council
- Family and Workplace Connection
- Statistical Analysis Center

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Communities Count data and maps.

*A special thank you to the Delaware
children and families featured on the
cover and throughout this book.*

A Message from KIDS COUNT in Delaware

KIDS COUNT celebrates ten years: A look at Delaware's children – then and now

Welcome to our tenth edition of KIDS COUNT in Delaware. As we reflect on the past ten years of compiling data for our annual KIDS COUNT Fact Book, we are grateful for the continued support of The Annie E. Casey Foundation, the State of Delaware, and the University of Delaware. Our annual publication has become the benchmark in the state for policy makers and citizens to learn about the status of children and families in Delaware.

Our initial KIDS COUNT Fact Book in 1995 has grown from tracking the ten national KIDS COUNT indicators in 65 pages to a broad compendium of data profiling not only kids, but families as well— and is now nearly 170 pages long. The scope of the data has expanded to include a broad range of indicators assessing the health, economic, educational and social well-being of our children and families. While we initially included some generic photographs to illustrate negative statistics, we soon realized that using more photos of Delaware children and families showing positive outcomes helped bring the message home even more effectively. Through the years we have watched these children grow and prosper, so in this anniversary edition, we urge you to enjoy the photos – then and now. You'll see babies who have become toddlers, young soccer players now competing in high school soccer matches, and families of three becoming families of four.

This 2005 Fact Book illustrates many favorable trends in Delaware over the past 10 years. We are pleased to see the decreasing rates of teen births, child poverty and high school dropouts. It speaks to the work of many in this state who have addressed tough issues and worked to solve them. However, the data also show trends in some areas that call for more attention from us, especially infant mortality and low birth weight babies. Investing in our children as a matter of public policy must remain a priority!

KIDS COUNT in Delaware is one of fifty-one similar projects throughout the United States funded by The Annie E. Casey Foundation. It is joined with Governor Minner's commitment to children and families through the FAMILIES COUNT initiative, which expands upon the ten core tracking indicators of National KIDS COUNT to look at a broad range of indicators relevant to the health and well-being of children and families. We also wish to express our appreciation for the support of the University of Delaware's Center for Community Research and Service, which houses KIDS COUNT in Delaware.

"The truest measure of our future potential is in the current condition of our youth." This statement by The Annie E. Casey Foundation reflects the sentiment that guides KIDS COUNT projects throughout the nation. Certainly, most citizen and policy groups embrace this statement from a value perspective. The real challenge continues to be the translation of this guiding principle into the budgetary, policy, and community and organizational actions necessary to effect positive change for children and families. As we look forward to our next ten years, KIDS COUNT remains optimistic that, by working together, we can assure the brightest possible future for Delaware's children.

Steven A. Dowsben, M.D.
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Theodore W. Jarrell, Ph.D.
Chair, Data Committee

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Director

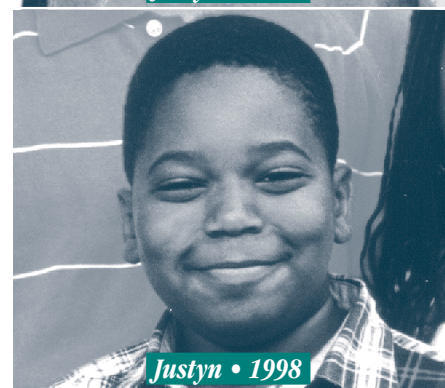
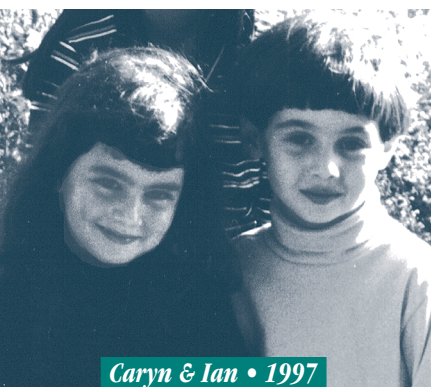
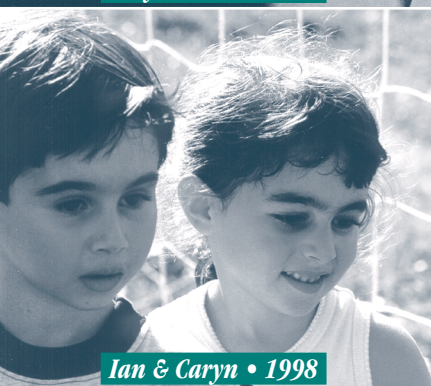


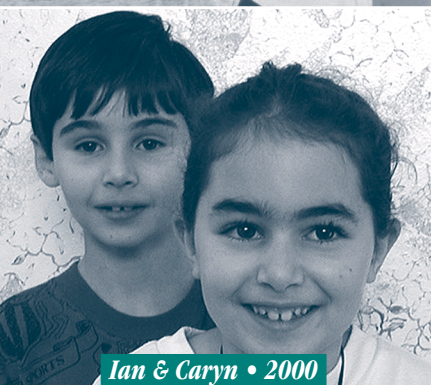
Table of Contents



Caryn & Ian • 1997



Ian & Caryn • 1998



Ian & Caryn • 2000

A Message from Kids Count in Delaware	3
List of Data Tables	5
Kids Count in Delaware Introduction	8
Overview	12
Counting the Kids: Delaware Demographics	14
<i>Health and Health Behaviors</i>	21
Prenatal Care	22
Kids Count Indicator Low Birth Weight Babies	24
Kids Count Indicator Infant Mortality	26
Women and Children Receiving WIC	33
Lead Poisoning	34
Child Immunizations	35
Childhood Asthma	36
Children without Health Insurance	38
Kids Count Indicator Child Deaths	40
Kids Count Indicator Teen Deaths by Accident, Homicide, & Suicide	42
Sexually Transmitted Diseases	45
Alcohol, Tobacco, and Other Drugs	46
Delaware Children Speak about Health and Health Behaviors	48
<i>Educational Involvement and Achievement</i>	55
Early Intervention	56
Head Start/ECAP	57
Student Achievement	58
Advanced Placement	62
Children Receiving Free and Reduced-Price School Meals	64
Kids Count Indicator High School Dropouts	65
Kids Count Indicator Teens Not in School and Not Working	68
Delaware Children Speak about Education	70
<i>Family Environment and Resources</i>	73
Kids Count Indicator Births to Teens	74
Kids Count Indicator No Parent with Full-time Employment	79
Kids Count Indicator Children in Poverty	80
Kids Count Indicator Children in One-Parent Families	87
Female Headed Families in Poverty	91
Child Support	92
Health Care Coverage	93
Child Abuse and Neglect	94
Foster Care	96
Juvenile Delinquents in Out-of-Home Care	97
Home Ownership	98
Domestic Violence	99
Delaware Children Speak about Family	100
<i>Community Environment and Resources</i>	103
Child Care	104
Juvenile Violent Crime Arrests	106
Gambling	108
Unemployment	110
Adult Crime	113
Delaware Children Speak about Community	114
<i>Data Tables</i>	117

Demographics

Table 1:	Population of Children by Age	118
Table 2:	Population	119
Table 3:	Population of Delaware Cities	120
Table 4:	Hispanic Population Estimates	121
Table 5:	Hispanic Population Estimates	121
Table 6:	Families with Children	122
Table 7:	Children and Their Living Arrangements	122

Health and Health Behavior

Table 8:	Prenatal Care	123
Table 9:	Births by Birth Weight, Race, Hispanic Origin of Mother, and Prenatal Care ...	124
Table 10:	Births by Birth Weight, Age of Mother, and Prenatal Care	125
Table 11:	Births by Birth Weight, Marital Status, and Prenatal Care	126
Table 12:	Percentage of Low Birth Weight Births	127
Table 13:	Percentage of Very Low Birth Weight Births	127
Table 14:	Low Birth Weight Births by Age, Race and Hispanic Origin of Mother	128
Table 15:	Very Low Birth Weight Births by Age, Race and Hispanic Origin of Mother ...	129
Table 16:	Infant Mortality Rates by Race and Hispanic Origin	130
Table 17:	Infant Mortality Rates by Risk Factor	131
Table 18:	Infant Deaths by Causes of Death and Race of Mother	132
Table 19:	Infant, Neonatal, and Postneonatal Mortality Rates	132
Table 20:	Ranking of Infant Mortality Rates by State	133
Table 21:	Infant Mortality Rates by Gestation	134
Table 22:	Infant Mortality Rates by Birth Weight	134
Table 23:	Infant Mortality Rates by Prenatal Care	134
Table 24:	Infant Mortality Rates by Source of Payment	135
Table 25:	Infant Mortality Rates by Single or Multiple Birth	135
Table 26:	Infant Mortality Rates by Mothers' Smoking	135
Table 27:	Infant Mortality Rates by Birth Interval	136
Table 28:	Lead Poisoning	136
Table 29:	Child Immunizations	136
Table 30:	Hospitalizations for Childhood Asthma	137
Table 31:	Children without Health Insurance	137
Table 32:	Child Death Rates	138
Table 33:	Teen Death Rates	138
Table 34:	Causes of Deaths of Children by Age	139
Table 35:	Crash Involvement Rate	140
Table 36:	Traffic Arrests of Teens Involved in Crashes	140
Table 37:	Drivers in Fatal Crashes	141
Table 38:	Sexually Transmitted Diseases	141
Table 39:	8th Graders Using Substances	142
Table 40:	11th Graders Using Substances	142

Educational Involvement and Achievement

Table 41:	Head Start/ECAP	143
Table 42:	Limited English Proficiency	143
Table 43:	Delaware Student Testing Program (DSTP)	144
Table 44:	Advanced Placement (AP) Students	145
Table 45:	Advanced Placement (AP) Tests	145
Table 46:	Free and Reduced-Price Lunches	146
Table 47:	Dropouts	147



Data Tables

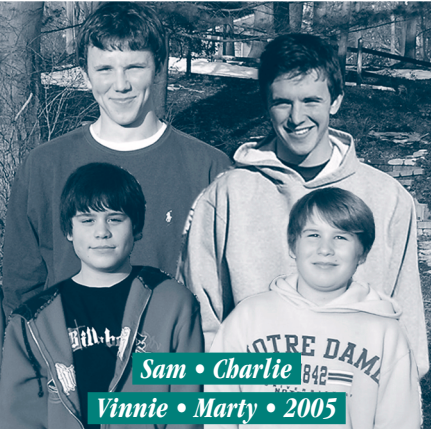
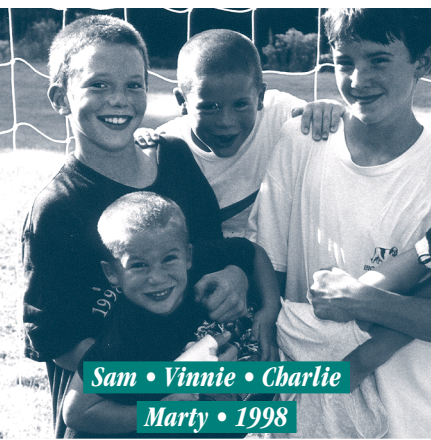


Table 48:	Dropouts and Enrollment by Race/Ethnicity	147
Table 49:	Dropout Rate and Percentage by Race/Ethnicity	148
Table 50:	Dropout Rate by Race/Ethnicity	148
Table 51:	Dropouts and Enrollment by Race/Ethnicity and Gender	148
Table 52:	Dropout Rate and Percentage by Race/Ethnicity and Gender	149
Table 53:	Graduation Rates	149
Table 54:	Teens Not in School and Not in the Labor Force	150
Table 55:	Teens Not Graduated, Not Enrolled, and Not Working	150

Family Environment and Resources

Table 56:	Teen Birth Rates (15–19 year olds)	151
Table 57:	Teen Birth Rates (15–17 year olds)	152
Table 58:	Pre- and Young Teen Birth Rates (10–14 year olds)	152
Table 59:	Births to Single Teen Mothers	153
Table 60:	Births by Race, Hispanic Origin, and Age of Mother	154
Table 61:	Children with No Parent Working Full-time	155
Table 62:	Children in Poverty	155
Table 63:	Children in Poverty by Household Structure	155
Table 64:	Income of Families with Children by Family Type	156
Table 65:	Poverty Thresholds	156
Table 66:	Births to Single Mothers	157
Table 67:	Births to Single Mothers by Age	158
Table 68:	Children in One-Parent Households	159
Table 69:	Poverty Rates for One-Parent Families	159
Table 70:	Poverty Rates for Female Householder Families	159
Table 71:	Female Headed Families in Poverty	160
Table 72:	Median Income of Female Headed Families	160
Table 73:	Current Child Support Owed that Is Paid	160
Table 74:	Home Ownership	161
Table 75:	Child Abuse and Neglect	161
Table 76:	Foster Care	161
Table 77:	Juvenile Delinquents in Out of Home Care	161
Table 78:	Health Insurance	162

Community Environment and Resources

Table 79:	Subsidized Child Care	162
Table 80:	Available Child Care	162
Table 81:	School Age Programs	163
Table 82:	Site-Based Public School Age Programs	163
Table 83:	Child Care Costs	163
Table 84:	Juvenile Violent Crime Arrests	164
Table 85:	Juvenile Part I Violent Crime Arrests	164
Table 86:	Juvenile Part I Property Crime Arrests	164
Table 87:	Juvenile Part II Crime Arrests	165
Table 88:	Juvenile Drug Arrests	165
Table 89:	Student Violence and Possession	166
Table 90:	Student Violence and Possession by County	166
Table 91:	Student Violence and Possession by Age	167
Table 92:	Student Violence and Possession by Race/Ethnicity	167
Table 93:	Unemployment	168
Table 94:	Adult Violent Crime Arrests	168
Table 95:	Adult Violent Crime Arrests, Adults 18–39	168



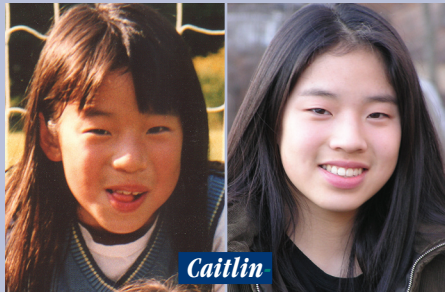
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Caitlin

*Dedicated to the children
of Delaware who have
shared their lives
through their photos
over the past 10 years*



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Justyn



Imena



Krista



Alex



Charlie



Sam



Emma



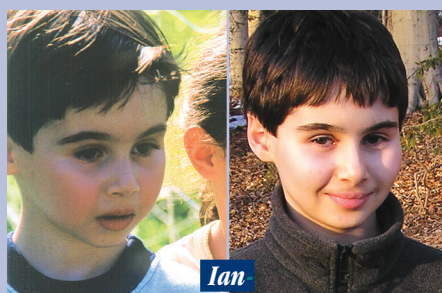
Noelle



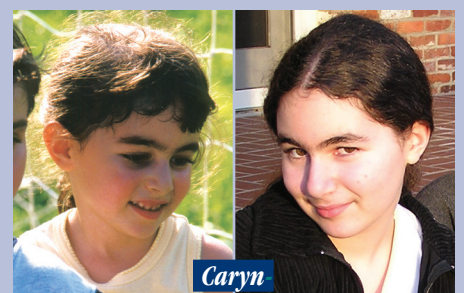
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Ian



Caryn

KIDS COUNT in Delaware

Welcome to the tenth edition of KIDS COUNT in Delaware and the seventh joint publication of KIDS COUNT in Delaware/FAMILIES COUNT in Delaware, a collaborative project of the State of Delaware and KIDS COUNT, which is housed in the Center for Community Research and Service at the University of Delaware. Since 1995 KIDS COUNT in Delaware has been reporting on the status of children in the state and, working with the State of Delaware since 1998, has been monitoring the conditions of families, children and individuals in the community.

The KIDS COUNT and FAMILIES COUNT indicators have been combined into four categories:

Health and Health Behaviors

Educational Involvement and Achievement

Family Environment and Resources

Community Environment and Resources

The ten KIDS COUNT indicators, featured in the Overview and throughout the book as KIDS COUNT Indicators, have been chosen by the national KIDS COUNT project because they possess three important attributes:

- They reflect a wide range of factors affecting the well-being of children.
- They reflect experiences across developmental stages from birth through early adulthood.
- They permit legitimate comparison because they are consistent across states and over time.

The featured indicators are:

Births to teens

Low birth weight babies

Infant mortality

Child deaths

Teen deaths by accident, homicide, and suicide

Teens not graduated and not enrolled

Teens not in school and not working

Children in poverty

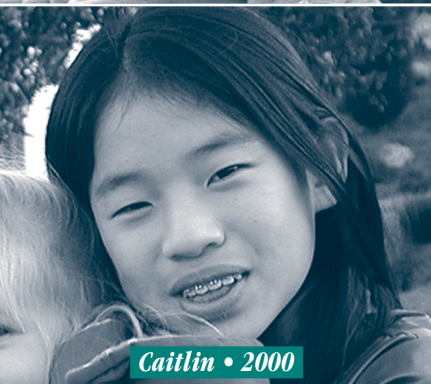
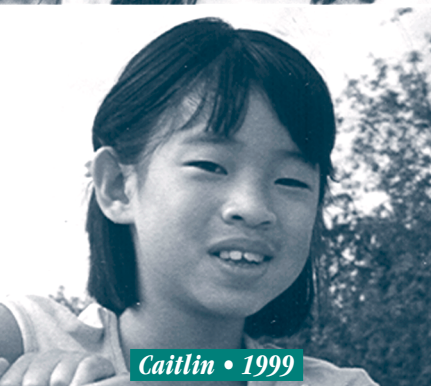
Children with no parent with full-time employment

Children in one-parent families

The ten indicators used reflect a developmental perspective on childhood and underscore our goal to provide a world where pregnant women and newborns thrive, infants and young children receive the support they need to enter school prepared to learn; adolescents choose healthy behaviors; and young people experience a successful transition into adulthood. In all of these stages of development, young people need the economic and social assistance provided by a strong family and a supportive community.

In addition to the featured indicators, we continue to report on a variety of indicators, such as early care and education, prenatal care, substance abuse and asthma data based on hospitalizations which all impact the lives of children. Indicators related to educational involvement and achievement especially highlighting the results of the Delaware Student Testing Program are included in the second category, while indicators relating to families and community follow. Additional tables with more extensive information are included at the end of the Fact Book. Demographic information with maps from the 2000 census provide an overview of the changing face of Delaware.

Ultimately the purpose of this book is to stimulate debate, not to end debate by producing definitive answers. We hope this information will add to the knowledge base of our social well being, guide and advance informed discussion and help us concentrate on issues that need attention, and focus on a better future for our children and families.



Trends in Delaware

- Measures Needing Attention:
- Infant Mortality
 - Low Birth Weight
- Measures Showing Improvement:
- Births to Teens
 - High School Dropouts
 - Children in Poverty
- Measures Remaining Constant:
- Child Deaths
 - Teens Deaths
 - Teens Not Attending School and Not Working
 - No Parent with Full-Time Employment
 - Children in One-Parent Families

Making Sense of the Numbers

The information on each indicator is organized as follows:

- Definition a description of the indicator and what it means
- Impact the relationship of the indicator to child and family well-being
- Related information material in the appendix or in FAMILIES COUNT relating to the indicators

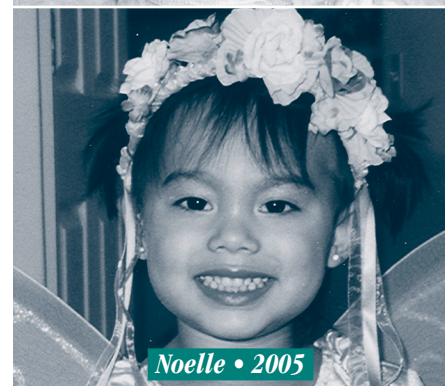
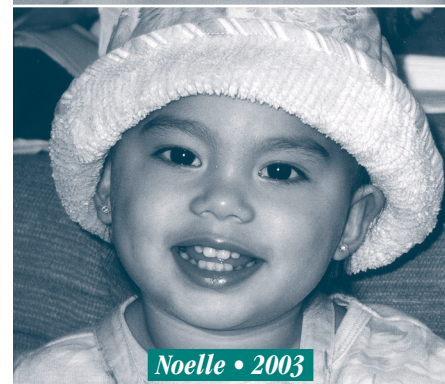
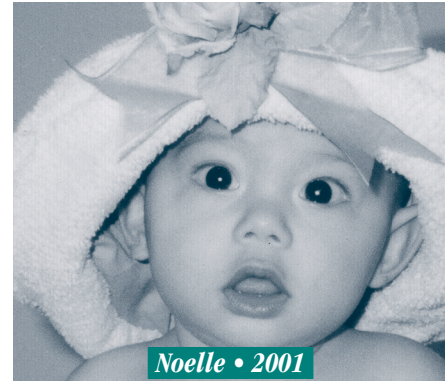
Sources of Data

The data are presented primarily in three ways:

- Annual data
- Three-year and five-year averages to minimize fluctuations of single-year data and provide more realistic pictures of children's outcomes
- Annual, three-year or five-year average data for a decade or longer to illustrate trends and permit long-term comparisons

The data has been gathered primarily from:

- The Center for Applied Demography and Survey Research, University of Delaware
- Delaware Health Statistics Center, Delaware Health and Social Services
- Department of Education, State of Delaware
- Delaware State Data Center, Delaware Economic Development Office
- Statistical Analysis Center, Executive Department, State of Delaware
- Delaware Department of Health and Social Services, State of Delaware
- Department of Services for Children, Youth and Their Families, State of Delaware
- U.S. Bureau of the Census
- National Center for Health Statistics, U.S. Department of Health and Human Services
- Delaware Population Consortium
- Family and Workplace Connection
- Division of State Police, Department of Public Safety
- Domestic Violence Coordinating Council
- Center for Drug and Alcohol Studies, University of Delaware



KIDS COUNT in Delaware

Interpreting the Data

The KIDS COUNT in Delaware/FAMILIES COUNT in Delaware Fact Book 2005 uses the most current, reliable data available. Data that was inadequate or unavailable was denoted by N/A. For some data, only the decennial census has information at the county level.

Most indicators are presented as three- or five-year averages because rates based on small numbers of events in this modestly-populated state can vary dramatically from year to year. A three- or five- year average is less susceptible to distortion. It is helpful to look at trends rather than at actual numbers, rates, or percentages due to the small numbers.

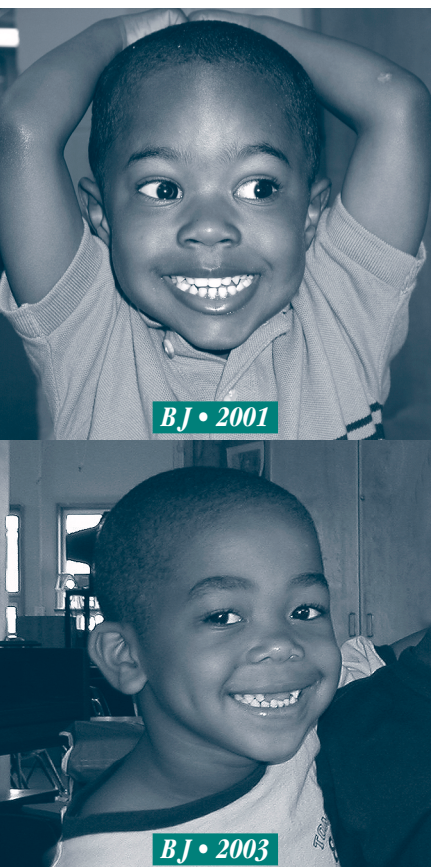
Accepted names for various racial and ethnic groups are constantly in flux and indicators differ in their terminology. KIDS COUNT has used the terminology reported by the data collection sources.

Fiscal Year Data: Most data presented here is for calendar years. Where data collected by state or federal authorities is available by school calendar year or fiscal year, the periods are from September to June or July 1 to June 30, respectively.

Notes: When necessary we have included technical or explanatory notes under the graphs or tables.

Counties and Cities: Where possible, data were delineated by counties and the city of Wilmington.

In a state with a small population such as Delaware, the standard sampling error is somewhat larger than in most states. For this reason, KIDS COUNT has portrayed the high school dropout rate in two ways: the sampling size, which shows trends, and the Department of Education's dropout numbers. There is a slight variation in those two graphs due to the size of the population.



Numbers, Rates, and Percentages

Each statistic tells us something different about children. The numbers represent real individuals. The rates and percentages also represent real individuals but have the advantage of allowing for comparisons between the United States and Delaware and between counties.

In this publication, indicators are presented as either raw numbers (25), percentages (25%), or rates (25 per 1,000 or 25 per 100,000). The formula for percents or rates is the number of events divided by the population at risk of the event (county, state, U.S.) and multiplied by 100 for percent or 1,000 or 100,000 for rates.

A Caution About Drawing Conclusions

Caution should be exercised when attempting to draw conclusions from percentages or rates which are based on small numbers. Delaware and its counties can show very large or very small percentages as a result of only a few events. KIDS COUNT encourages you to look at overall trends.

The key in the evaluation of statistics is to examine everything in context. The data challenges stereotypes — pushing us to look beyond the surface for the less obvious reasons for the numbers. Individual indicators, like the rest of life's concerns, do not exist in a vacuum and cannot be reduced to a set of the best and worst in our state.

Where county level data are presented, readers can gain a better understanding of the needs in particular segments of the state. Delaware rankings within the National KIDS COUNT Data Book can fluctuate from year to year. Therefore, it is important to look at the trends within the state and over a significant period of time. Hopefully, the graphs help to clarify that picture.

What's New This Year

This report represents the seventh edition of the combined KIDS COUNT/FAMILIES COUNT Fact Book and the tenth edition of the KIDS COUNT in Delaware Fact Book focusing on measuring child and family well-being. Over the past ten years most key trend measures have remained consistent, but changes are made as new data become available and measures are modified to focus on particular issues.

Photographs

KIDS COUNT in Delaware has made a special attempt through the years to use photographs of our own Delaware children. It seemed appropriate that, in this anniversary edition, we highlight our children – then and now. Look at all the pictures and smile as we have, to see the happy faces of growing children and families.

Look for these changes:

- **Ten Year Trends**

For each of the ten National KIDS COUNT indicators we have reported yearly

- Delaware compared to the United States – better, worse, or similar
- Recent trend in Delaware – getting better, getting worse, or staying the same

In this tenth anniversary edition, we have included a line which displays the ten year trend so readers can see how each indicator has progressed over the past ten years. One can follow the trend line to see if that indicator has improved, declined or stayed the same over this period. We've also marked the ten year interval on the U.S./Delaware comparison graphs.

- **Expanded Infant Mortality Data**

Due to the concern over Delaware's rising infant mortality rate, KIDS COUNT has included additional data on this critical indicator. Looking at the rate compared to weeks of gestation, prenatal care, source of payment, smoking during pregnancy, birth weight, birth spacing, and single/multiple births may provide some new insights into this issue.

- **Advanced Placement:**

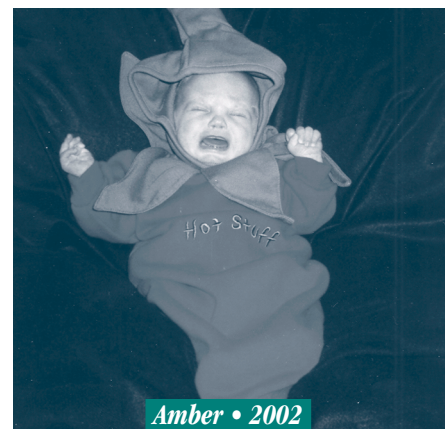
The Advanced Placement (AP) program gives students an opportunity to take college-level courses and exams while still in high school. Based on their performance on rigorous AP examinations, students can earn credit, advanced college class placement or both, for college. Research indicates a direct positive correlation between AP classes taken in high school and the likelihood of earning a college degree.

- **Communities Count Maps:**

Our newest publication, Communities Count in Delaware, provides a snapshot of data for each census tract in the state. As part of this, census tract maps were developed using data from the 2000 Census to visually give a picture of the well-being of children and families. Each map is color-coded to show the relationship of census tracts to the state as a whole, moving from "worse than the State as a whole to better than the State."

The following maps are included within this 2005 Fact Book:

- Percent of Female Headed Households
- Percent of Population below 100% of Poverty
- Percent of Persons 25 and Over that are High School Dropouts
- Percent of Men 16 to 64 that are Unemployed or Not in the Labor Force



Overview

Births to Teens

Page 74

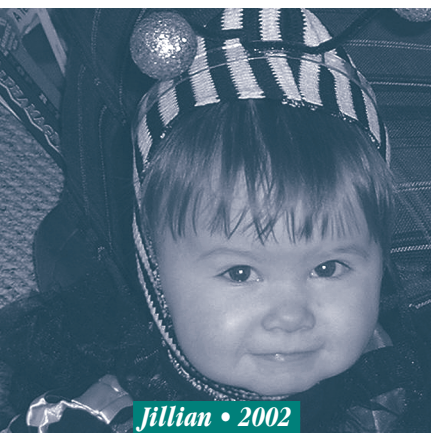
Number of births per 1,000 females ages 15–17
Five year average, 1998–02: Delaware 27.0, U.S. 29.7



Low Birth Weight Babies

Page 24

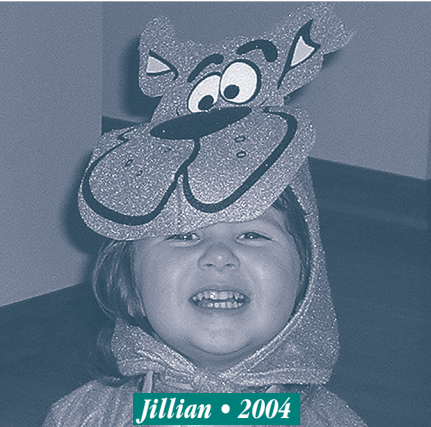
Percentage of infants weighing less than 2,500 grams (5.5 lbs.) at live birth (includes very low birth weight)
Five year average, 1998–02: Delaware 9.0, U.S. 7.6



Infant Mortality

Page 26

Number of deaths occurring in the first year of life per 1,000 live births
Five year average, 1998–02: Delaware 9.2, U.S. 7.0



Child Deaths

Page 40

Number of deaths per 100,000 children 1–14 years old
Five year average, 1998–02: Delaware 22.8, U.S. 22.5



Teen Deaths by Accident, Homicide, and Suicide

Page 42

Number of deaths per 100,000 teenagers 15–19 years old
Five year average, 1998–02: Delaware 53.0, U.S. 53.3



High School Dropouts

Page 65

Percentage of youths 16–19 who are not in school and not high school graduates

School year, 2002–03: Delaware 5.4



Teens Not Attending School and Not Working

Page 68

Percentage of teenagers 16–19 who are not in school and not employed

Three year average, 2002–04: Delaware 7.9, U.S. 9.2



Children in Poverty

Page 80

Percentage of children in poverty. In 2004 the poverty threshold for a one-parent, two-child family was \$15,219. For a family of four with two children, the threshold was \$19,157.

Three year average, 2001–03: Delaware 11.0, U.S. 16.9



No Parent with Full-time Employment

Page 79

Percentage of families in which no parent has full-time employment.

Three year average, 2002–04: Delaware 18.3, U.S. 22.3



Children in One-Parent Families

Page 87

Percentage of children ages 0–17 living with one parent.

Three year average, 2001–04: Delaware 31.1, U.S. 30.6

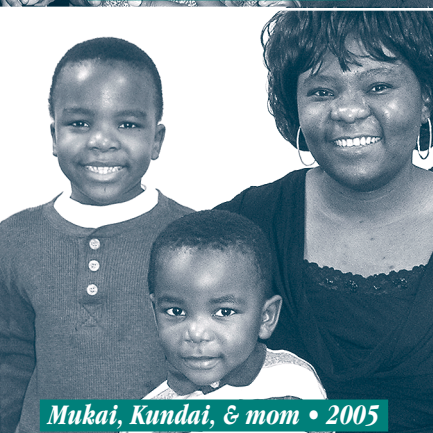


Counting the Kids: Delaware Demographics

Data from the 2000 Census provides a picture of the population of the state of Delaware, its counties and cities, and the nation. Demographically speaking, we are much less of a child-centered society now than we were 100 years ago. In the United States, children accounted for 40 percent of the population in 1900, but only 26 percent in 2000. Similar trends are evident in Delaware.

Nationwide the number of children grew 14 percent between 1990 and 2000. Delaware experienced an increase of 19 percent, growing from 163,341 children in 1990 to 194,587 in 2000. This increase ranked Delaware as having the 11th highest percentage increase among all fifty states.

Sussex County had the largest percentage increase of children (30%), followed by New Castle County (18%) and Kent County (14%).



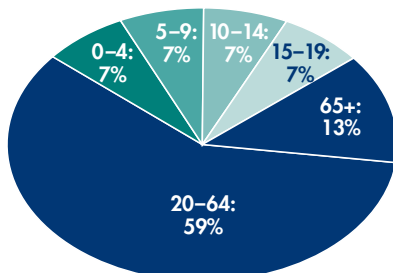
Population at a Glance

	2000 Total Population	2000 Total Age 0-17	2000 Total Age 18+	2000 Total % 0-17	1990 Total Age 0-17
Delaware	783,600	194,587	589,013	24.8%	163,341
New Castle County	500,265	124,749	375,516	25.0%	106,079
Wilmington	72,664	18,793	53,871	25.9%	17,822
Kent	126,697	34,533	92,164	27.2%	30,174
Sussex	156,638	35,305	121,333	22.5%	27,088

Source: 2000 Census, U.S. Census Bureau

Total Population Estimate and Age Distribution

Delaware, 2000

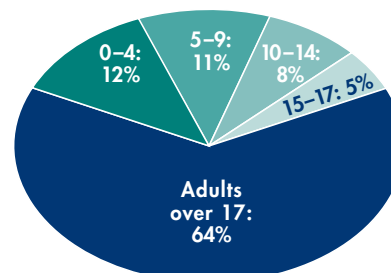


Delaware Total	783,600
Total Children 0-19	218,250
Children 0-4	51,531
Children 5-9	55,813
Children 10-14	55,274
Children 15-19	55,632

Source: Delaware Population Consortium;
Population Estimates Program, Population Division,
U.S. Census Bureau

Hispanic Population Estimate and Age Distribution

Delaware, 2000

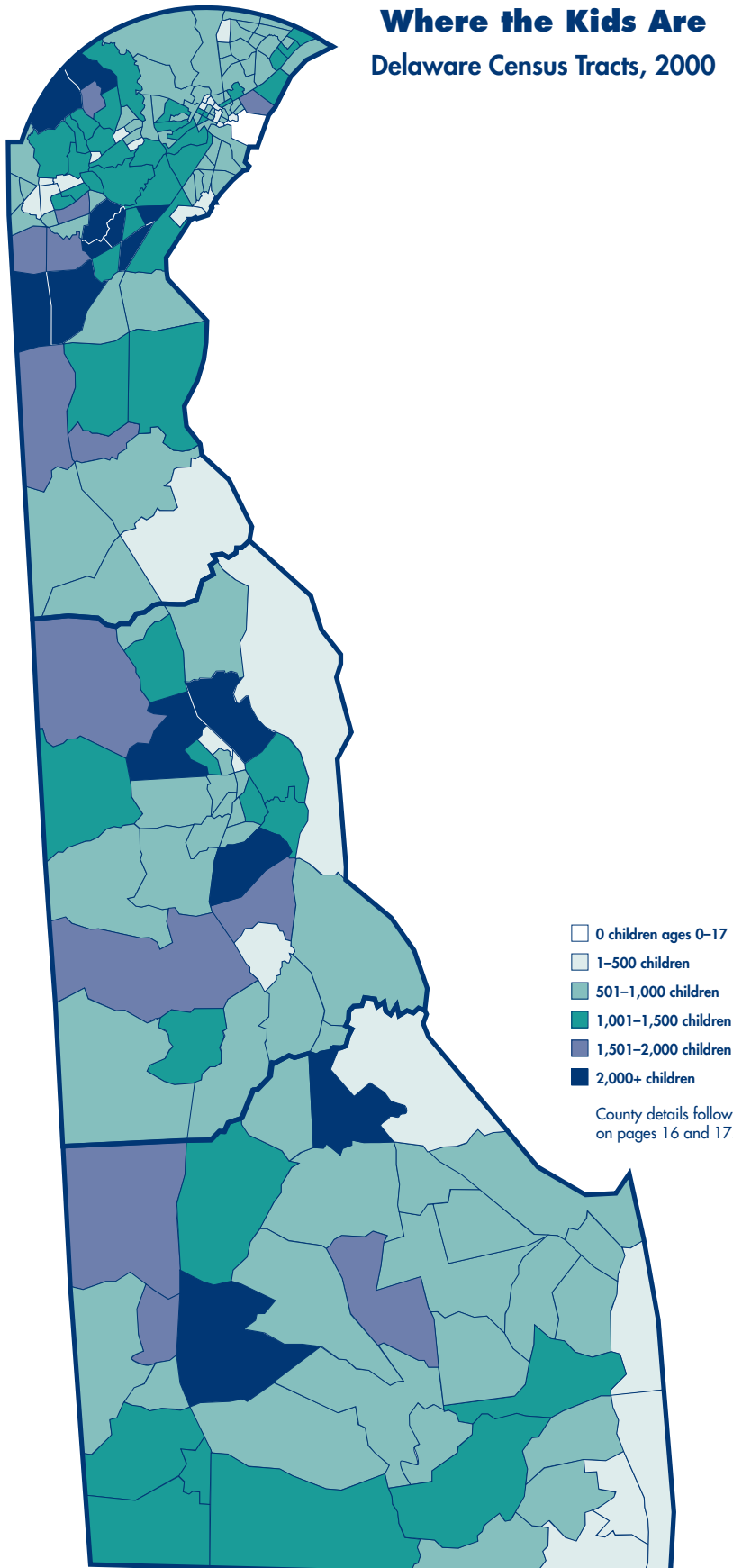


Delaware Hispanic Total	37,277
Total Children 0-17	13,565
Children 0-4	4,517
Children 5-9	3,970
Children 10-14	3,174
Children 15-17	1,904
Adults over 17	23,712

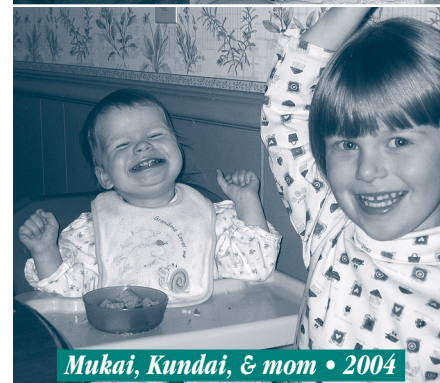
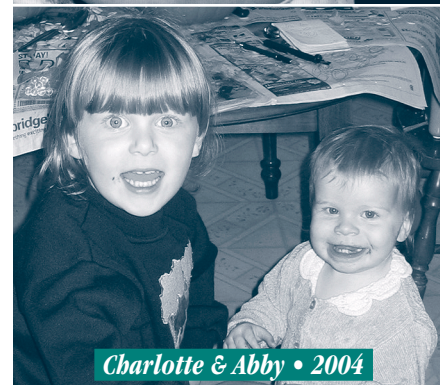
Source: Population Reference Bureau, 2000 Census

The Hispanic population in Delaware grew from 15,820 in 1990 to 37,277 in 2000, an increase of 136%. Among the counties, Sussex showed the largest percent increase at 369%. The census county divisions that showed that greatest increase were Georgetown (1536%), Selbyville-Frankford (816%), and Millsboro (670%).

Where the Kids Are Delaware Census Tracts, 2000



Source: Population Reference Bureau, 2000 Census, U.S. Census Bureau

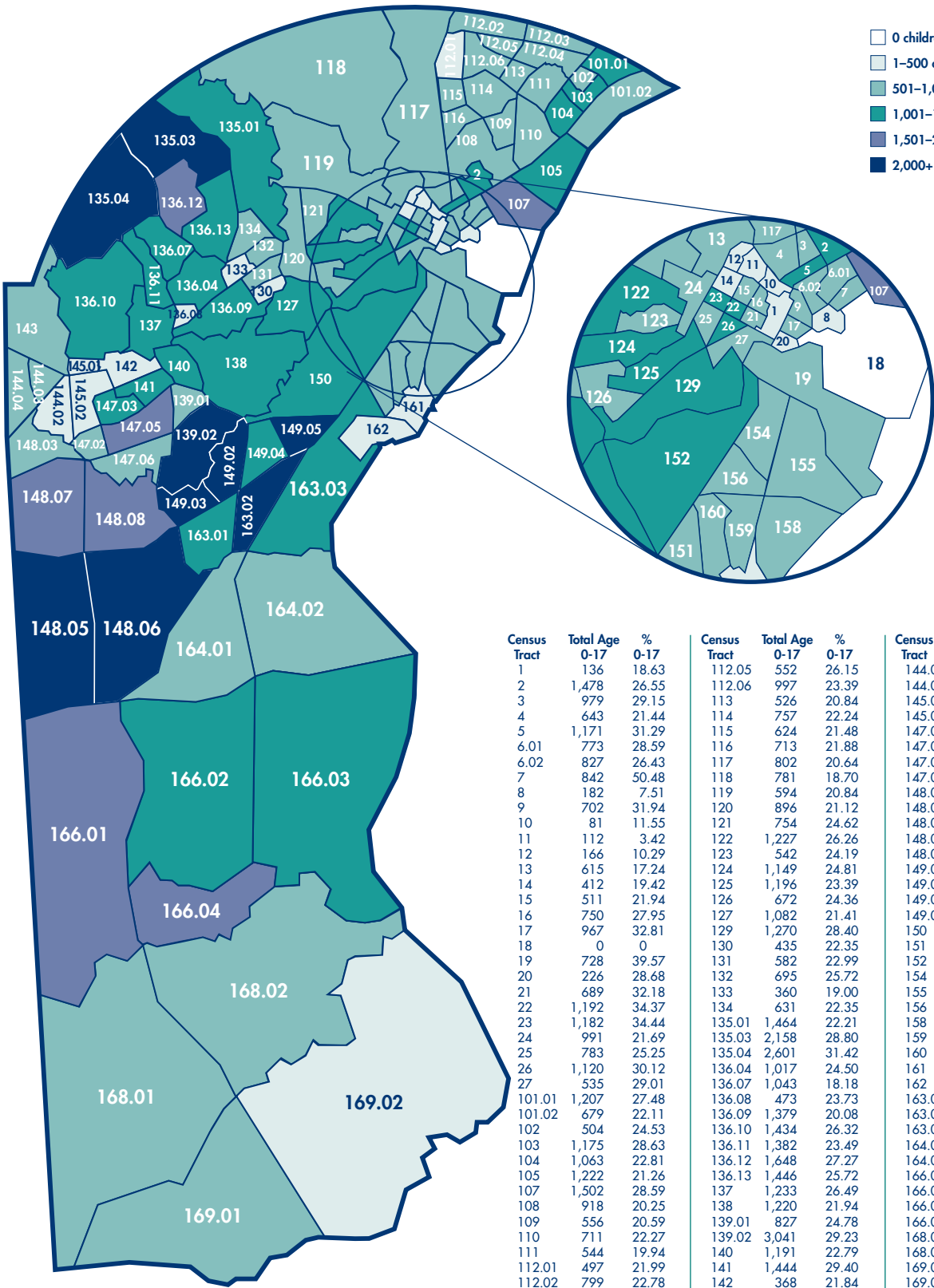


For detailed information on census tracts and blocks: <http://factfinder.census.gov>

Counting the Kids

Where the Kids Are New Castle County, 2000

- 0 children ages 0-17
- 1-500 children
- 501-1,000 children
- 1,001-1,500 children
- 1,501-2,000 children
- 2,000+ children



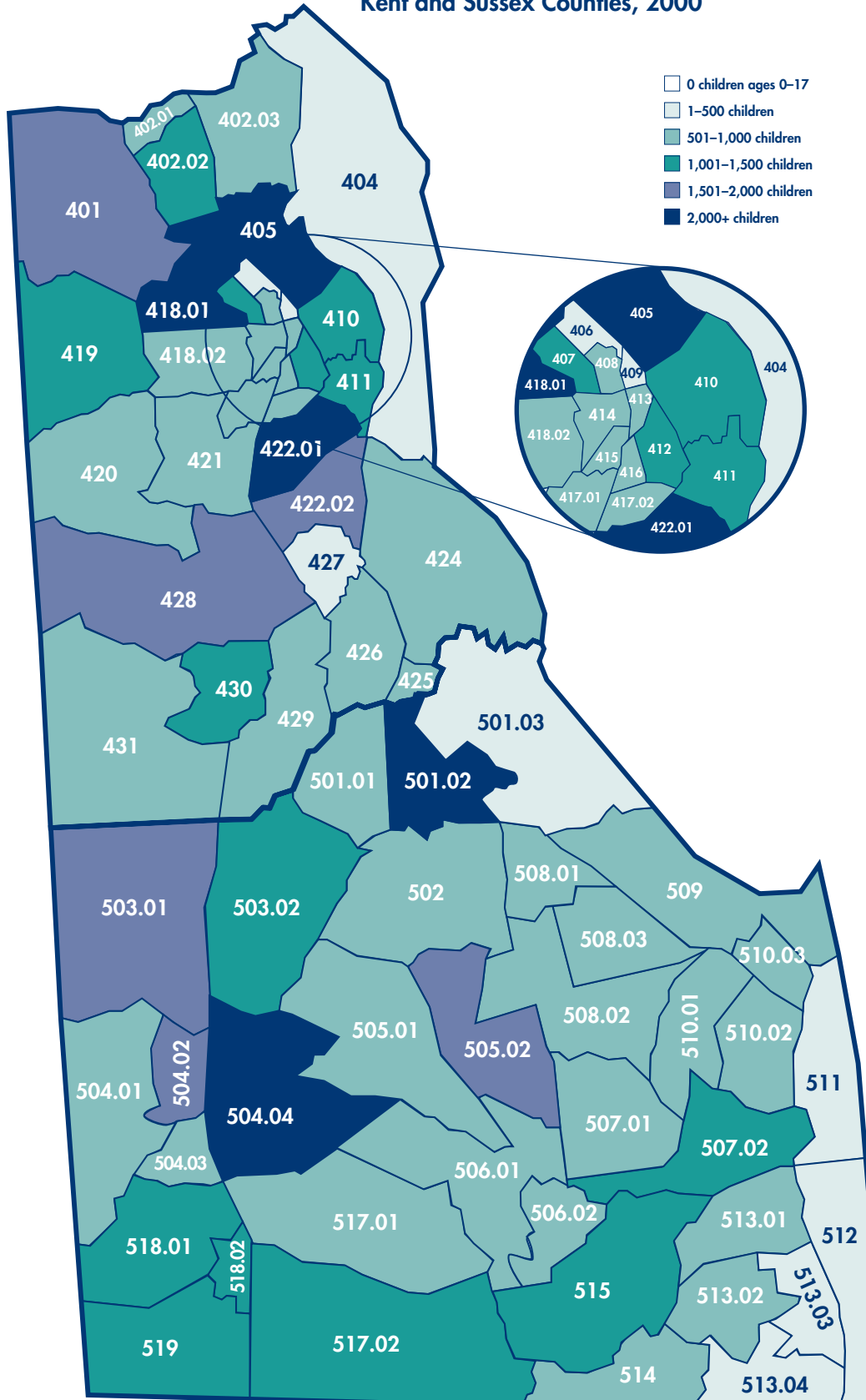
Census Tract	Total Age 0-17	% 0-17	Census Tract	Total Age 0-17	% 0-17	Census Tract	Total Age 0-17	% 0-17
1	136	18.63	112.05	552	26.15	144.03	551	10.35
2	1,478	26.55	112.06	997	23.39	144.04	804	22.65
3	979	29.15	113	526	20.84	145.01	115	6.05
4	643	21.44	114	757	22.24	145.02	150	2.18
5	1,171	31.29	115	624	21.48	147.02	502	26.38
6.01	773	28.59	116	713	21.88	147.03	1,120	23.97
6.02	827	26.43	117	802	20.64	147.05	1,502	26.15
7	842	50.48	118	781	18.70	147.06	886	35.27
8	182	7.51	119	594	20.84	148.03	673	19.45
9	702	31.94	120	896	21.12	148.05	2,134	31.54
10	81	11.55	121	754	24.62	148.06	3,729	29.94
11	112	3.42	122	1,227	26.26	148.07	1,962	30.06
12	166	10.29	123	542	24.19	148.08	1,809	28.50
13	615	17.24	124	1,149	24.81	149.02	2,678	29.29
14	412	19.42	125	1,196	23.39	149.03	2,665	36.99
15	511	21.94	126	672	24.36	149.04	1,141	24.23
16	750	27.95	127	1,082	21.41	149.05	2,356	27.84
17	967	32.81	129	1,270	28.40	150	1,472	25.96
18	0	0	130	435	22.35	151	804	22.95
19	728	39.57	131	582	22.99	152	1,446	23.68
20	226	28.68	132	695	25.72	154	920	28.48
21	689	32.18	133	360	19.00	155	779	28.57
22	1,192	34.37	134	631	22.35	156	620	25.72
23	1,182	34.44	135.01	1,464	22.21	158	630	28.15
24	991	21.69	135.03	2,158	28.80	159	841	25.77
25	783	25.25	135.04	2,601	31.42	160	694	25.01
26	1,120	30.12	136.04	1,017	24.50	161	438	20.50
27	535	29.01	136.07	1,043	18.18	162	470	20.97
101.01	1,207	27.48	136.08	473	23.73	163.01	1,216	28.74
101.02	679	22.11	136.09	1,379	20.08	163.02	2,060	30.99
102	504	24.53	136.10	1,434	26.32	163.03	1,303	24.51
103	1,175	28.63	136.11	1,382	23.49	164.01	994	30.07
104	1,063	22.81	136.12	1,648	27.27	164.02	544	23.83
105	1,222	21.26	136.13	1,446	25.72	166.01	1,807	31.64
107	1,502	28.59	137	1,233	26.49	166.02	1,424	32.06
108	918	20.25	138	1,220	21.94	166.03	1,215	31.53
109	556	20.59	139.01	827	24.78	166.04	1,555	31.13
110	711	22.27	139.02	3,041	29.23	168.01	818	27.42
111	544	19.94	140	1,191	22.79	168.02	678	27.32
112.01	497	21.99	141	1,444	29.40	169.01	544	24.64
112.02	799	22.78	142	368	21.84	169.02	332	11.04
112.03	985	21.17	143	897	17.12			
112.04	712	20.87	144.02	398	11.85			

Source: Population Reference Bureau, 2000 Census, U.S. Census Bureau



Where the Kids Are

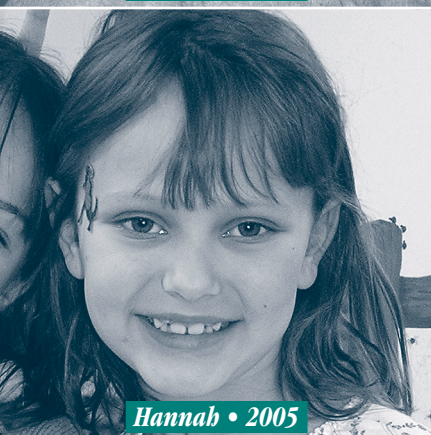
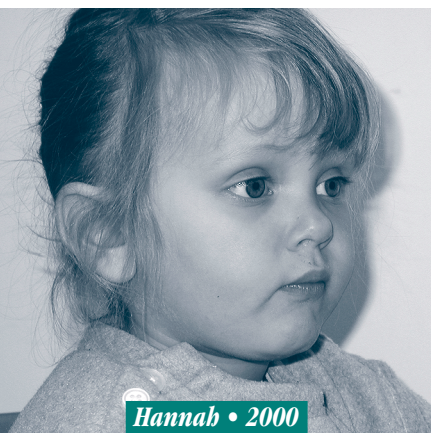
Kent and Sussex Counties, 2000



Kent County		
Census	Total Age	%
Tract	0-17	0-17
401	1,535	28.76
402.01	951	27.35
402.02	1,217	23.45
402.03	949	30.92
404	300	25.95
405	2,074	25.24
406	180	7.56
407	1,323	29.60
408	586	21.16
409	291	12.09
410	1,212	26.34
411	1,389	36.09
412	1,011	29.48
413	580	27.28
414	764	25.31
415	969	25.57
416	536	23.31
417.01	976	25.76
417.02	984	29.43
418.01	2,200	28.82
418.02	828	31.70
419	1,387	28.67
420	891	29.75
421	799	24.84
422.01	2,096	34.48
422.02	1,771	29.63
424	618	23.75
425	842	28.87
426	538	25.52
427	306	26.40
428	1,508	27.45
429	933	27.17
430	1,321	29.42
431	668	27.51

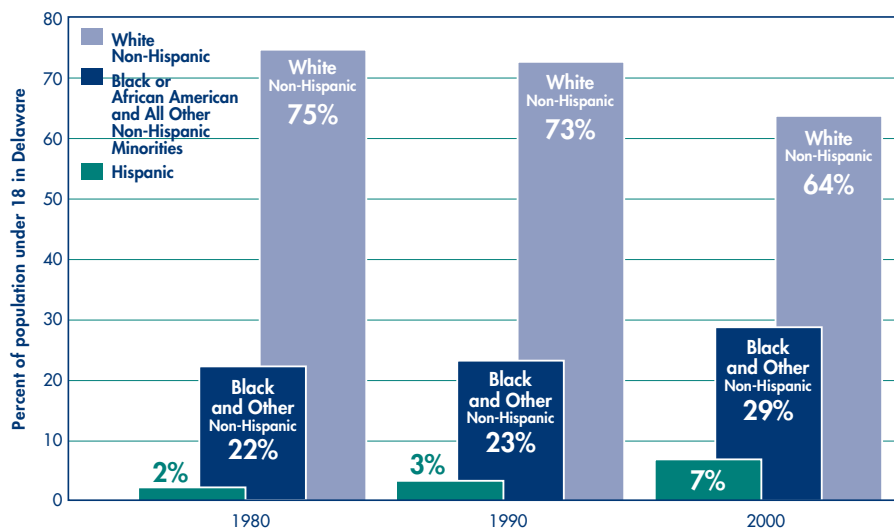
Sussex County		
Census	Total Age	%
Tract	0-17	0-17
501.01	837	25.46
501.02	2,204	27.37
501.03	471	19.81
502	812	28.91
503.01	1,591	28.10
503.02	1,108	29.15
504.01	939	28.41
504.02	1,972	24.83
504.03	833	28.00
504.04	2,326	28.68
505.01	689	24.05
505.02	1,973	23.05
506.01	862	22.28
506.02	888	23.14
507.01	653	23.68
507.02	1,483	16.02
508.01	676	25.64
508.02	804	24.17
508.03	942	20.27
509	738	14.44
510.01	973	18.58
510.02	754	14.56
510.03	741	23.55
511	235	8.26
512	431	10.34
513.01	635	16.34
513.02	553	22.53
513.03	461	16.54
513.04	460	12.04
514	820	27.78
515	1,029	24.63
517.01	906	26.38
517.02	1,194	24.72
518.01	1,092	26.31
518.02	1,150	28.81
519	1,070	26.73

For detailed information on census tracts and blocks:
<http://factfinder.census.gov>



The Changing Face of Delaware's Children

by Race and Hispanic Origin, Delaware, 1980–2000



Source: 2000 Census, U.S. Census Bureau

Note: Persons of Hispanic origin may be of any race.

Children under 18 by Race and Hispanic Origin, U.S. and Delaware

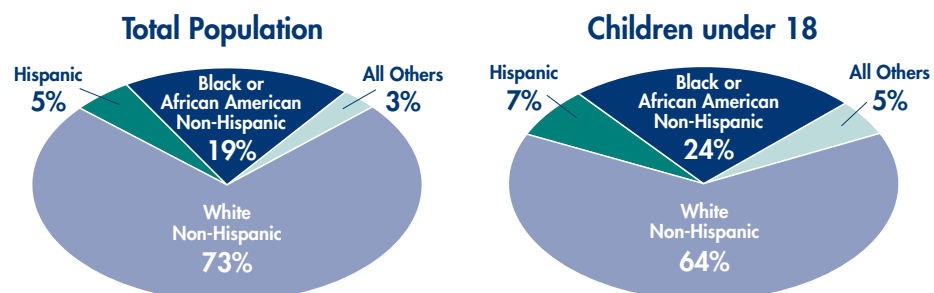
Race		1980		1990		2000	
		Number	Percent of population under 18	Number	Percent of population under 18	Number	Percent of population under 18
Total Population under 18	US	63,754,960	100.0	63,604,432	100.0	72,293,812	100.0
	DE	166,595	100.0	163,341	100.0	194,587	100.0
Non-Hispanic White	US	47,035,526	73.8	43,807,311	68.9	44,027,087	60.9
	DE	125,376	75.3	119,582	73.2	124,918	64.2
Minorities	US	16,719,434	26.2	19,797,121	31.1	28,266,725	39.1
	DE	41,219	24.7	43,597	26.8	69,669	35.8
Black and Other Non-Hispanic	US	11,091,478	17.4	12,039,621	18.9	15,924,466	22.0
	DE	37,141	22.3	38,170	23.4	56,104	28.8
Hispanic	US	5,627,956	8.8	7,757,500	12.2	12,342,259	17.1
	DE	4,078	2.4	5,589	3.4	13,565	7.0

Note: Children who marked White and another racial category in the 2000 Census are classified as minorities. Persons of Hispanic origin may be of any race.

Source: www.aecf.org/kidscount/census, 2000 Census, U.S. Census Bureau

Delaware Population

by Race and Hispanic Origin, 2000



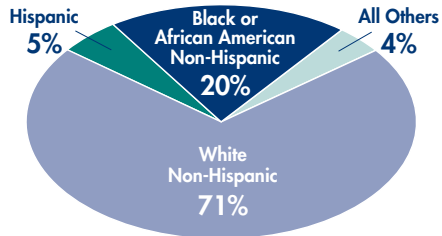
Source: 2000 Census, U.S. Census Bureau

Note: Persons of Hispanic origin may be of any race.

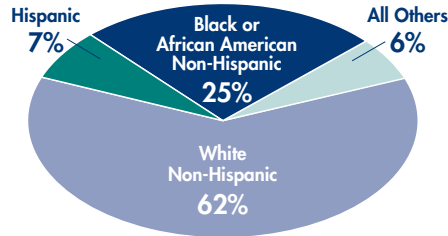
New Castle County Population

by Race and Hispanic Origin, 2000

Total Population



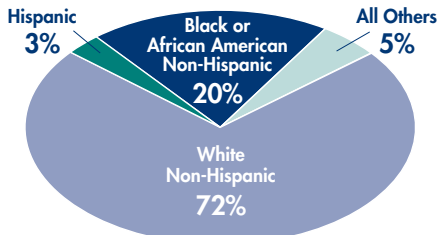
Children under 18



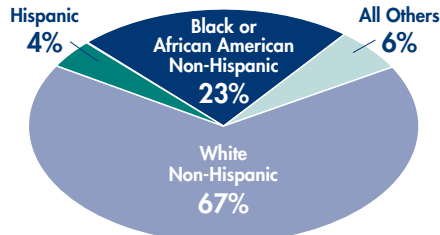
Kent Population

by Race and Hispanic Origin, 2000

Total Population



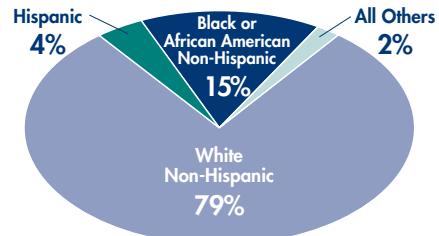
Children under 18



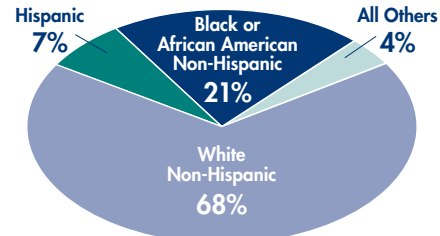
Sussex Population

by Race and Hispanic Origin, 2000

Total Population



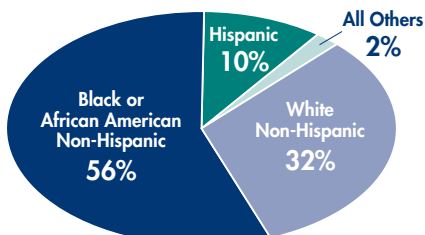
Children under 18



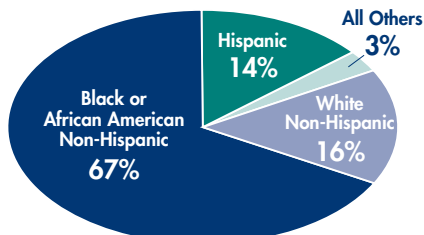
Wilmington Population

by Race and Hispanic Origin, 2000

Total Population



Children under 18

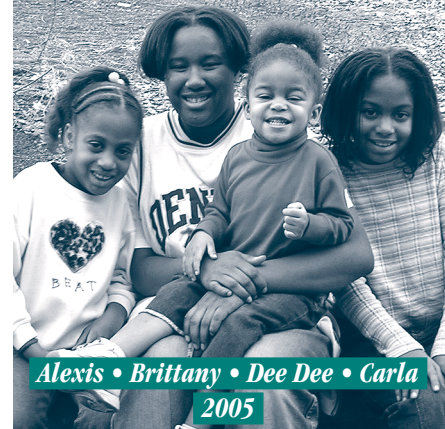


Source: 2000 Census, U.S. Census Bureau

Note: Persons of Hispanic origin may be of any race.



Alexis • Brittany • Dee Dee • Carla
2003



Alexis • Brittany • Dee Dee • Carla
2005

For more information see

Tables 1-7 p. 118-122

www.rdms.udel.edu/census

www.aecf.org/kidscount/census

www.cadsr.udel.edu/census2k

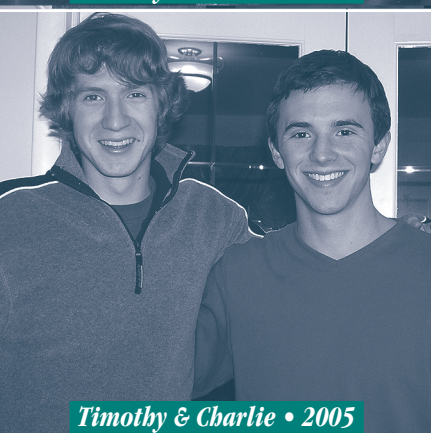
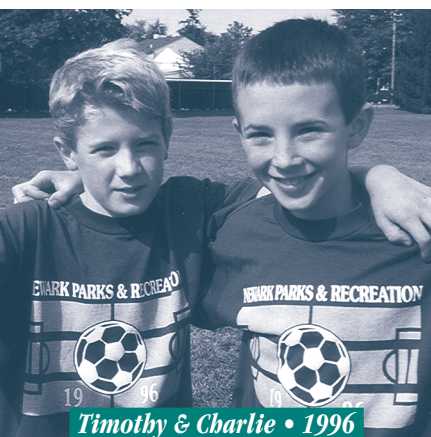
www.census.gov

www.prb.org

Definitions

Household – A household consists of all the people who occupy a housing unit. It may be a family household or a non-family household. A non-family household consists of a householder living alone or where the householder shares the home exclusively with people to whom he/she is not related. A family household is a household maintained by a householder who is in a family and includes any unrelated people who may be residing there.

Family – A family is a group of two people or more related by birth, marriage, or adoption who are residing together.



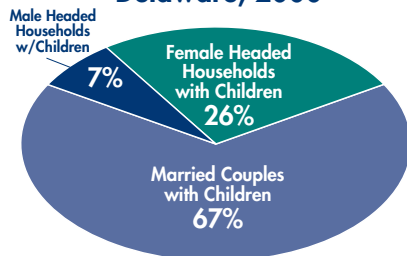
Definitions

Own Children – A child under 18 years old who is a son or daughter by birth, marriage (a stepchild), or adoption.

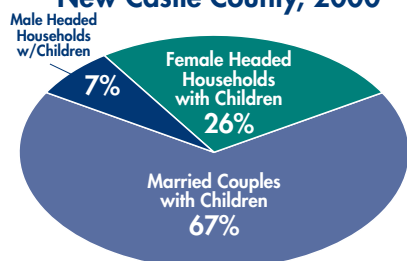
Related Children – All people in a household under the age of 18 who are related to the householder. Does not include householder's spouse or foster children, regardless of age.

Families with Related Children by Household Structure

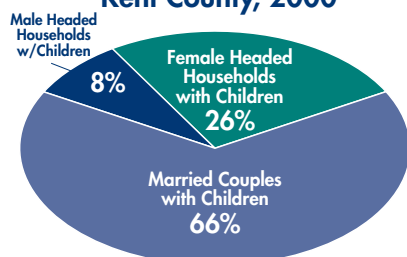
Delaware, 2000



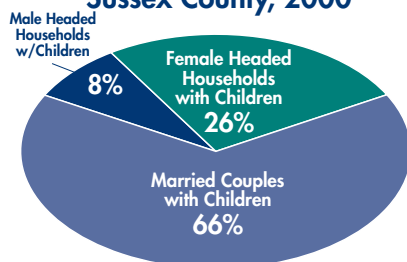
New Castle County, 2000



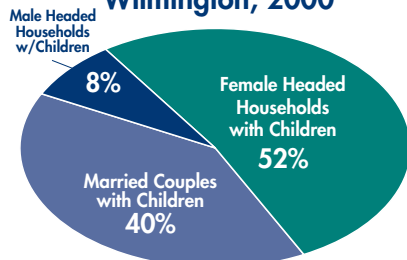
Kent County, 2000



Sussex County, 2000



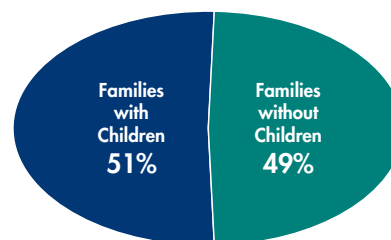
Wilmington, 2000



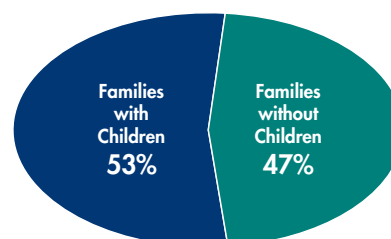
Source: Population Reference Bureau, 2000 Census, U.S. Census Bureau

Families with & without Children under 18 Living in Household

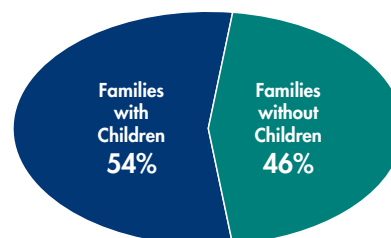
Delaware, 2000



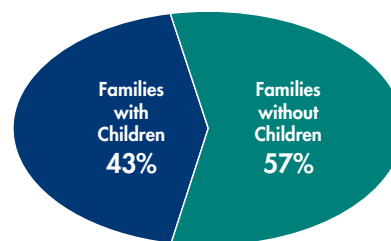
New Castle County, 2000



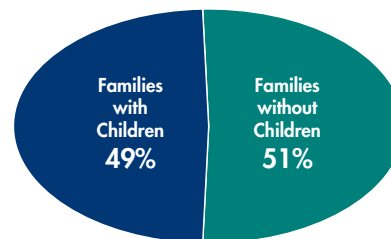
Kent County, 2000



Sussex County, 2000



Wilmington, 2000



Source: Population Reference Bureau, 2000 Census, U.S. Census Bureau

Health and Health Behaviors

Prenatal Care	22
Low Birth Weight Babies	24
Infant Mortality	26
Women and Children Receiving WIC	33
Lead Poisoning	34
Child Immunizations	35
Childhood Asthma	36
Children without Health Insurance	38
Child Deaths.....	40
Teen Deaths by Accident, Homicide, & Suicide....	42
Sexually Transmitted Diseases	45
Alcohol, Tobacco, and Other Drugs	46
Delaware Children Speak about Health and Health Behaviors	48



Prenatal Care



The purpose of prenatal care is to help ensure that both the mother and her baby have a healthy pregnancy. Prenatal care appointments allow for the doctor to identify potential problems before they become serious for the mother or baby. Unfortunately, each year almost one million American women deliver babies without receiving adequate medical attention.¹ Research has shown that babies who are born to mothers who do not receive prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those who are born to mothers who receive prenatal care.¹ Prenatal and post-birth appointments should always be attended even if the mother is feeling well.

1. Maternal and Child Health Bureau, U.S. Department of Health and Human Services. Available at: <http://www.mchb.hrsa.gov/programs/womeninfants/prenatal.htm>



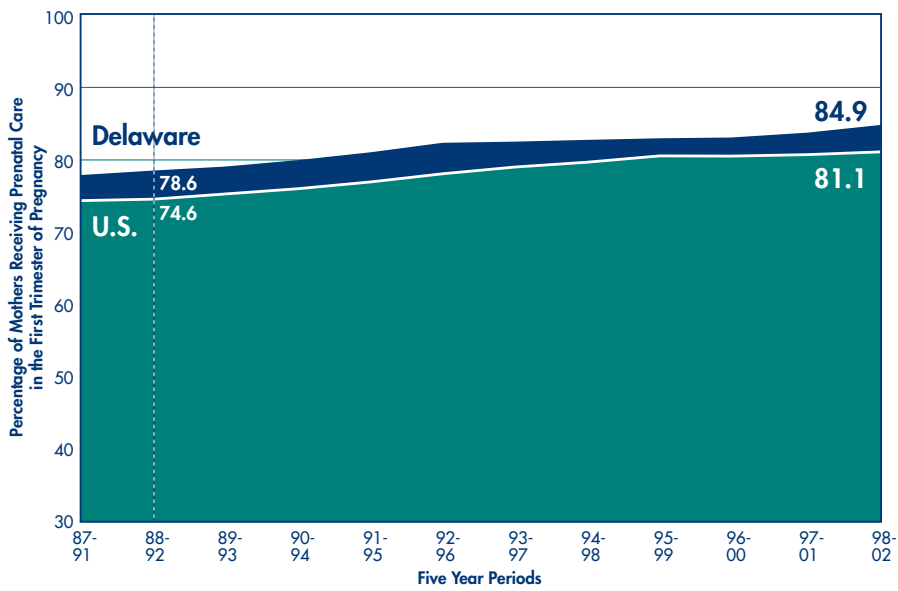
Emma & mom • July 2, 2003



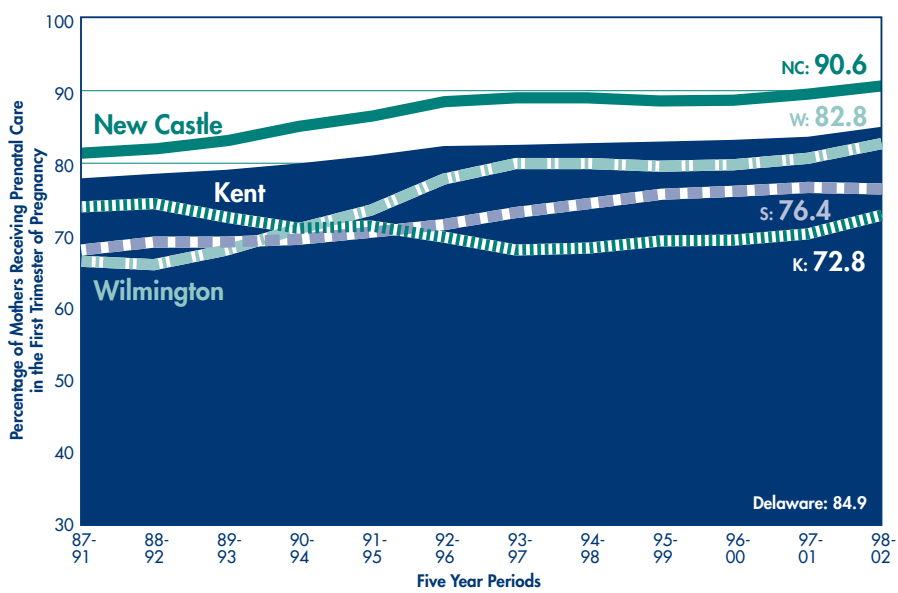
Emma • July 2, 2004

Prenatal Care

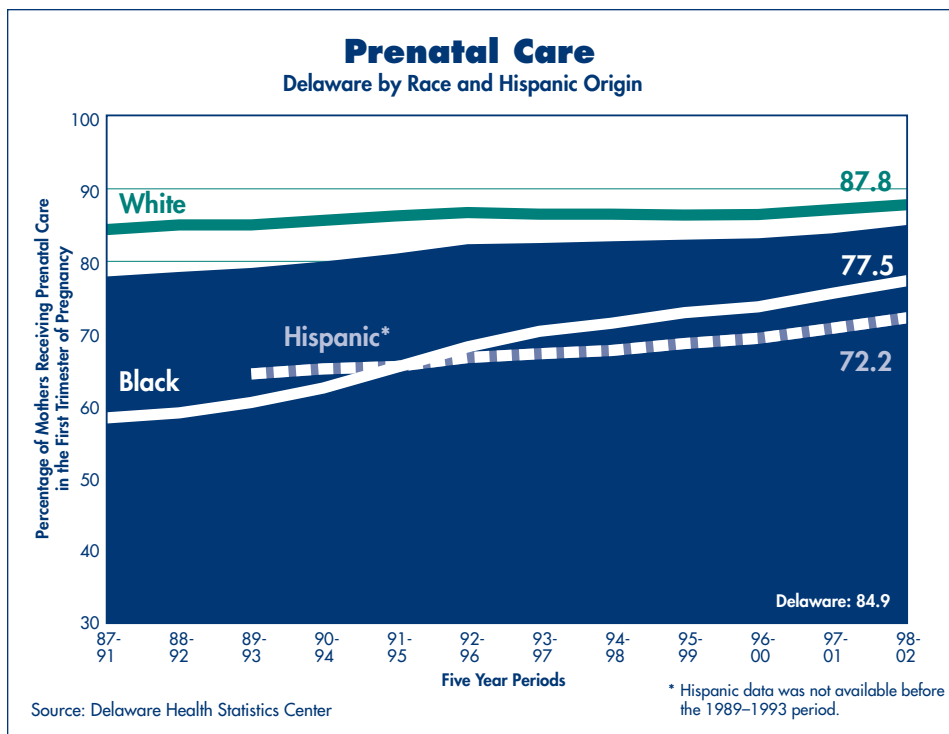
Delaware Compared to U.S.



Delaware, Counties and Wilmington



Sources: Delaware Health Statistics Center, National Center for Health Statistics



Did you know?

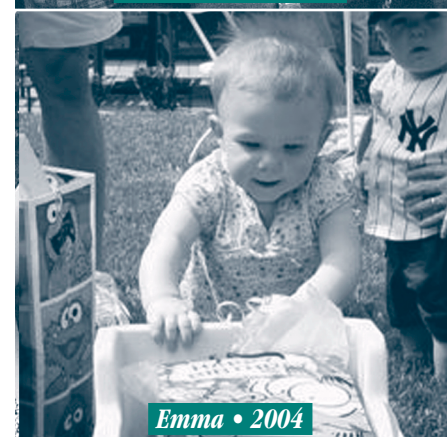
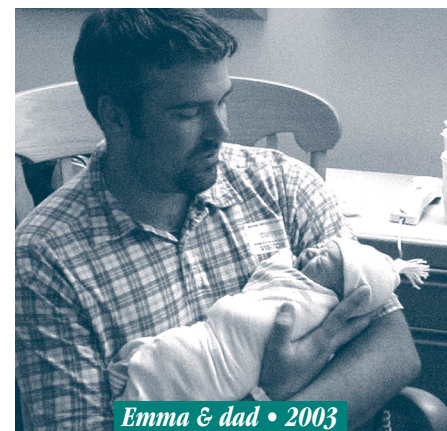
- In 2001, 88.5 percent of non-Hispanic White women and 84.0 percent of Asian/Pacific Islander women received early prenatal care compared to 74.5 percent of non-Hispanic Black, 75.7 percent of Hispanic, and 69.3 percent of American Indian/Alaska Native women.¹
- One-third of pregnant teens do not receive adequate prenatal care, which means their babies are more likely to have a low birth weight and childhood health problems.²
- The U.S. Public Health Service recommends that women who are pregnant or planning to become pregnant should receive at least 400 micrograms of folic acid each day. Folic acid has been shown to help prevent birth defects.³
- New research suggests that eating more vegetables, fruits, and foods in the protein group before pregnancy may lower the risk of mother having a child who develops childhood leukemia.⁴

1 Maternal and Child Health Bureau. Available at: http://www.mchb.hrsa.gov/pages/page_50.htm

2 Teenwire, Planned Parenthood. Available at: <http://www.teenwire.com>

3 National Institutes of Child Health and Human Development. Available at: http://www.nichd.nih.gov/about/womenhealth/prenatal_care.cfm

4 Medline Plus, National Institute of Environmental Health Sciences. Available at: <http://www.nlm.nih.gov/medlineplus/prenatalcare.html>



put data into action

To assist women in having healthier babies, Delaware provides a Start Smart Program for Medicaid eligible pregnant women. These extended services include:

- Providing visits by a nurse or social worker before and after birth
- Providing diets outlined by a nutritionist
- Finding community resources for family needs
- Providing education about childbirth and parenting skills

Source: Delaware Health and Social Services. Available at: <http://www.state.de.us/dhss>

For more information see

Tables 8-11 p. 123-126
 Table 23 p. 134
www.kidshealth.org
www.cdc.gov/ncbddd/
www.med.umich.edu/obgyn/smartmoms/
www.aafp.org/
www.modimes.org/
www.4woman.gov

Low Birth Weight Babies



One out of every 13 babies born each year in the U.S. is a low birth weight baby and 65% of infant deaths are attributed to low birth weight.¹ Research has shown that certain environmental factors, lifestyles choices, and medical conditions greatly increase the risk of a mother delivering a low-birth weight baby.² These risks include receiving little or no prenatal care, smoking, drinking alcohol, using illegal drugs, experiencing violence, obesity, diabetes, high blood pressure, and being underweight before pregnancy. Respiratory distress syndrome and bleeding in the brain are the two most serious complications low birth weight babies' experience; more common occurring problems include mental retardation, cerebral palsy, and hearing or sight dysfunctions. Usually, the more severe complications occur if the baby is born before the 34th week of pregnancy. In the U.S., 12% of all infants are born before the 37th week.¹ Fortunately, medical advances have lead to a reduction in the number of deaths and disabilities related to low birth weight. Nonetheless, reports from 2001 indicate that the number of premature births has risen 29% since 1981.²

1 Professionals and Researchers (2003). March of Dimes. Available from: http://www.modimes.org/professionals/681_1153.asp

2 Premature Facts (2002-2003). March of Dimes. Available from: http://www.marchofdimes.com/prematurity/5415_5790.asp



Alex • May 9, 2003



Alex • May 9, 2004

Definitions

Infancy – the period from birth to one year

Neonatal – the period from birth to 27 days

Low Birth Weight Babies – infants weighing less than 2,500 grams (5.5 lbs.) at birth (includes very low birth weight)

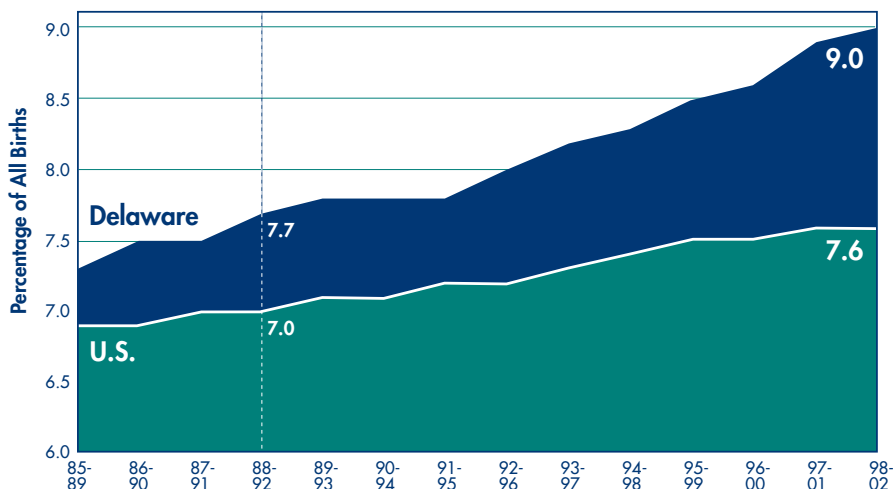
Very Low Birth Weight – less than 1,500 grams (3.3 lbs.)

Preterm – babies born before the 37th week of pregnancy.

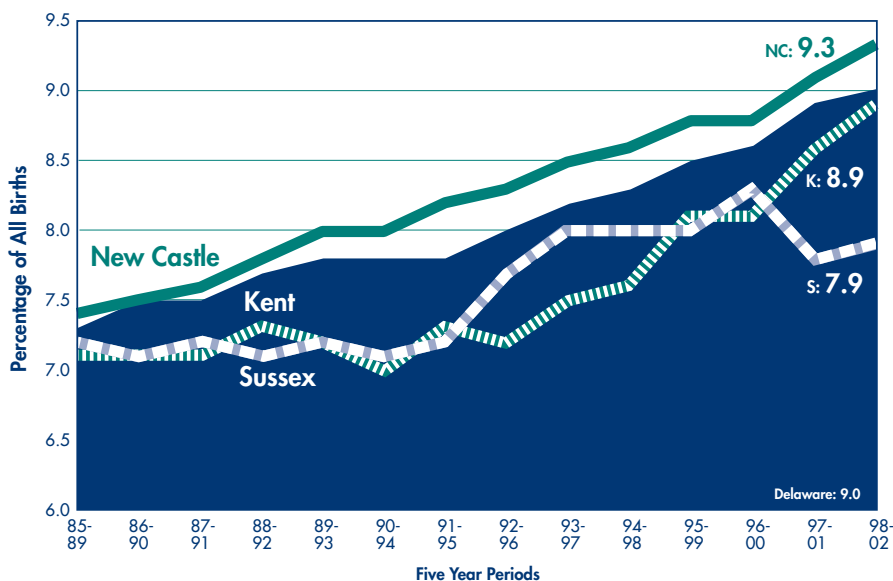
Full Term – babies born between the 37th and 42nd week of pregnancy.

Low Birth Weight Babies

Delaware Compared to U.S.

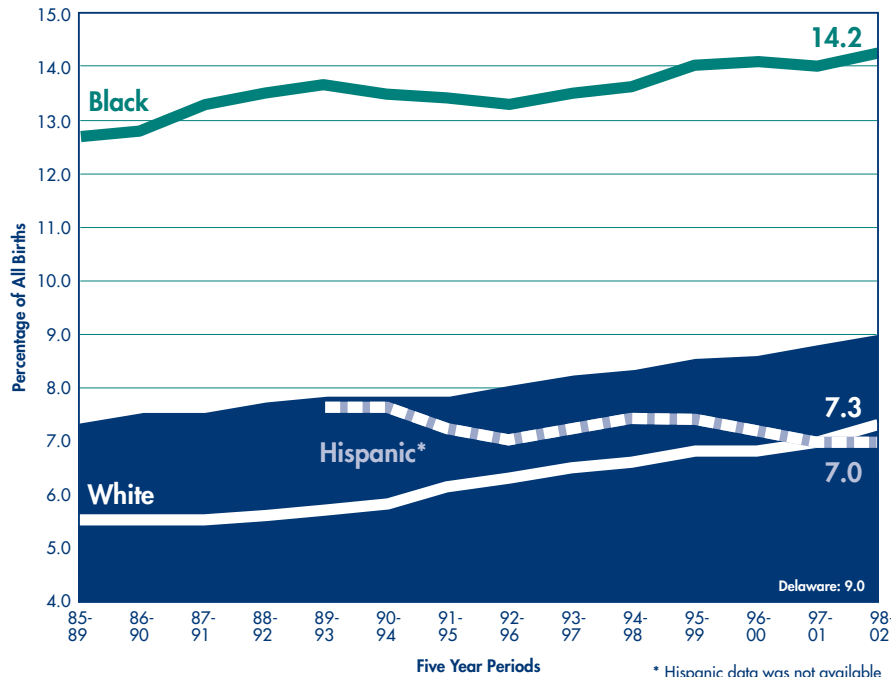


Delaware and Counties



Source: Delaware Health Statistics Center

Low Birth Weight Babies Delaware by Race and Hispanic Origin



* Source: Delaware Health Statistics Center

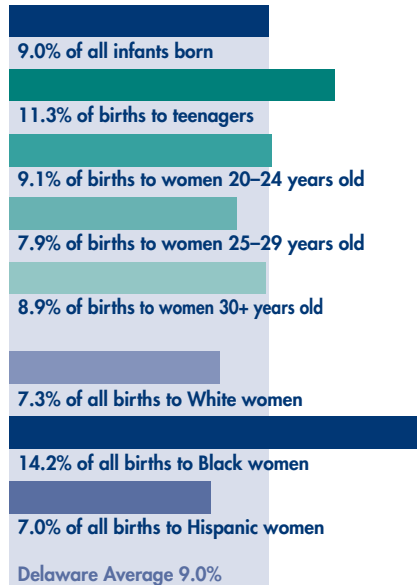
* Hispanic data was not available before the 1989-1993 period.



Alex & dad • 2003

Percentage of Babies with Low Birth Weight (weight less than 2500 grams) by Age and Race of Mother

Low birth weight babies in Delaware represent:

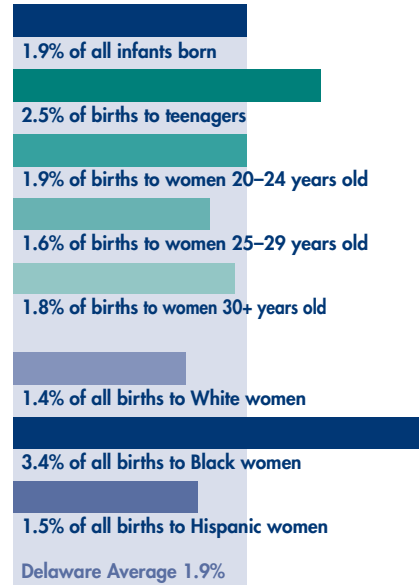


Five-year average percentages, 1998-2002

Source: Delaware Health Statistics Center

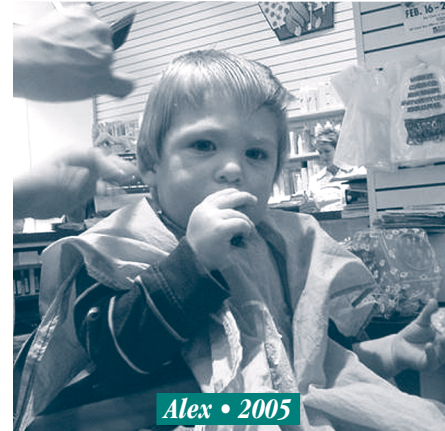
Percentage of Babies with Very Low Birth Weight (weight less than 1500 grams) by Age and Race of Mother

Very low birth weight babies in Delaware represent:



Five-year average percentages, 1998-2002

Source: Delaware Health Statistics Center



Alex • 2005

For more information see

Tables 9-15 p. 124-129

Table 22 p. 134

www.modimes.org

www.kidshealth.org

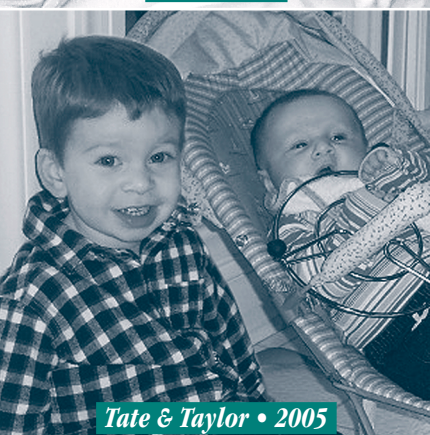
www.promisingpractices.org/

http://www.modimes.org/professionals/681_1153.asp

Infant Mortality



In the United States, the infant mortality rate (the rate at which babies less than one year of age die), has continued to decline over the past several decades. In Delaware, however, after steady improvement since the 1970s, the infant mortality rate began climbing in the mid-1990s. In June 2004, Governor Minner established the Delaware Infant Mortality Task Force to study the infant mortality rate in Delaware.

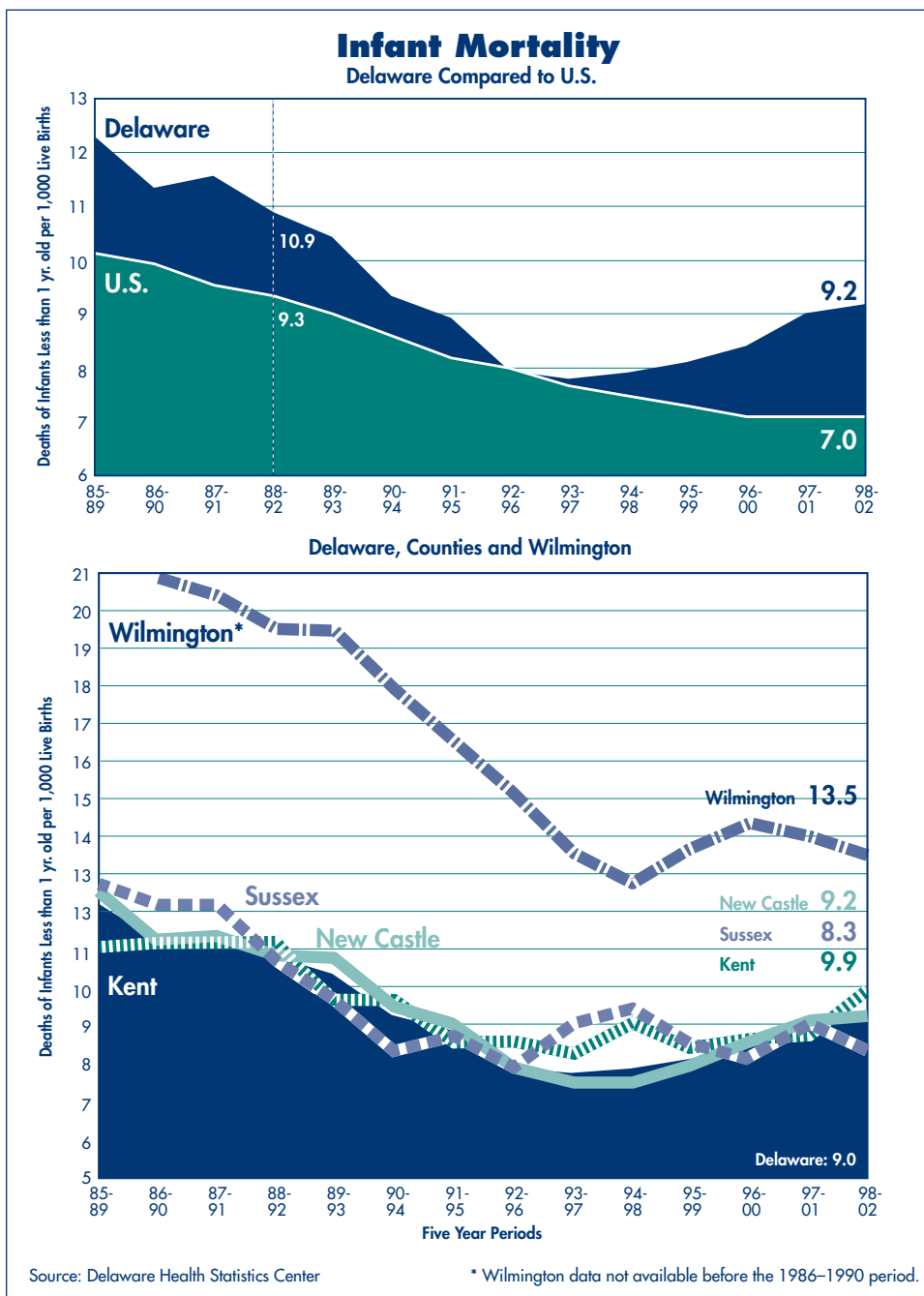


Definitions

Infant Mortality Rate – number of deaths occurring in the first year of life per 1,000 live births.

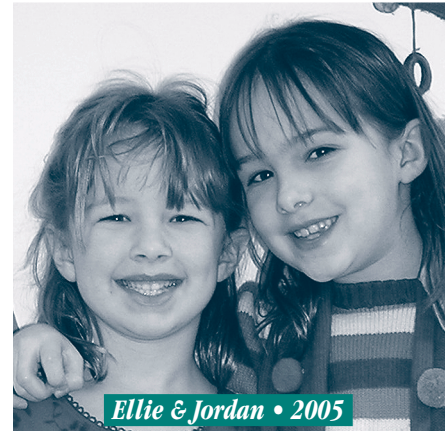
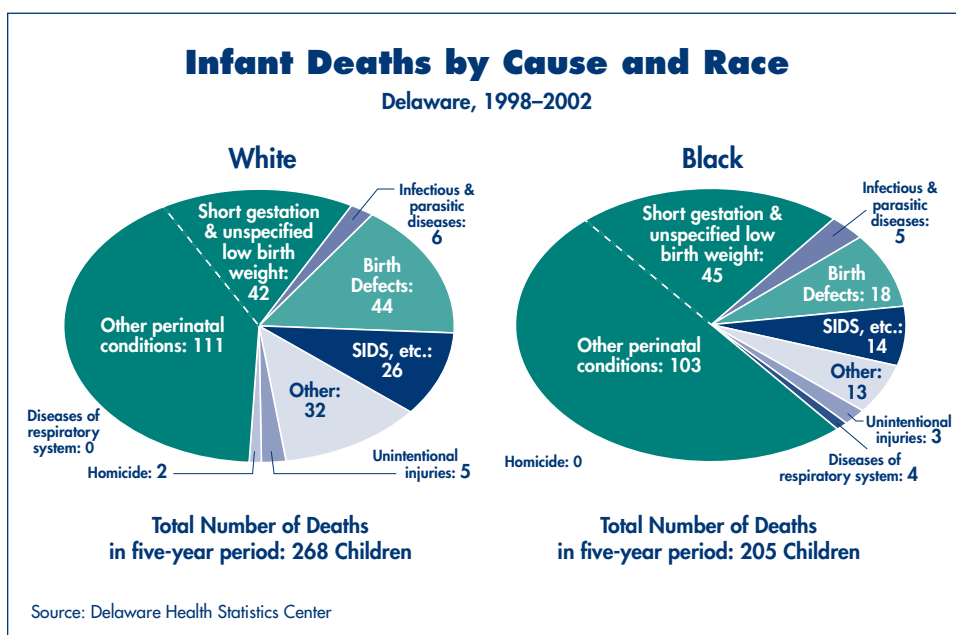
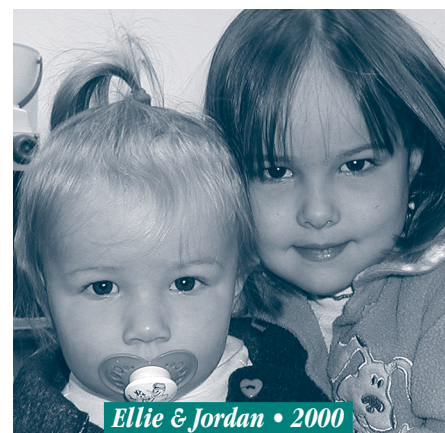
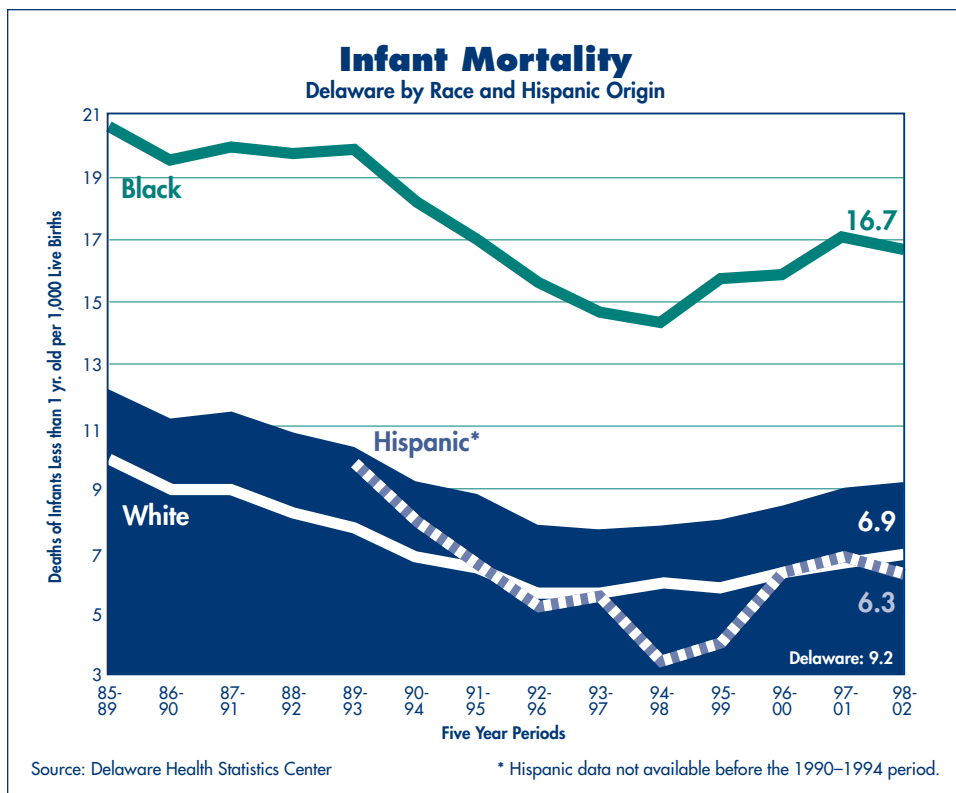
Birth Cohort – all children born within a specified period of time. An infant death in the cohort means that a child born during that period died within the first year after birth.

Weeks of Gestation – the number of weeks elapsed between the first day of the last normal menstrual period and the date of birth.



Did you know?

The Infant Mortality Task Force has garnered knowledge from several sources. First, it convened experts from throughout the state and set up committees to address specific aspects of the problem. Second, it sought input from over 3,000 Delawareans, utilizing a web-based process called concept mapping. Third, it reached well beyond our borders to think about this problem by tapping into some of the nation's foremost experts on this issue.



Did you know?

Through the efforts of the Division of Public Health (DPH), Delaware was accepted into a five state collaborative convened by the Centers for Disease Control and Prevention, the March of Dimes, and the Association of Maternal and Child Health Programs to create a state research agenda on infant mortality and develop a tool kit for other states to use in their efforts to solve this complex problem. DPH also secured the services of academicians from Johns Hopkins Bloomberg School of Public Health to consult on the Task Force's efforts.

Definition

Other perinatal conditions – other perinatal conditions include maternal complications and risk factors that affect the infant, as well as complications of birth/delivery, and fetal infections.

Definition

Gestation – the period of time a baby is carried in the uterus, usually referred to in weeks. A full-term gestation is between 37 and 42 weeks.



Melissa • 1999



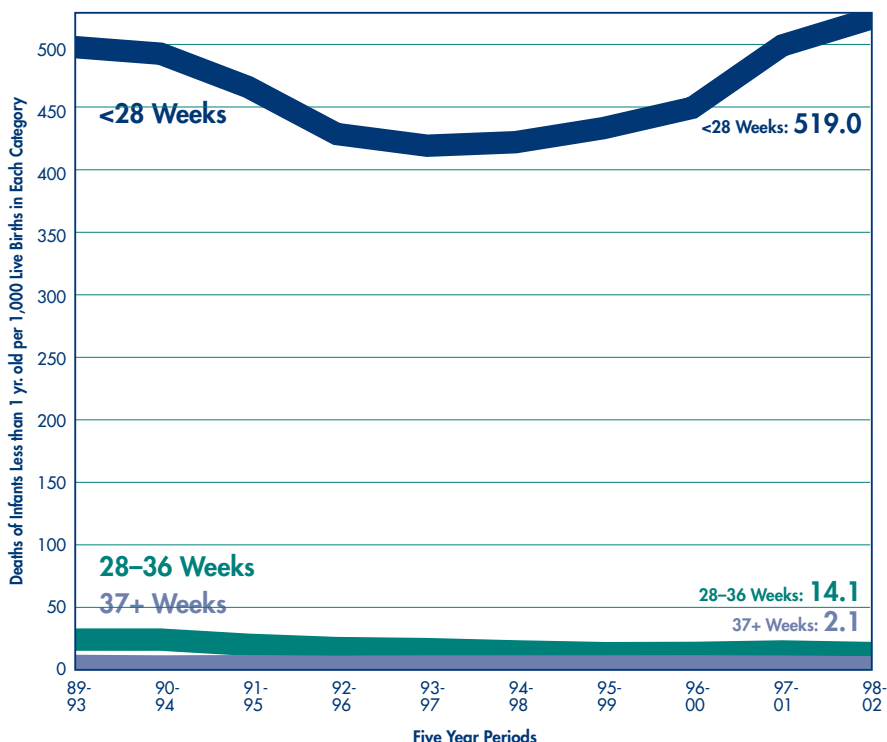
Melissa • 2000



Melissa • 2005

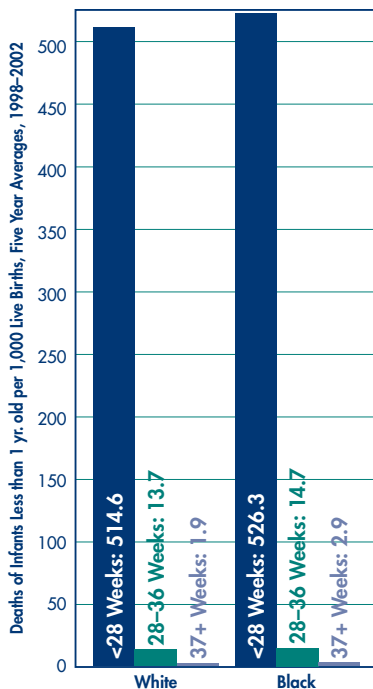
Infant Mortality by Gestation

Delaware by Weeks of Gestation



Source: Delaware Health Statistics Center

Infant Mortality in Delaware by Gestation and Race



Source: Delaware Health Statistics Center

Did you know?

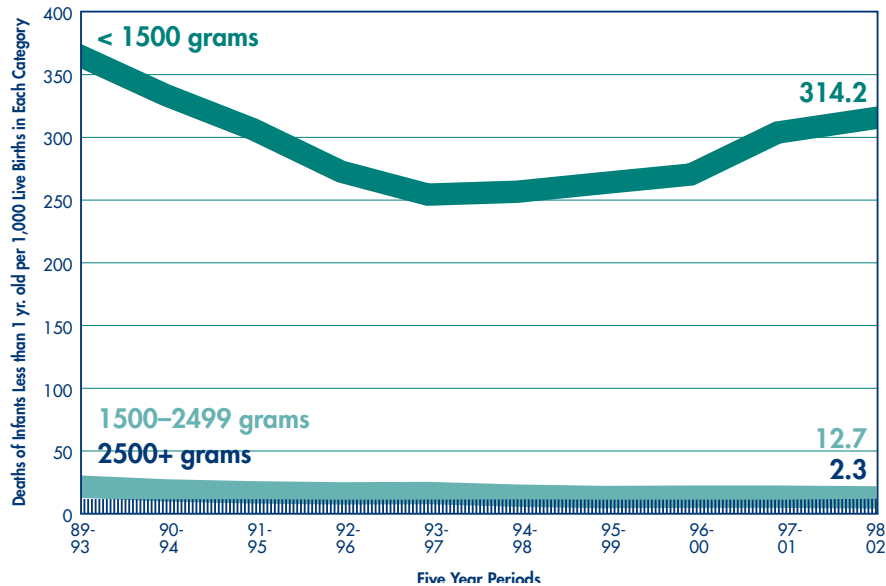
- Infants born to mothers less than 20 years old or over 35 years are more likely than infants born to mothers 20–35 to be preterm.
- A 1996 study indicates that pregnant women who receive the recommended amount of folic acid throughout pregnancy are less likely to have a baby preterm or a low birth weight baby.¹
- In 2001 the charges for hospital stays for infants with any diagnosis of prematurity was estimated at \$13.6 billion.
- From 1981 to 2002, premature births increased 29 percent and prematurity now affects about 12 percent of all live births.²
- 61 percent of the increase in the U.S. infant mortality rate can be attributed to increases in births of the smallest and earliest infants.²

¹ Premature Facts (2002-2003). March of Dimes. Available from: http://www.marchofdimes.com/prematurity/5415_5790.asp

² Increased Infant Death Rate Due to Rise in Premature Births (2005). March of Dimes.

Infant Mortality by Birth Weight

Delaware



Source: Delaware Health Statistics Center

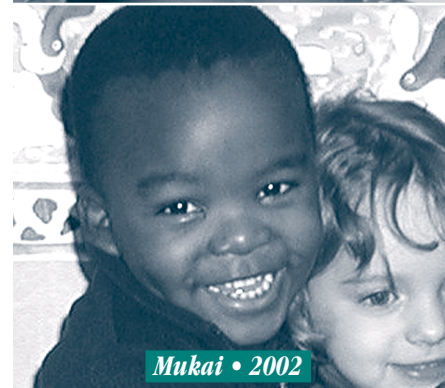
Definitions

Low Birth Weight Babies – infants weighing less than 2,500 grams (5.5 lbs.) at birth (includes very low birth weight)

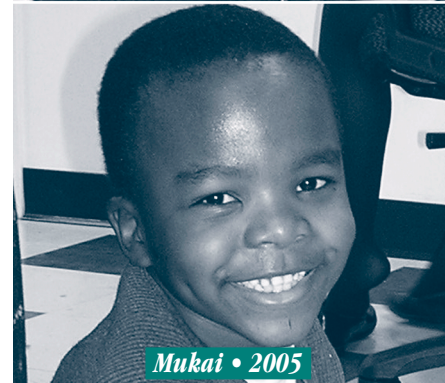
Very Low Birth Weight – less than 1,500 grams (3.3 lbs.)



Mukai • 1999

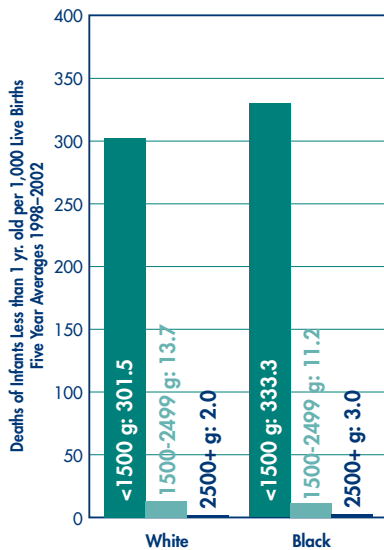


Mukai • 2002



Mukai • 2005

Infant Mortality in Delaware by Birth Weight



Source: Delaware Health Statistics Center

Did you know?

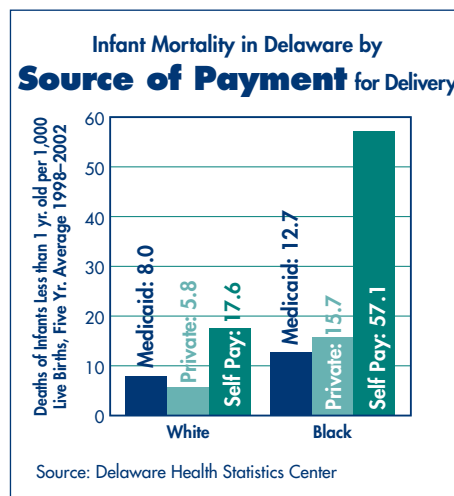
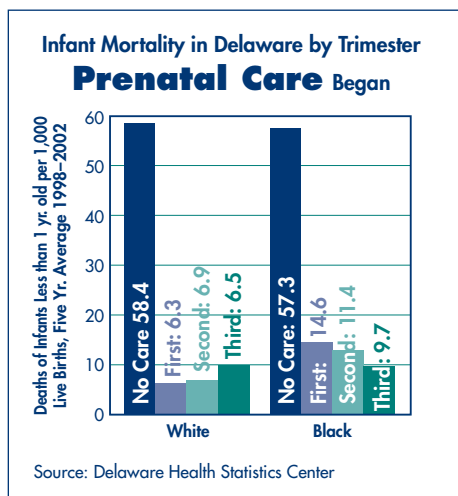
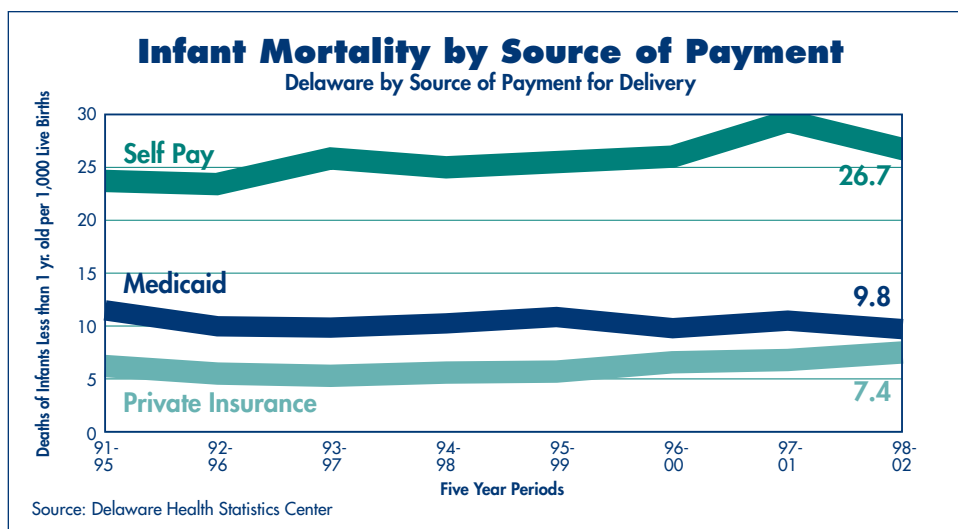
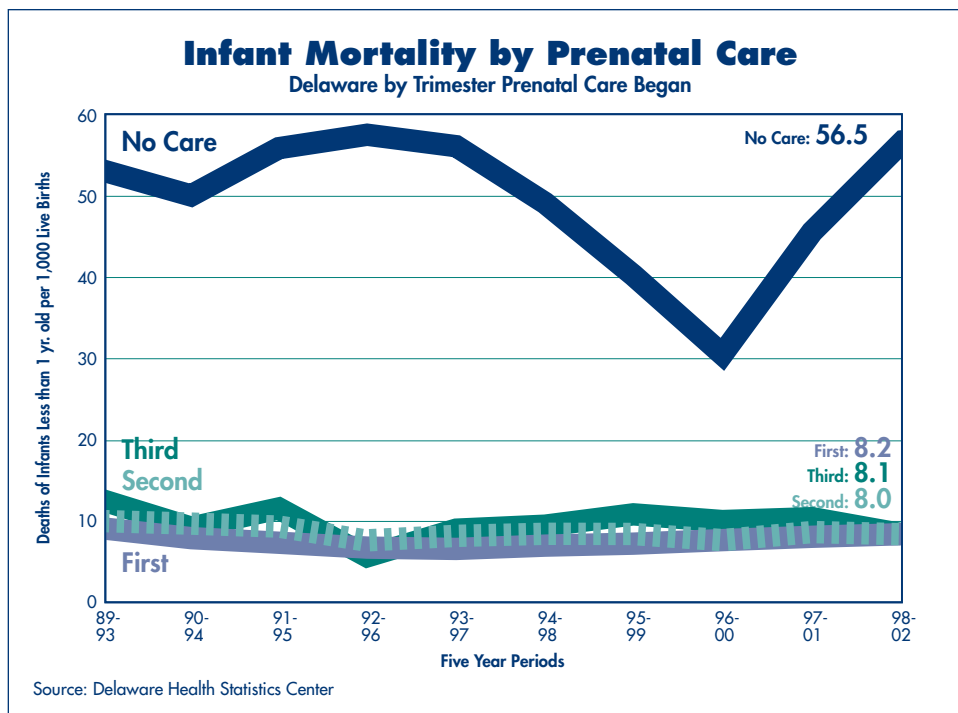
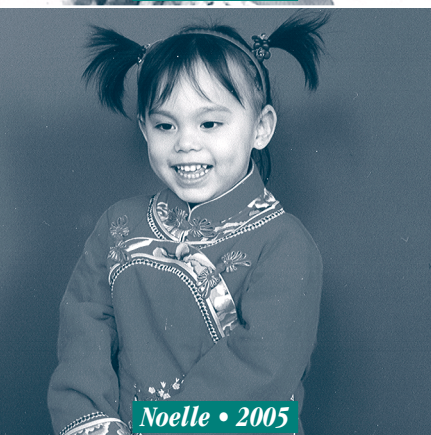
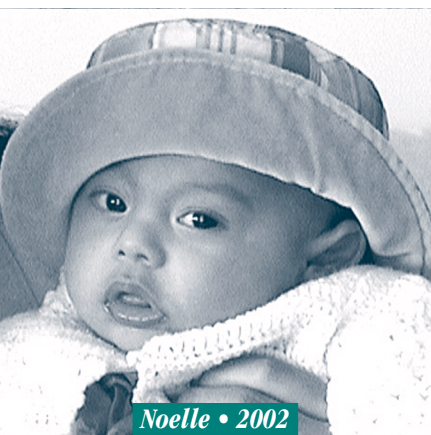
- Infants born to Asian mothers have the lowest infant mortality rate of any ethnic or racial group in the United States.
- Prematurity and low birth weight are the leading causes of death among African American infants, occurring at five times the rate of Whites.
- Hispanics, who have a slightly higher rate of poverty than African Americans, have an overall low birth weight rate that is comparable to Whites.
- Studies show that inequalities in social and economic circumstances cannot explain the differences in infant mortality and morbidity rates, even though the poverty rate of African Americans is twice the rate of Whites.

Source: Health Disparities: Bridging the Gap. Available from: www.nichd.nih.gov/strategicplan/disparities/disparities.pdf

put data into action

Early Warning Signs of a Premature Birth:

- Abdomen contractions every 10 minutes or more often.
- Change in vaginal discharge (leaking fluid or bleeding from the vagina)
- Pelvic pressure
- Low, dull backache
- Cramps that feel like menstrual cramps
- Abdominal cramps with or without diarrhea

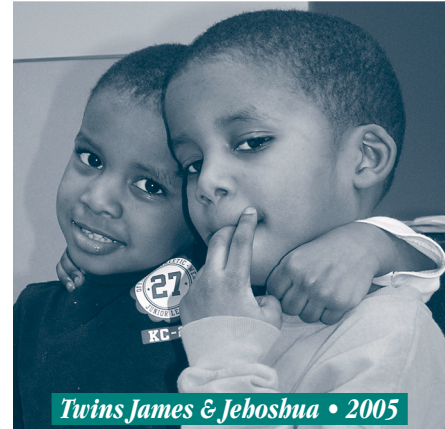


Infant Mortality by Single vs. Multiple Birth Delaware

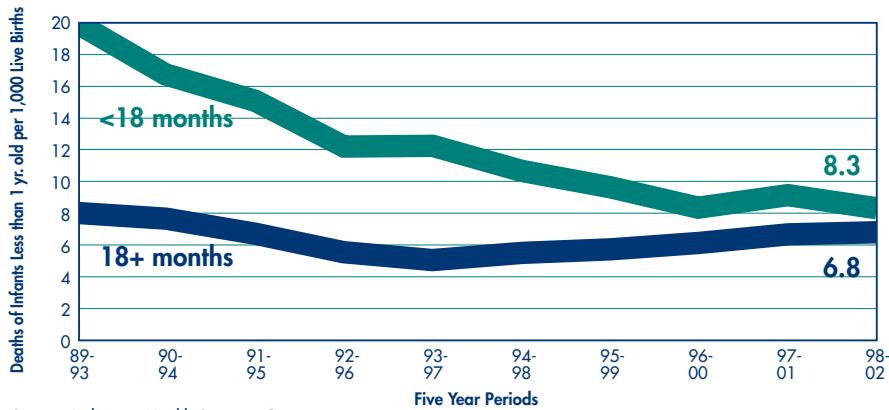


Definition

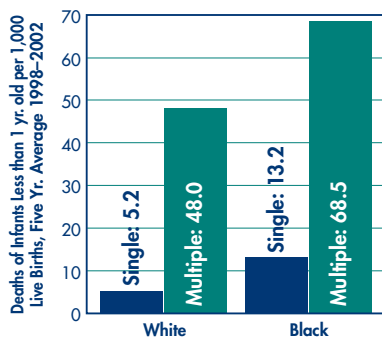
Birth Interval – the period of time between the birth of one child and the birth of the next. Birth interval stats do not include multiple births.



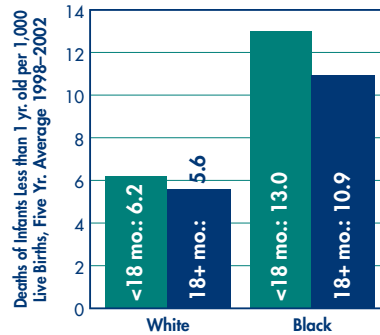
Infant Mortality by Birth Interval Delaware



Infant Mortality in Delaware by Multiple vs. Single Birth



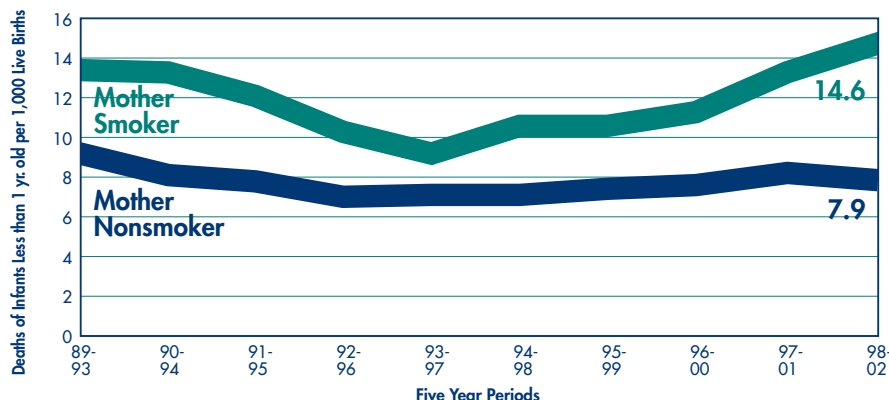
Infant Mortality in Delaware by Birth Interval





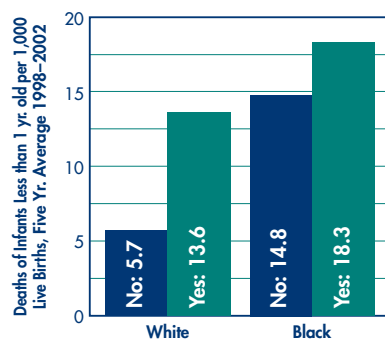
Infant Mortality by Smoking During Pregnancy

Delaware



Source: Delaware Health Statistics Center

Infant Mortality in Delaware by Smoking in Pregnancy



Source: Delaware Health Statistics Center

put data into action

2004 marks the ten year anniversary of the launching of the Back to Sleep Campaign, an effort to teach caregivers to place

infants on their backs to reduce the risk of SIDS (Sudden Infant Death Syndrome). This has been one of the most successful public health efforts in recent years, with deaths from SIDS decreasing dramatically. Although SIDS rates have declined in all populations, the SIDS rate among African Americans remains more than twice that of whites.

The Infant Mortality Task Force

The Infant Mortality Task Force will be presenting a final report with recommendations for a sustained reduction in our infant mortality rate to the Governor in March, 2005. Although at this writing the committees remain engaged in the rigorous process of assembling final recommendations, several task force-wide initiatives are likely to prevail. The first of these is funding for a Fetal and Infant Mortality Review (FIMR) process that explores the individual medical and social determinants of fetal and infant death. This takes us further than death and birth certificate data in our understanding of factors associated with infant deaths in our state. A pilot FIMR is already under way through the cooperation of the Division of Public Health, Nemours Health and Preventive Services, and the Child Death, Near Death and Stillbirth Commission. The second likely recommendation is to create a structure, similar to the very successful Cancer Consortium and as a follow-up to the very effective Perinatal Board, to execute the recommendations of the IMTF and take accountability for their effectiveness.

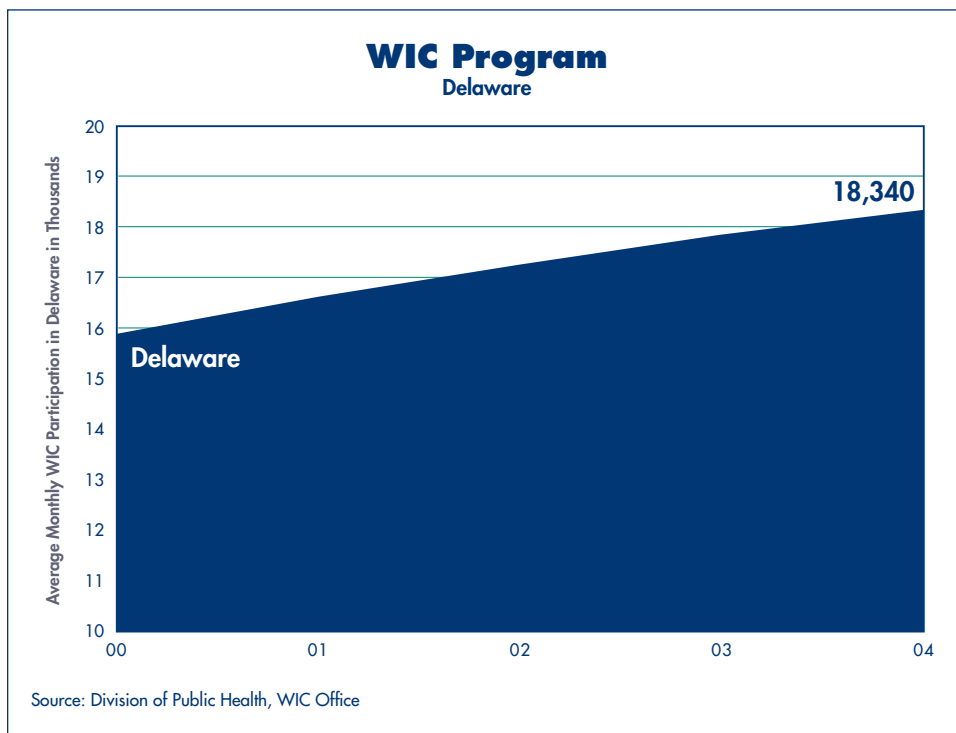
Recommendations in the final report will be presented in the context of the periods of risk leading to infant mortality—preconception or healthy “girlhood”; the prenatal period; the neonatal period; and the internatal period. Each recommendation will have actionable implementation steps, a budget, timeline, and a responsible agency. Look for this report online in the spring of 2005.

For more information see

Tables 16-27 p. 130-136
www.modimes.org
www.cdc.gov/nccdphp/dhrh/index.htm
www.hmh.org

Women, Infants, and Children Receiving WIC

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally-funded program that safeguards the health of low-income women, infants and children up to age five. WIC provides qualifying individuals with nutritious foods, nutrition education, and referrals to appropriate healthcare and social services. WIC supports breastfeeding and promotes it as the preferred form of infant nutrition.



WIC Program Delaware, 2004

- More than half the babies born in Delaware in 2004 were on WIC.
- Studies have shown that, for every \$1 WIC spends, \$3 is saved in future health care costs.

Source: Division of Public Health, WIC Office

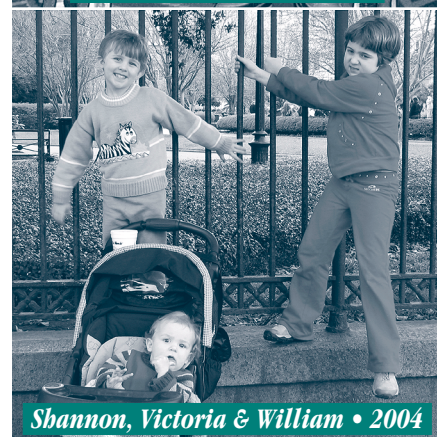
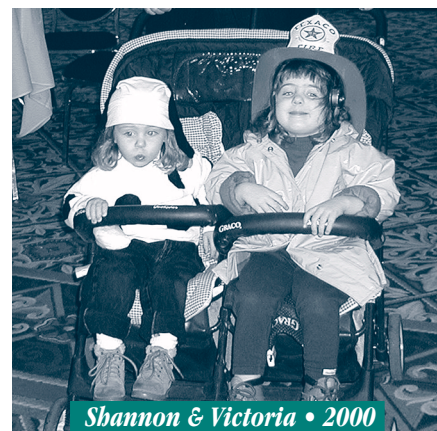
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action

Delaware WIC contact information:

Address: WIC Program,
655 Bay Road, Suite 4-B,
Dover, DE 19901

Toll-free phone number: 1-800-222-2189

Web site: <http://www.state.de.us/dhss/dph/chca/dphwichominf01.html>



Did you know?

- WIC is available in all 50 states, 33 Indian Tribal Organizations, American Samoa, District of Columbia, Guam, Puerto Rico and the Virgin Islands.
- In fiscal year 2004 almost 8 million people received WIC benefits monthly.
- Children make up about half of all WIC participants.
- Congress appropriated nearly \$5 billion for WIC in fiscal year 2004.
- By negotiating rebates with formula manufacturers, States are able to serve more people. For FY 2003, rebate savings were over \$1.5 billion. That was enough to support an average of about 2 million participants each month or 25% of the estimated average monthly caseload.

Source: WIC Fact Sheets: Federal Food and Nutrition Service. Available at: <http://www.fns.usda.gov/wic/WIC-Fact-Sheet.pdf>
Division of Public Health, WIC Office

For more information see

Table 46

p. 146

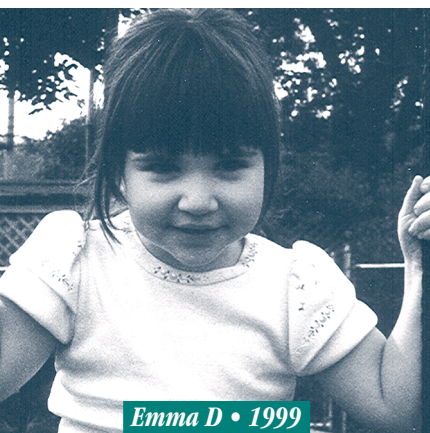
www.fns.usda.gov/wic



Lead Poisoning

RECENT TREND
IN DELAWARE
**GETTING
BETTER**

LEAD POISONING • 10 YEARS
KIDS COUNT IN DELAWARE



Emma D • 1999



Emma D • 2005

For more information see

Table 28 p. 136

www.aecp.org

www.nlm.nih.gov/medlineplus/leadpoisoning.html

www.epa.gov/opptintr/lead/nlic.htm

www.cdc.gov/nceh/lead/lead.htm

www.epa.gov/opptintr/lead/index.html

www.hud.gov/offices/lead/

1-212-BAN-LEAD

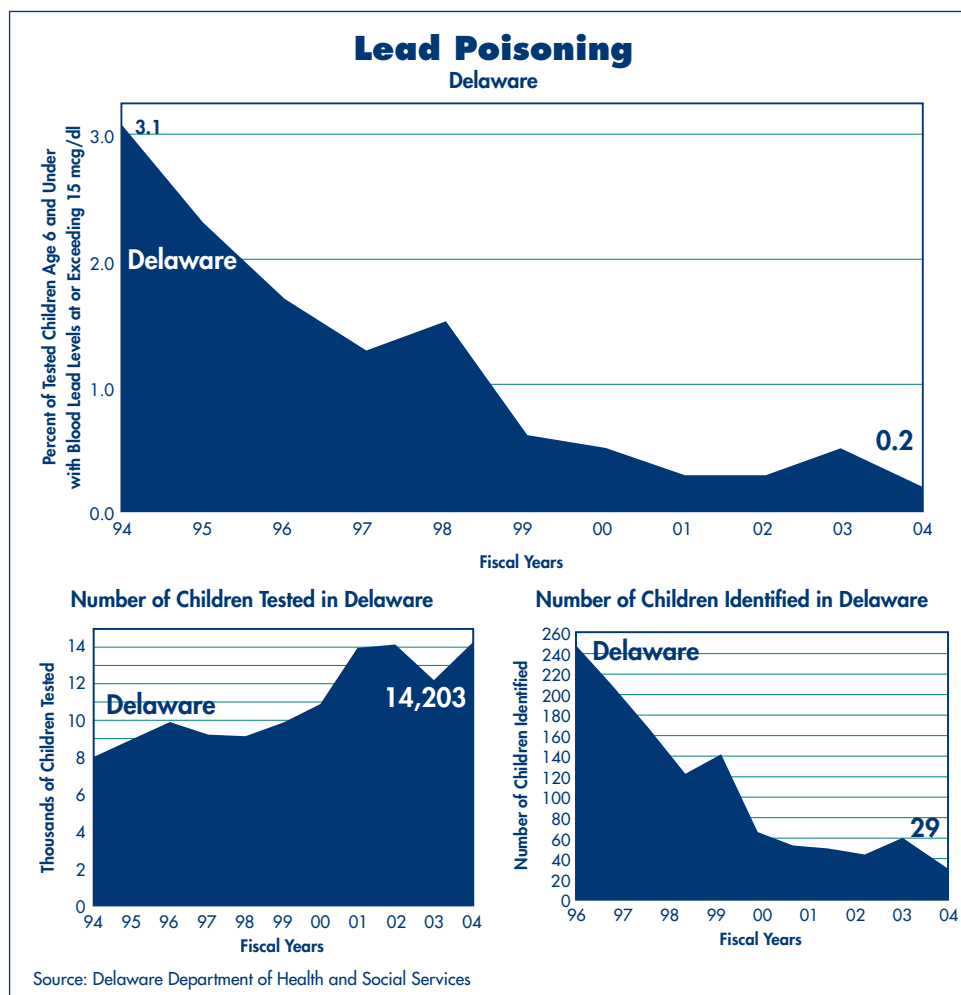
The National Lead Information Center
1-800-424-LEAD (5323)

In the late 1970's, lead-based paint stopped being used on most houses; however, many older homes still have surfaces painted with lead paint.¹ Today, childhood lead poisoning is considered to be the most preventable environmental disease of young children, yet an estimated 434,000 U.S. children have elevated blood-lead levels.² Lead poisoning is dangerous because the high blood-lead levels alter the way nerve cells signal one another and disturb the connections the brain uses for thinking.³ Some of the conditions caused by lead poisoning include mental retardation, convulsions, kidney damage, and in severe cases, death.³ Pregnant women, infants, and young children are especially susceptible to lead poisoning and should avoid engaging in any activity that stirs-up lead based paint. The only way to detect lead poisoning is a simple blood test.¹ Children should have a blood-lead level test every year until the age of six. The average blood-lead level in children has decreased approximately 80% since the late 1970's; however low-income children, urban children, and those living in older homes could be at risk for elevated blood-lead levels.²

1 FAQ-Lead Poisoning (2002). Environmental Protection Agency. Available from: http://www.epa.gov/region02/faq/lead_p.htm

2 Children's Blood Lead Levels in the United States (2002). Center for Disease Control. Available from: www.cdc.gov/nceh/lead/lead.htm

3 Lead and Your Health: Lead is All Around Us (1998). National Institute of Environmental Health Sciences. Available from: <http://www.niehs.nih.gov/oc/factsheets/lyh/lyh.htm>



put
data
into
action

If a child living in housing authority housing has a blood-lead level of 25 µg/dL or more, the housing authority must test the child's apartment within 5 days after being notified by a doctor. In addition, they must treat all lead-based surfaces within 14 days, and, if unable to treat the surface, must move the family into a unit previously tested or built after 1978.

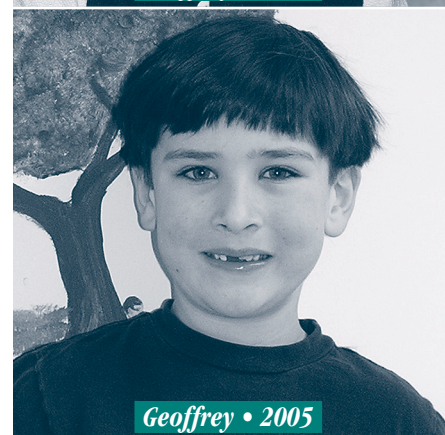
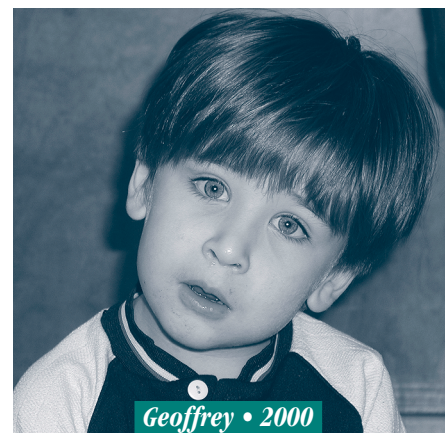
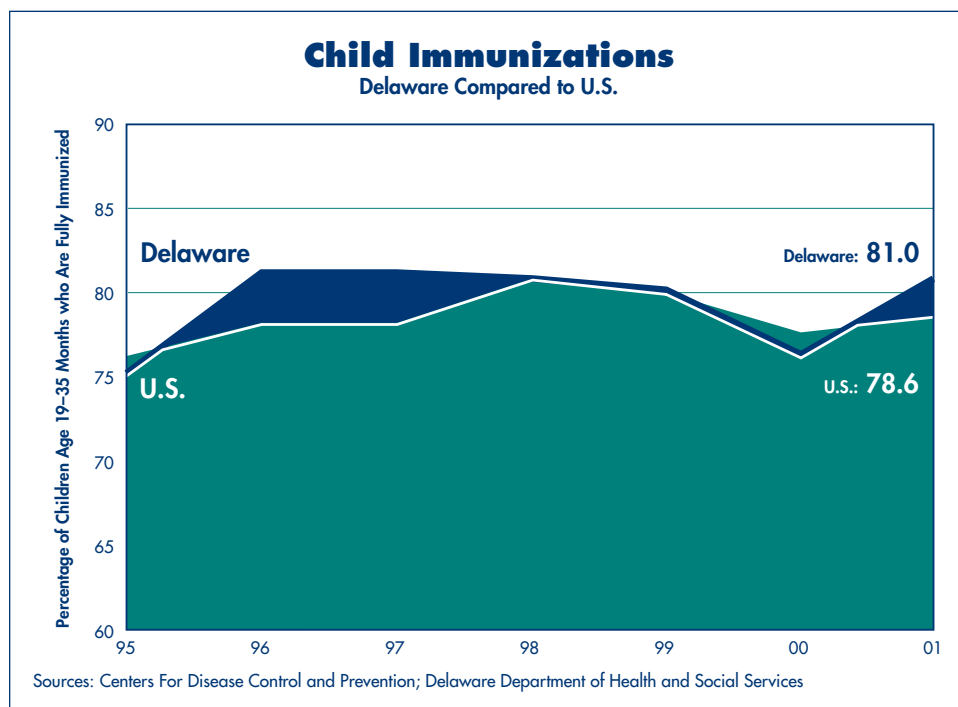
Source: FAQ-Lead Poisoning (2002). Environmental Protection Agency. Available from: www.epa.gov/region02/faq/lead_p.htm



Child Immunizations

According to the Centers for Disease Control and Prevention (CDC), every day 11,000 babies are born in the United States, each of which will need up to 20 vaccinations before they are 2 years old.¹ Child immunizations are vaccinations that create immunity to certain contagious diseases that young children are prone to. Vaccines protect against twelve serious diseases, including hepatitis B, pneumonia, bacterial meningitis, whooping cough, meningitis, measles, mumps, and chicken pox. Child immunizations have reduced or eliminated many of the infectious diseases that once consistently killed or harmed many infants, children, and adults.

Source CDC Vaccine-Preventable Diseases. Available at: www.cdc.gov/programs/immun.htm



Did you know?

- Delaware is able to provide free immunizations for children who are uninsured, underinsured, Native American, Alaskan Native, or eligible for Medicaid, through the Vaccine for Children Program (VFC), which is sponsored by the CDC and funded by the federal government.
- In 2003, Immunization rates for measles-mumps -rubella (MMR), hepatitis B, and Haemophilus influenzae type b (Hib) vaccines each met or exceeded 90 percent of the *Healthy People 2010* target levels.¹
- Parents can order free immunization guides from the CDC website that explain the 12 diseases and how these vaccinations can protect their children.
- If vaccinations were discontinued, each year about 2.7 million measles deaths worldwide could be expected.²
- Immunization completion rates vary by racial and ethnic groups. In 2003 the completion rates were Caucasian: 85%, African American: 76.7%, Hispanic: 79.3%, American Indian: 78.5, and Asian: 83.8%.³

¹ Immunizations. Child Trends Data Bank. www.childtrendsdatabank.org

² National Immunization Program. CDC. Available at: www.cdc.gov/nip/publications/fs/gen

³ Delaware Health and Social Services

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data
into
action

Parents may obtain immunization information by calling the immunization hotline at 1-800-262-8672

For more information see

Table 29 p. 136

www.kidshealth.org/parent/general/body/vaccine_p9.html

Childhood Asthma

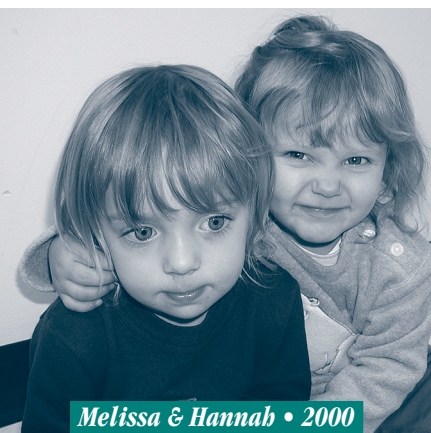
Asthma is a common chronic inflammatory lung condition of the bronchial airways. The inflammation causes a narrowing of the small airways in the lungs, which in turn produces airway obstruction, wheezing and/or coughing, and difficulty breathing. In 2002, over 13.9 million Americans over the age of 18 and 6.1 million Americans under the age of 18 had asthma.¹ Asthmatic episodes or “attacks” can be the result of several factors such as allergies, viral respiratory infections, and airborne irritants. Cigarette smoke, air pollution, strong odors, aerosol sprays, and paint fumes are just some of the airborne irritants that could trigger an asthmatic episode.² Between 1997 and 2002 the asthma prevalence rates were higher for 5–17-year olds, than for those over 65.¹ Asthma is a major public health concern. In adults, it is the leading work-related lung disease. Each year, children lose an estimated 10 million days of school to asthma. While asthma attacks can be very dangerous and possibly result in death, most attacks are mild and can be prevented with medication and by developing self-management skills. Parents and children can become experts at spotting early signs of an asthma episode and with careful management these children can lead productive, active lives.

1 Trends in Asthma Morbidity and Mortality. American Lung Association Epidemiology and Statistics Unit Research and Scientific Affairs (2004).

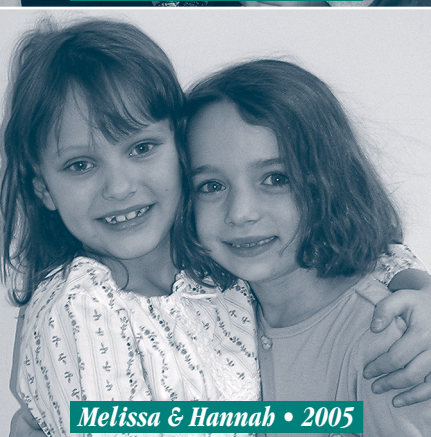
2 Childhood Asthma Overview. American Lung Association. Available from: www.lungusa.org

3 Coordination of Federal Asthma Activities (2001). Clause Lenfant, M.D. Available from: <http://aspe.hhs.gov/sp/asthma/overview.htm>.

4 Asthma and Children Fact Sheet (2003). American Lung Association. Available from: <http://www.lungusa.org/site/pp.asp?c=dvLUK900E&b=44352>



Melissa & Hannah • 2000



Melissa & Hannah • 2005

Definitions

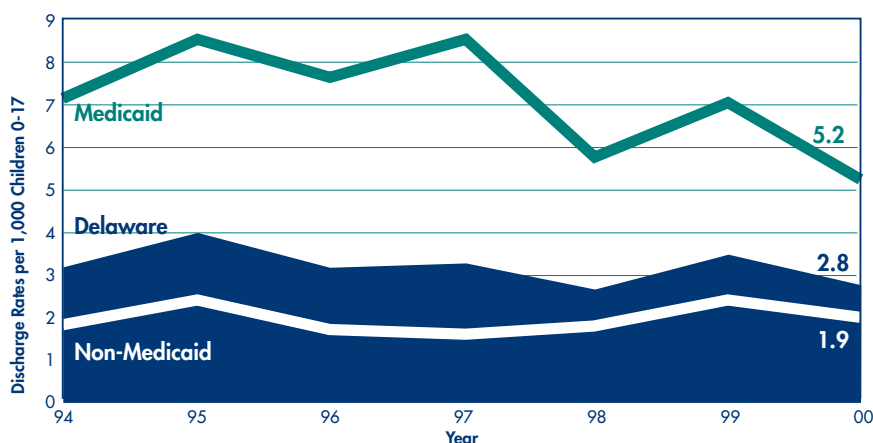
Discharge Rate – Number of inpatient asthma discharges for children 0-17 per 1,000 children in the same age group

Readmissions – Number of asthma inpatient hospital admissions for children 0-17 who had previously been discharged with a diagnosis of asthma in the same year

Readmission Rate – Number of inpatient asthma readmissions for children 0-17 per 100 children previously admitted in the same year

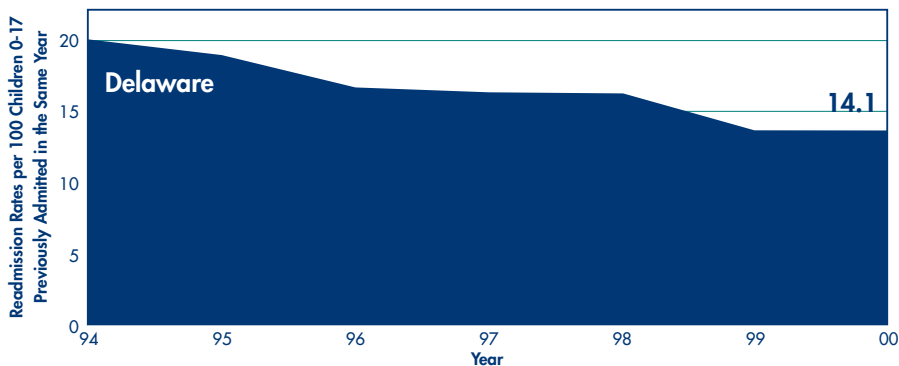
Hospitalizations for Childhood Asthma

Inpatient Asthma Discharges for Children 0-17 Years of Age
by Health Insurance Status, Delaware Hospitals



Readmissions for Childhood Asthma

Delaware



Source: Delaware Health Statistics Center

Did you know?

- Swimming seems to be the least asthma-provoking form of exercise.¹
- The use of bronchodilator medications before exercise can prevent most episodes brought on by physical activities.
- Asthma is the third leading cause of hospitalization among children under the age of 15 and the leading cause of chronic illness among children.²⁴
- Attack prevalence rates are higher for women than men, African Americans than whites, and African Americans and whites than Hispanics.³

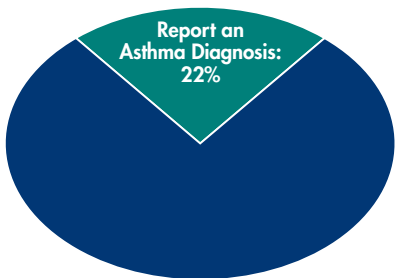
1 Childhood Asthma Overview. American Lung Association. Available from: www.lungusa.org

2 Asthma and Children Fact Sheet (2003). American Lung Association. Available from: <http://www.lungusa.org/site/pp.asp?c=dvLUK900E&b=44352>

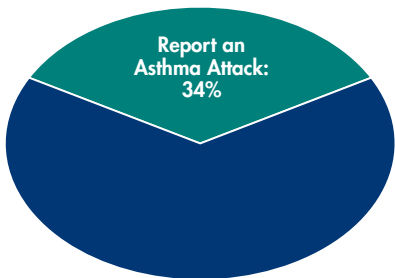
3 Trends in Asthma Morbidity and Mortality. American Lung Association Epidemiology and Statistics Unit Research and Scientific Affairs (2004).

Students with Asthma Delaware, 2003

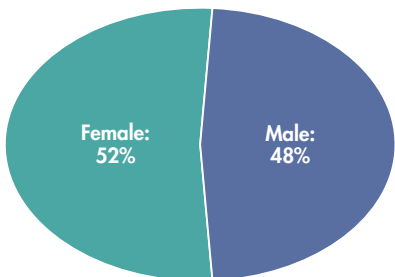
High school students who report having
being diagnosed with asthma



Students with asthma who report an
asthma attack in the past 12 months

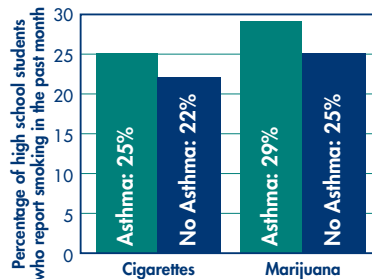


High school students who report having
asthma by gender



Source: 2,975 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

Asthma and Smoking Delaware, 2003



Source: 2,975 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

Did you know?

Common Warning Signs of an Asthmatic Episode:

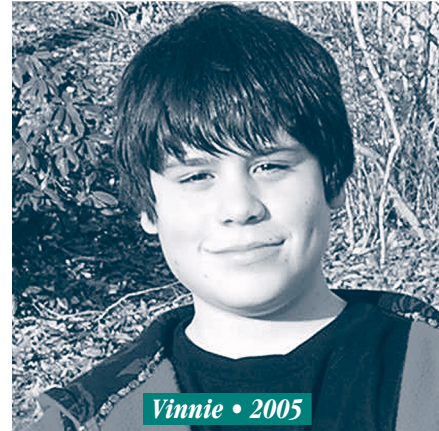
- Anxious or a scared look
- Coughing
- Wheezing
- Unusual paleness or sweating
- Fast breathing
- Hunched-over body posture

put data into action

In 2001 the American Lung Association started the Asthma-Friendly Schools Initiative (AFSI) in a co-operative agreement with the Centers for Disease Control and Prevention's Division of Adolescent and School Health. The goal of this initiative is to help communities plan and implement comprehensive school asthma management programs. The tool-kit can be downloaded for free from the American Lung Association's web page: <http://www.lungusa.org/site/pp.asp?c=dvLUK900E&b=22590>.



Vinnie • 1997

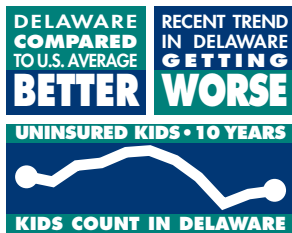


Vinnie • 2005

For more information see

Tables 30 p. 137
www.kidshealth.org
www.childasthma.com
www.lungusa.org/asthma/ascchildhood.html

Children without Health Insurance

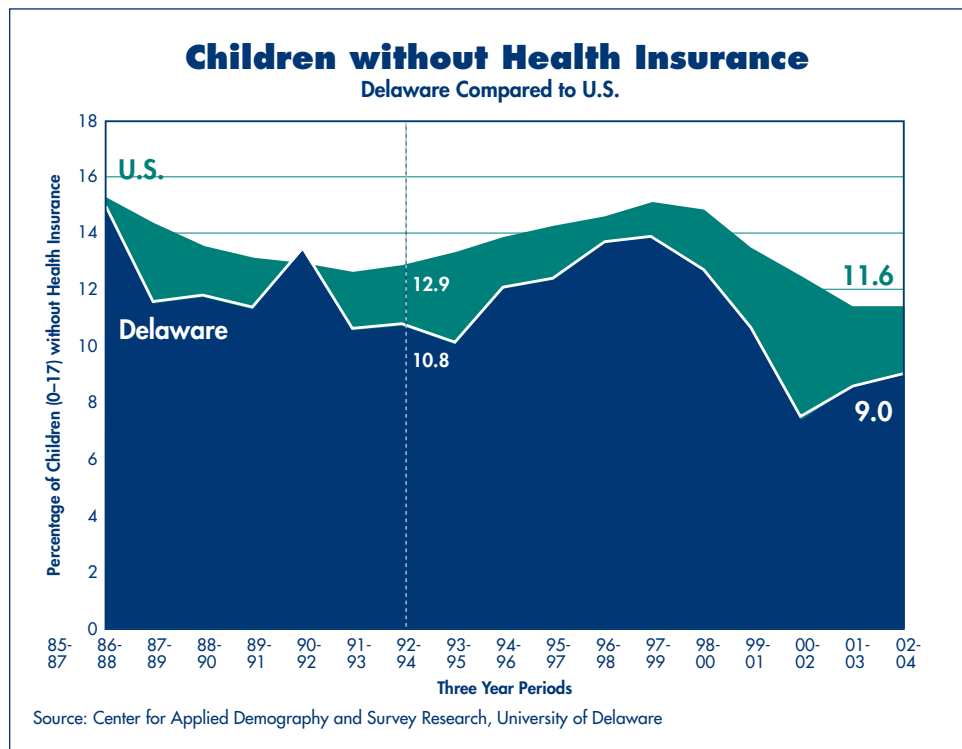
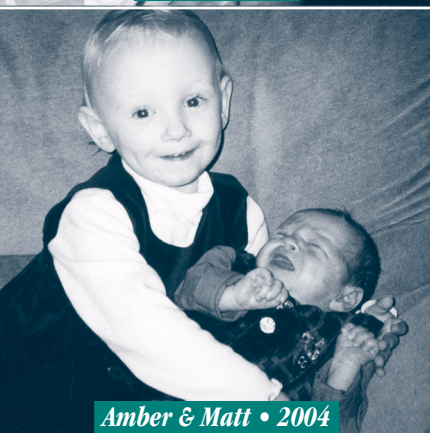
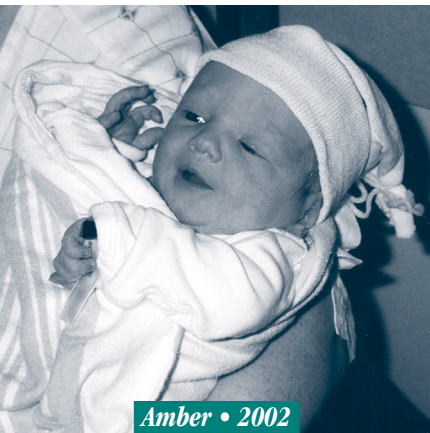


Children who have health insurance are more likely to receive vaccinations, treatments for chronic illnesses such as asthma, and preventative care, than children without health insurance.¹ Children without health insurance are more likely to miss school due to sickness, which can substantially hinder their academic performance now and in the future.¹ In 2003, the percentage of all children under the age of 18 with private health insurance coverage decreased to 66 percent from 71 percent in 2000.² In response to the loss of private health insurance and the increase in the number of low-income people, enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) increased to cover 2.4 million more low-income children and adults in 2003.³ However, 11.4 percent of the children at that time remained uninsured. SCHIP and Medicaid are health insurance programs that operate at the state level and provide children and families with free or low-cost health care based on income guidelines.

1 Insure Kids Now. Available at: www.insurekidsnow.gov

2 Health Care Coverage. Child Trends Data Bank. Available at: www.childtrendsdatabank.org

3 Center on Budget and Policy Priorities. Available at: <http://www.cbpp.org/8-26-04health.htm>



Did you know?:

- Uninsured children are over five times more likely to have an unmet need for medical care and over three times more likely not to get a needed prescription drug.¹
- Only 79% of Hispanic children in 2003 had health insurance as compared with 93 percent of non-Hispanic white children, 88% of Asian children, and 86% of black children.²
- 2003 data showed that 80% of children in single-father families and 86% of single-mother families had health insurance coverage, compared to 91% of children in married couple families.²
- As a family's level of income increases so does the likelihood that they will have health insurance coverage. In 2003, 95% of children living in families with incomes of \$75,000 or more were covered by health insurance, versus only 82% of children in families with incomes under \$25,000.²

1 The Kaiser Commission on Medicaid and the Uninsured. Fact Sheet. Available at: <http://www.kff.org>

2 Health Care Coverage. Child Trends Data Bank. Available at: <http://www.childtrendsdatabank.org>

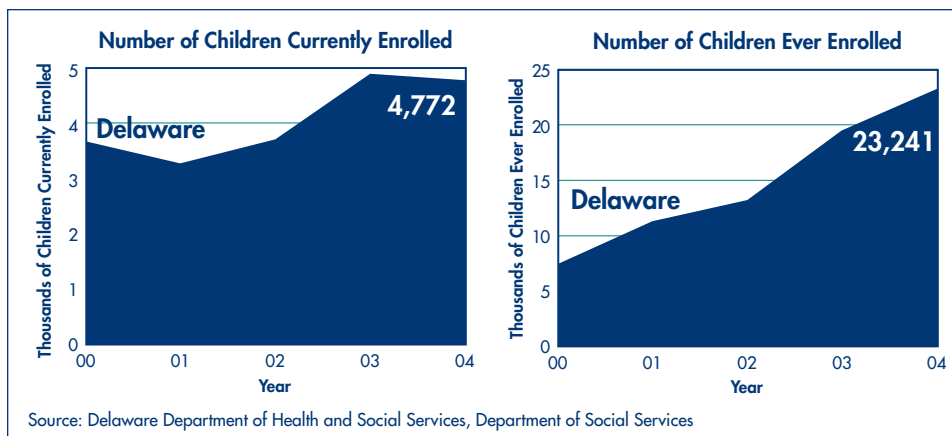
Delaware Healthy Children Program

Applications and Enrollment through October 31, 2004

Applications mailed to families	17,176
Total enrolled ever	23,241
Total currently enrolled	4,772

Source: Delaware Department of Health and Social Services, Department of Social Services

Begun in 1999, the Delaware Healthy Children Program (DHCP) provides low-cost health insurance for uninsured children under the age of 19 who live in families with incomes below 200% of the Federal Poverty Level. Many children in the state of Delaware transition between DHCP and Medicaid as their families' incomes fluctuate.



Did you know?

- 66 percent of poor children are covered by Medicaid, which covers about 26% of the entire population. Among poor children in 2003, Medicaid covered the following percentages of children: 73% of Black children, 67% of Hispanic children, 60% of White children, and 47% of Pacific Islander children.
- Children living in the Midwest and Northwest are more likely than children living in the South and West to have health insurance coverage (92% and 91% versus 86% and 88%, respectively).

Source: Health Care Coverage. Child Trends Data Bank. Available at: <http://www.childtrendsdatabank.org>

put data into action

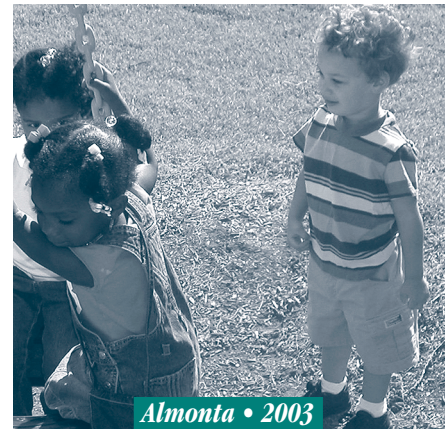
In general, children must be U.S. citizens to be eligible for the Delaware Healthy Children Program. However, some children who are classified by the Federal government as "qualified aliens" are eligible.

Examples of Non-Citizen Children Who May Be Eligible:

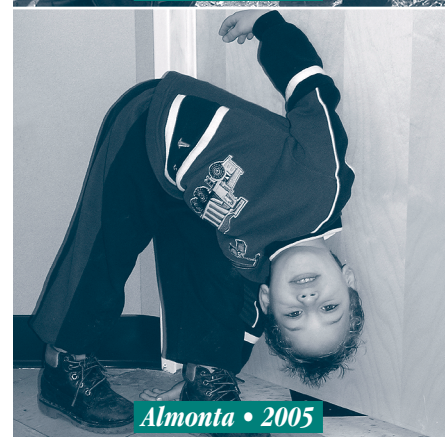
- Lawful permanent residents who entered the U.S. before August 22, 1996
- Parolees of more than one year and conditional entrants
- Refugees, asylees, and those whose removal has been withheld
- Cuban and Haitian entrants
- Amerasians
- Dependents of veterans and active-duty military

For more information about the Delaware Healthy Children Program please call 1-800-996-9969 or write at DHCP at P.O. Box 950, New Castle, DE 19720-9914.

Source: Delaware Health and Social Services. Available at: www.state.de.us/dhss/dss/shcpfaq.html



Almonta • 2003



Almonta • 2005

For more information see

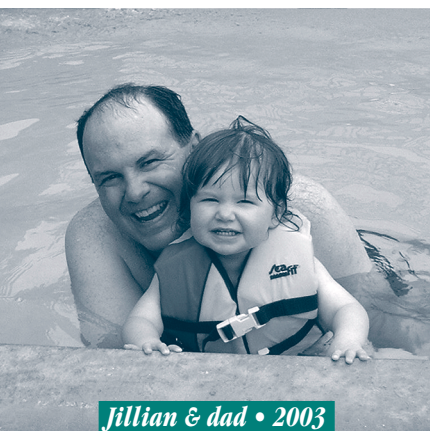
Table 31	p. 137
Table 77	p. 161
www.childrensdefense.org	
www.state.de.us/dhss/dssl	
www.kff.org	
www.cms.gov	
www.insurekidsnow.gov	

Child Deaths Children 1–14

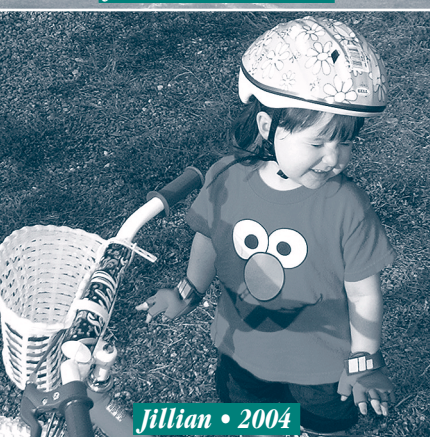


The death of a child may be one of the greatest tragedies a family, friend, or a community will ever face. Injury is the leading cause of death among children and youth. Injury accounts for more than a third of all deaths among children ages one to four and half of all deaths among teens ages 15 to 19. Educating children on proper safety procedures, using appropriate car seat restraints, installing working smoke alarms, providing children with appropriate safety gear, and teaching young children to swim are just a few ways parents and caregivers can reduce the chance of a child dying from an unnecessary injury. Fortunately, since 1980 the death rate for children has fallen dramatically in the U.S.. The death rate for children ages one to four has dropped from 64 to 31 per 100,000 and rates for children 5 to 14 have fallen from 31 to 17 per 100,000. Data from 2002 indicated that among every age group African American and Indian children had the highest death rates, Asian/Pacific Islander children had the lowest death rates, and Hispanic and Caucasian children fell in the middle.

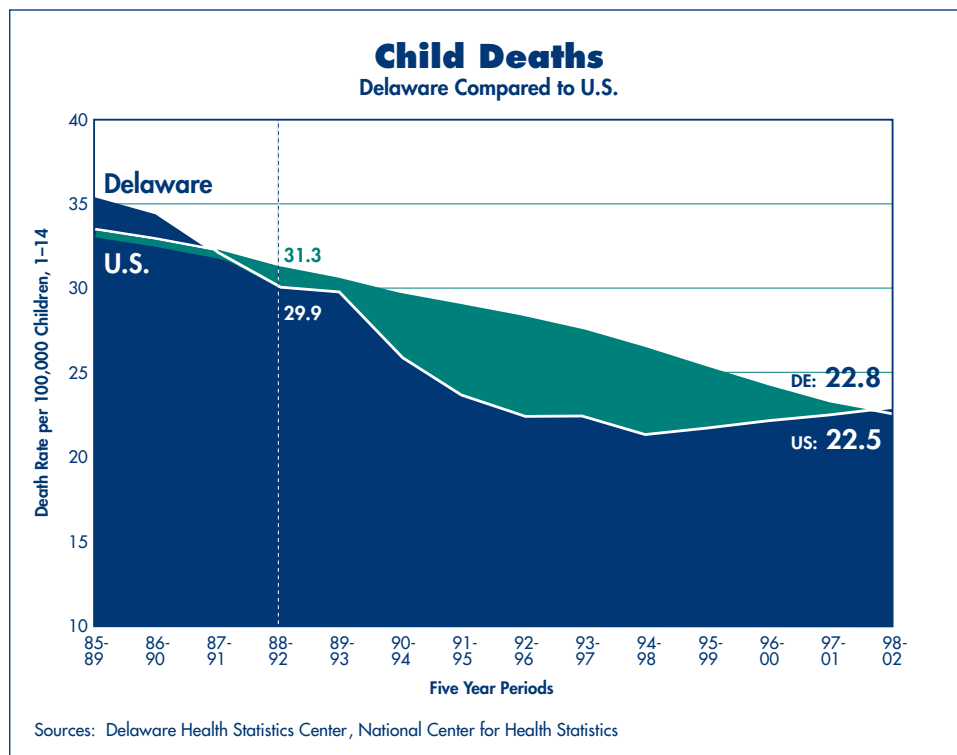
Source: Infant, Child, and Youth Mortality. Child Trends Data Bank. Available at: www.childtrendsdatabank.org



Jillian & dad • 2003



Jillian • 2004



Sources: Delaware Health Statistics Center, National Center for Health Statistics

Did you know?

- One in four crash-related deaths among child passengers age 14 or younger involved alcohol use.
- 2,335 children have died in alcohol-related crashes between 1997 and 2002. Of the 2,335 children, 1,588 (68%) were riding with a driver that was drinking and the majority of these children were not in seatbelts or car seats. The average blood alcohol concentration (BAC) of the drivers for these alcohol-related crashes was above 0.08g/dL. Accordingly, thirty one states have raised their legal BAC to above 0.08 g/dL for drivers over 21 years of age, as of December 31, 2002.

Source: Child Passenger Deaths Involving Drinking Drivers—United States, 1997–2002. Center for Disease Control and Prevention, CDC. Available at: <http://www.cdc.gov/mmwr>

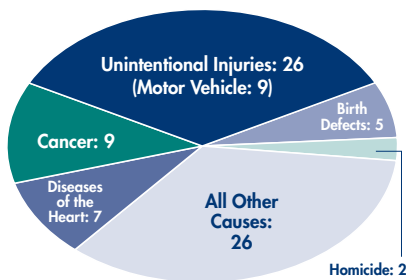
Definitions

Child Death Rate – number of deaths per 100,000 children 1–14 years old

Unintentional Injuries – accidents, including motor vehicle crashes

Causes of Death of Children 1-4

Delaware, 1998-2002

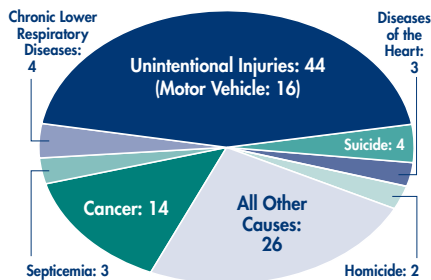


Total Number of Deaths
in five-year period: 75 Children

Source: Delaware Health Statistics Center

Causes of Death of Children 5-14

Delaware, 1998-2002



Total Number of Deaths
in five-year period: 98 Children

Source: Delaware Health Statistics Center

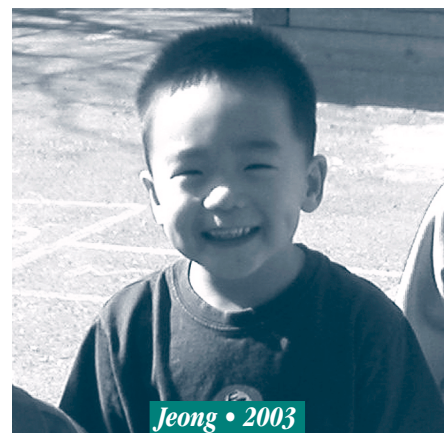
put data into action

Swimming on a hot summer's day may seem harmless, but each year 300 children under the age of 5 drown in swimming pools owned by their families. Also, more than 2,000 children each year are treated in hospital emergency rooms for submersion injuries. Pool submersion can happen very quickly and 75 percent of the time the victim has only been missing from sight for 5 minutes or less.

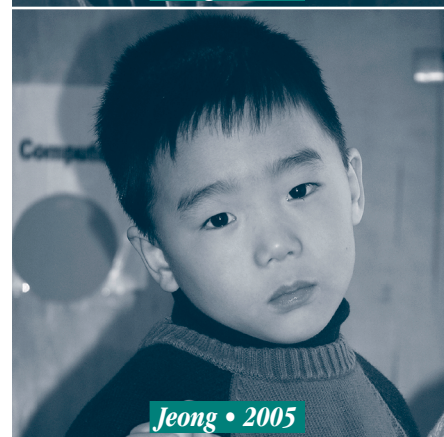
If you own a pool or your family lives near one, below is a list of guidelines that might prevent an accidental submersion injury or death:

- Pool areas should have fences and gates that are self-closing and self-latching.
- Do not allow young children in the pool without an adult.
- Keep rescue equipment by the pool and be sure there is a telephone with emergency numbers posted nearby.
- If a child is missing check the pool first. Seconds count in preventing death or disability.
- Do not use flotation devices as a substitute for supervision.

Source: U.S. Consumer Product Safety Commission, How to plan for the unexpected. Available at: www.cpsc.gov



Jeong • 2003

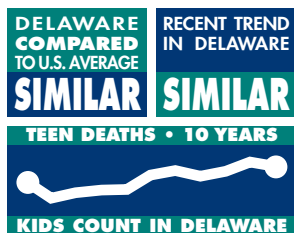


Jeong • 2005

For more information see

Tables 16-27 p. 130-136
 Tables 32-35 p. 138-140
 Table 74 p. 161
www.kidshealth.org
www.cdc.gov/ncipc/duip/duip.htm
www.coderedrover.org/home.asp

Teen Deaths by Accident, Homicide, & Suicide



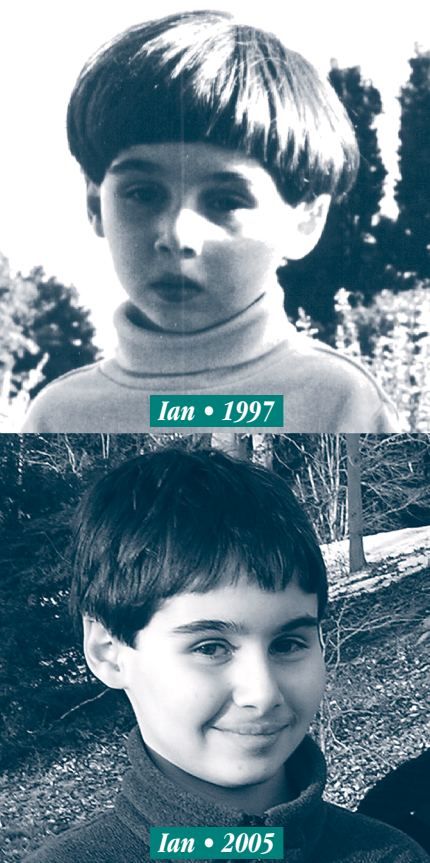
Deaths by accident, homicide, and suicide account for 75% of all deaths of teens between the ages of 15 and 19, which account for 28 preventable deaths a day in the U.S.¹ Accidents account for the majority of teen deaths, with the most lethal being vehicle accidents.¹ The second and third leading causes of death among teens aged 15 to 19 are homicide and suicide.² Suicide was also the third leading cause of death among children ages 10 to 14.³ Reports have found firearms to be the instrument of death in 80% of homicides and 60% of teen suicides.⁴ Often teens experience stress, confusion, and depression from situations that occur within their families, schools, and communities that lead them to consider suicide or violence as a “solution.”² Graduated licensing programs for teen drivers, access to mental health facilities, crisis intervention programs in schools, as well as family and community support groups are suggested as protective factors to help reduce teen death.

1 Rate of Teen Deaths by Accident, Homicide, and Suicide. The Annie E. Casey Foundation (2004). Available from: www.aecf.org/kidscount/databook/pdfs_e/summary_e.pdf.

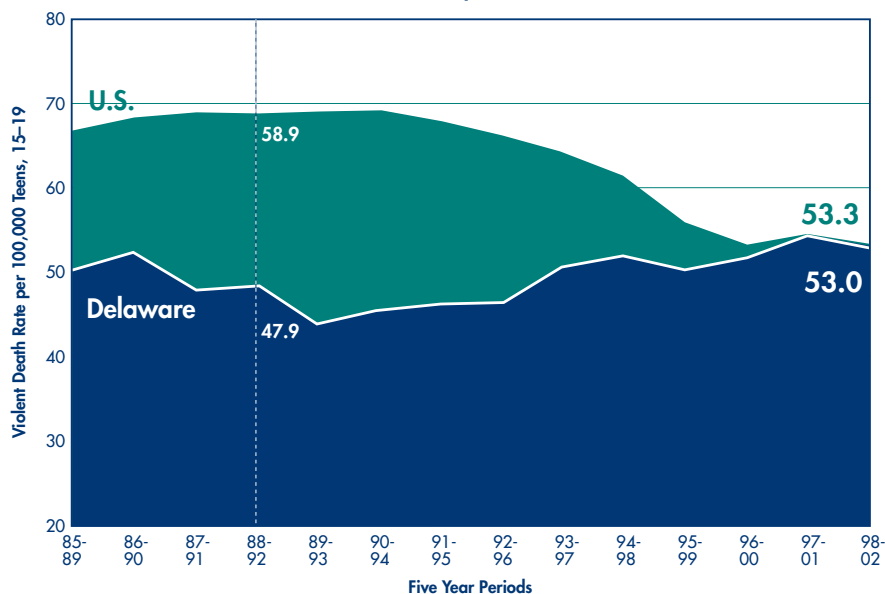
2 Suicide Fact Sheet. National Center for Injury Prevention and Control. Available from: www.cdc.gov/ncipc/factsheets/suifacts.htm.

3 In Harms Way: Suicide in America. National Institute of Mental Health. Available from: www.nimh.nih.gov/publicat/harmaway.cfm.

4 Child Trends DataBank- Teen Homicide, Suicide, and Firearm Death. Available from: www.childtrendsdatabank.org/indicators/70ViolentDeath.cfm.



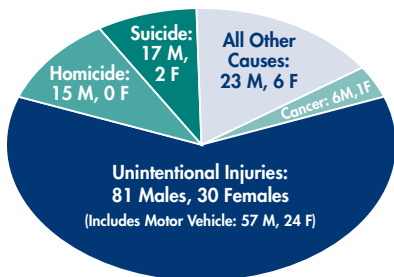
Teen Deaths by Accident, Homicide, and Suicide Delaware Compared to U.S.



Sources: Delaware Health Statistics Center, National Center for Health Statistics

Deaths of Teens 15-19

Number in Delaware by Cause and Gender, 1998-2002



Total in 5-year Period: 181 Teens
142 Males, 39 Females

Source: Delaware Health Statistics Center

Deaths of Teens 15-19

Number in Delaware by Cause, 2002

Motor Vehicle Crashes	10 males 3 females
Suicide	6 males 0 females
Homicide	5 males 0 females
Other Unintentional Injuries	6 males 0 females
All Other Causes	5 males 1 females

Total Number of Deaths: 36 Teens

Source: Delaware Health Statistics Center

Definitions

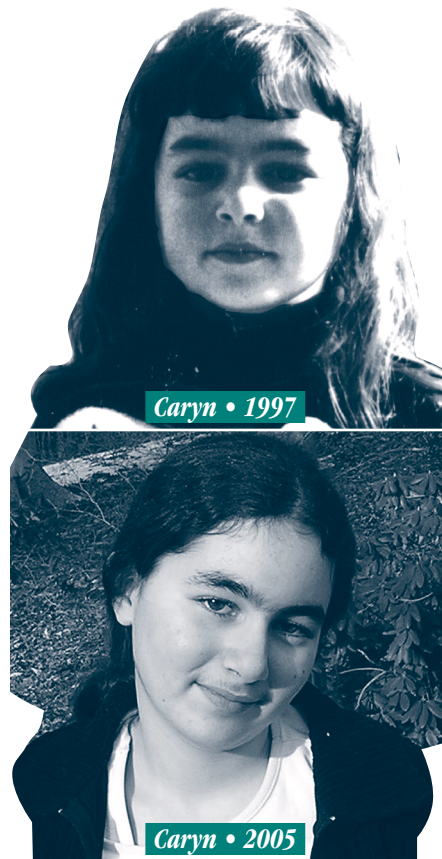
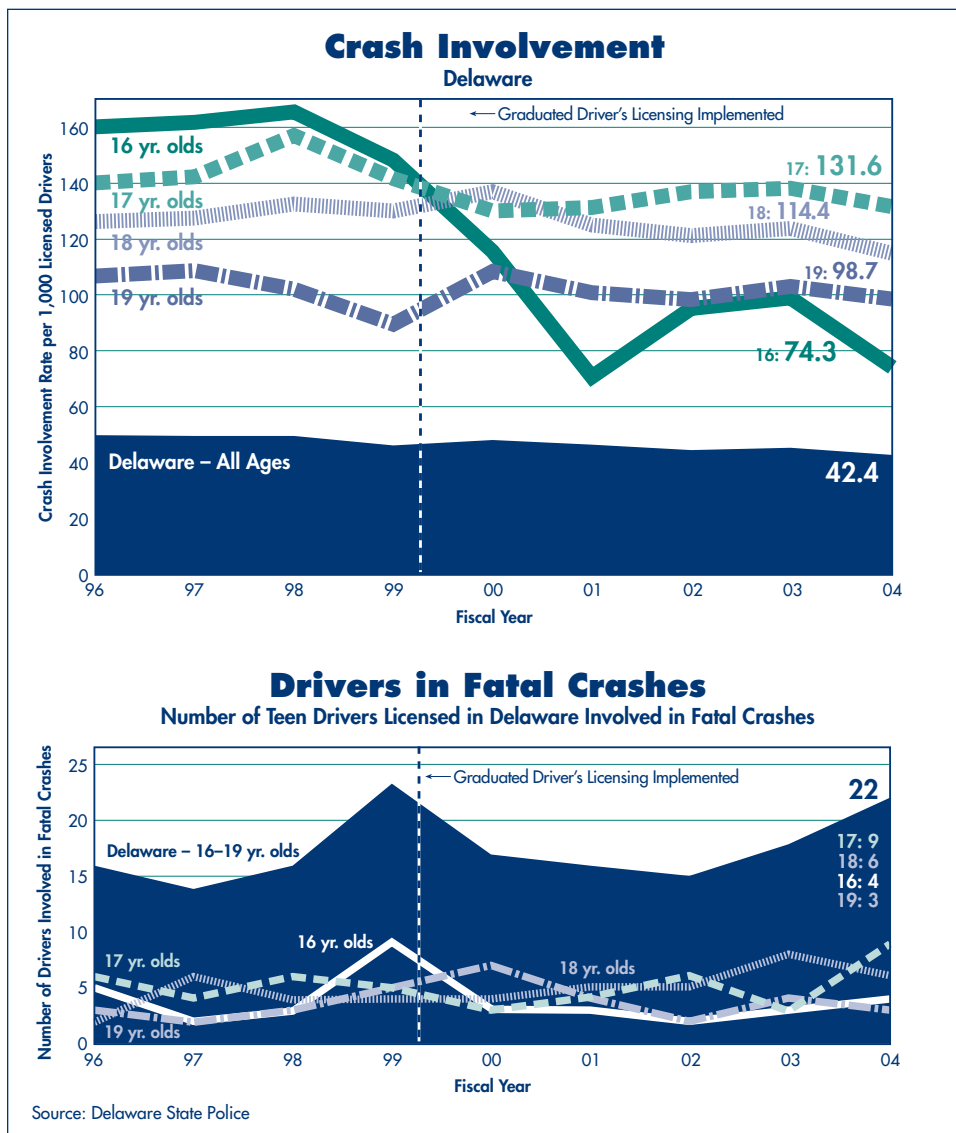
Teen Deaths by Accident, Homicide, and Suicide – number of deaths per 100,000 teenagers 15-19 years old

Unintentional Injuries – accidents, including motor vehicle crashes

Impact of Graduated Driver License on 16 Year Old Driver Crashes in Delaware

Delaware is one of thirty-seven states that have implemented a Graduated Driver's Licensing (GDL) program. The program was enacted on July 1, 1999 and the state has since experienced a substantial decline in crashes involving teens ages 16 to 19.

The program involves all three levels recommended by the National Conference of State Legislatures, Energy and Transportation Program. Level 1 involves obtaining a learner's permit and requires supervised driving at all times for a six month time period. Level two is reached six months after the issuance of a Level 1 learner's permit. Level 2 involves limited unsupervised driving and passenger restrictions. After twelve months of driving experience with a learner's permit a Level 3 license, which is full licensure with unrestricted privileges, can be obtained.



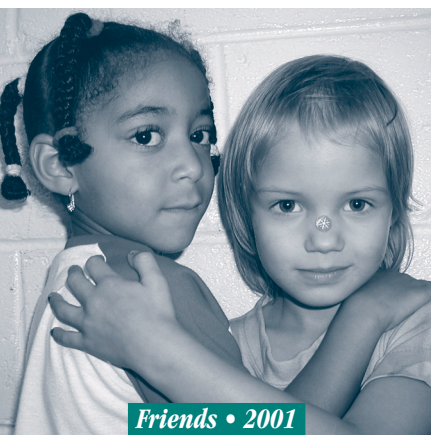
Did you know?

- The risk for motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, teen drivers ages 16 to 19 are four times more likely than older drivers to crash.
- The motor vehicle death rate for male occupants 16–19 was nearly twice that of females.

Source: Teen Drivers Fact Sheet. National Center for Injury Prevention and Control. Available from: <http://www.cdc.gov/ncipc/factsheets/teenmwh.htm>

continued on next page

Teen Deaths by Accident, Homicide, & Suicide



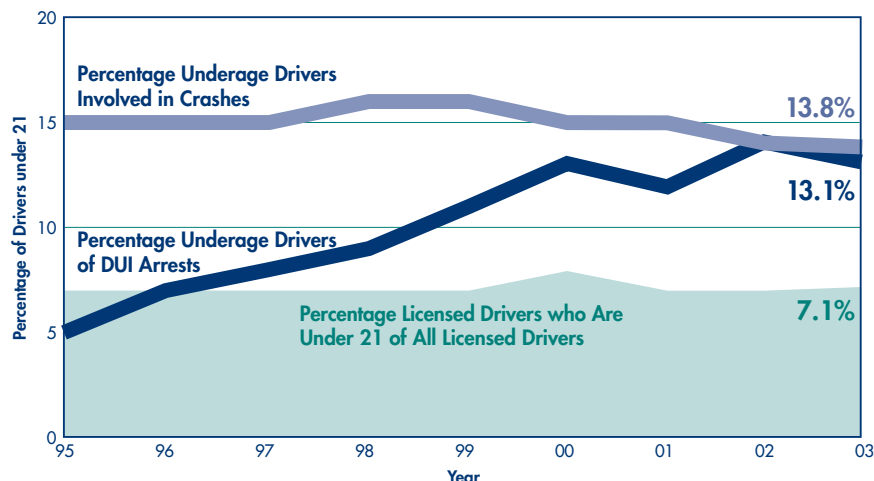
Friends • 2001



Friends • 2003

Traffic Reports on Young Drivers

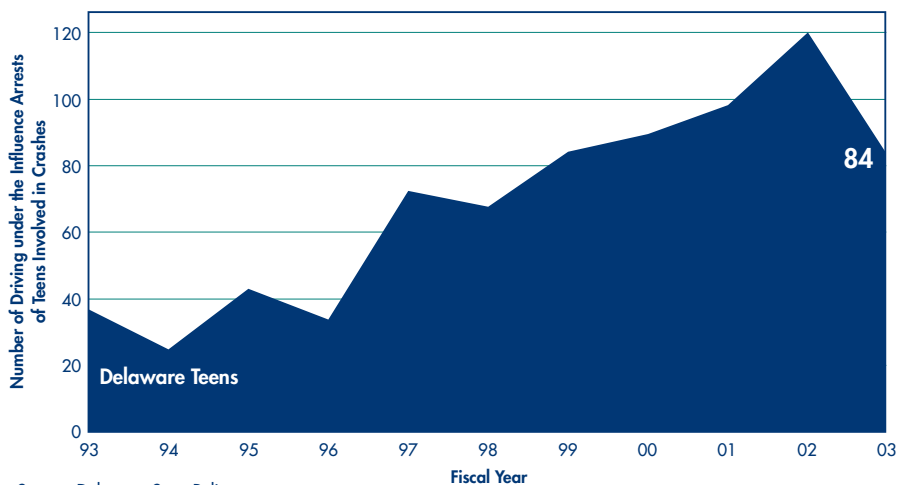
Selected Reports on Drivers under Age 21, Delaware



Source: Delaware State Police

DUI Arrests of Teens Involved in Crashes

Delaware



Source: Delaware State Police

put data into action

Listed below are some of the strategies outlined in the KIDS COUNT Indicator Brief for reducing the teen mortality rate:

- Structure family and parent education programs to include parents with children of all ages.
- Develop programs that help parents gain the skills needed to act as effective advocates for their children.
- Expand access to family mental health services geared to adolescents.
- Support youth development programs that equip youth with academic, vocational, and work readiness skills, as well as "life skills" and developmental opportunities.
- Support broad, multi-faceted substance abuse prevention programs.
- Teach violence prevention and conflict resolution.

Source: KIDS COUNT Indicator Brief: Reducing Teen Death Rate (July 2003). The Annie E. Casey Foundation. Available from: www.aecf.org/kidscount/indicator_briefs/teen_death.pdf

For more information see

Tables 32-36 p. 138-140
www.highwaysafety.org
www.talkingwithkids.org

Sexually Transmitted Diseases STDs

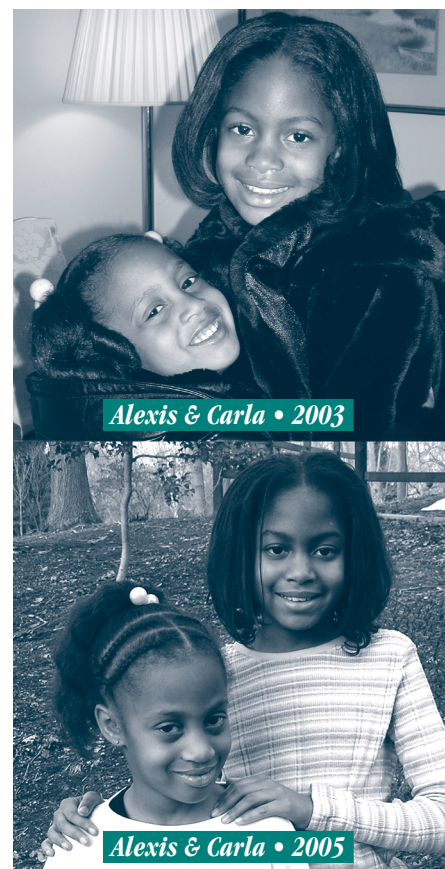
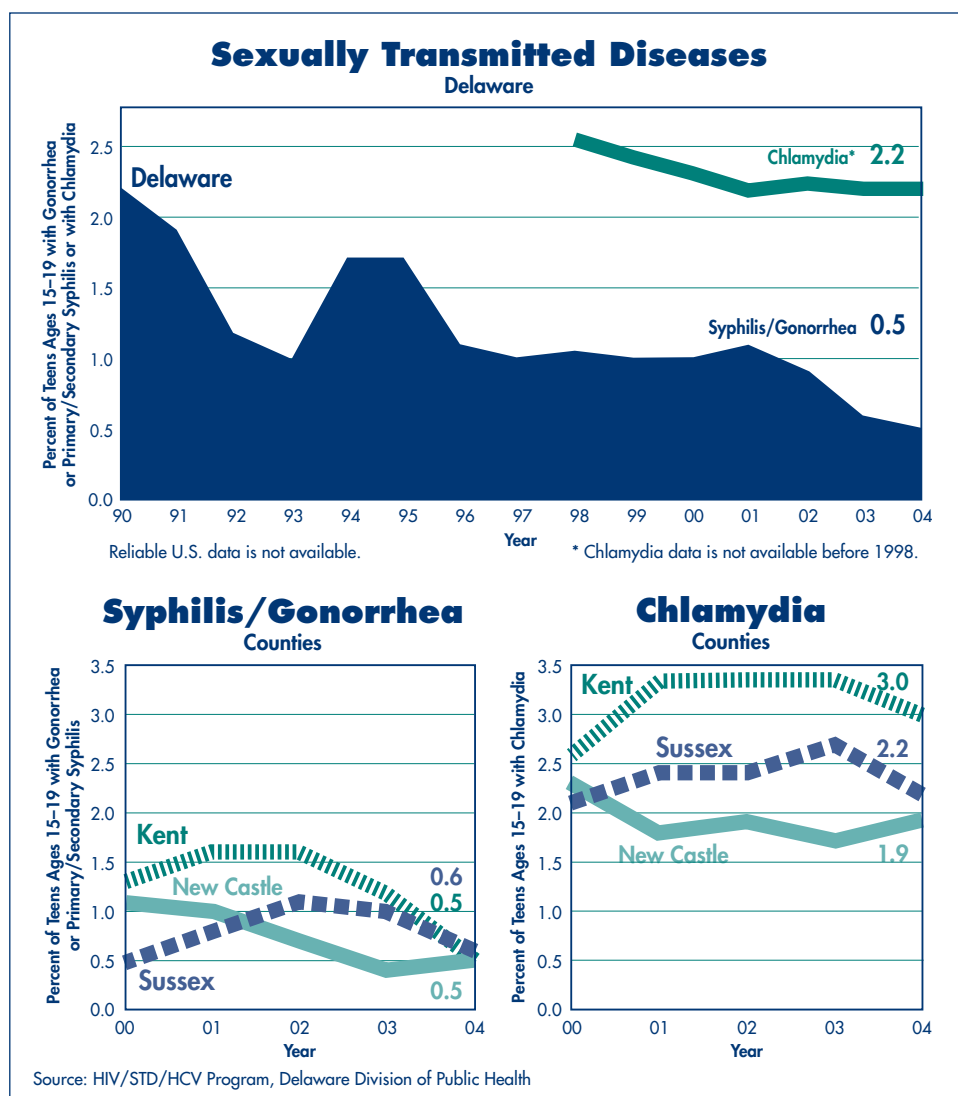
Sexually transmitted diseases (STDs) are among the most common infectious diseases in the United States today. ¹ Over twenty STDs have been identified and they affect more than 13 million Americans each year. ¹ In the U.S. over 65 million people live with an incurable STD and there are approximately 15 million new cases of curable STDs diagnosed each year. ² One in four new STD infections occur among teenagers and one in three sexually active people will have contracted an STD by the age of 24. ^{3,4} Teens are more at risk of acquiring an STD because they are more likely to engage in unprotected sex, have multiple sex partners, and are less likely to openly discuss sex or seek advice. The risk of contracting an STD can be greatly reduced by education, abstinence, condom use, and delaying the age at which teens first have intercourse.

1 National Institute of Allergy and Infectious Diseases. Available at: <http://www.niaid.nih.gov/factsheets/stdinfo.htm>

2 American Social Health Association. Available at: <http://www.ashastd.org/stdfaq/statistics.html>

3 Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/nchstp/std/Stats_Trends/Trends2000.pdf

4 Sexually Transmitted Diseases in America: How Many Cases and at What Cost? Menlo Park, CA: Kaiser Family Foundation and American Social Health Association. (1998).



**put
data
into
action**

Pelvic inflammatory disease (PID) is the consequence of an untreated Chlamydia infection and research has shown that an estimated 42% of PIDs could be prevented if screening, as outlined by the Centers for Disease Control and Prevention, were conducted.

Source: Planned Parenthood. Available at: <http://plannedparenthood.org.master.com/texis/master/search/mysite.html>

For more information see

Table 37 p. 141
www.thebody.com
www.agi-usa.org/sections/std.html
www.plannedparenthood.org
www.cdc.gov/hiv/pubs/facts.htm



Alcohol, Tobacco, & Other Drugs

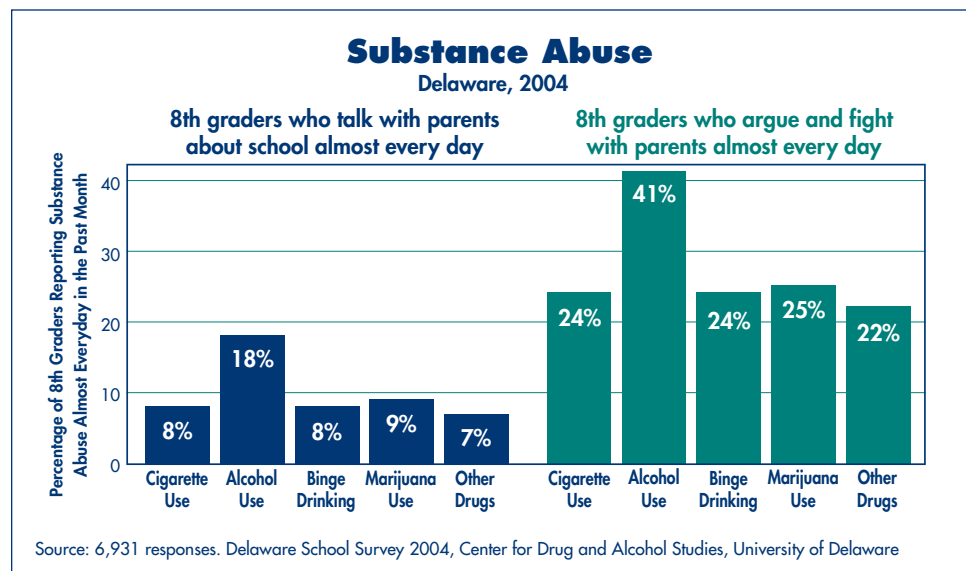
Illicit drug use among youth in the U.S. has declined by 11 percent between 2001 and 2003, reaching levels not seen in nearly a decade.¹ There were an estimated 400,000 fewer drug users in 2003 than in 2001.¹ While this is promising, the number of children and adolescents who try or use alcohol, tobacco, or other drugs is still substantial. Among children and adolescents, alcohol is the number one used drug.² In 2002, 1.5 million youth ages 12–17 met the criteria for needing alcohol treatment and studies have shown that 40 percent of those who start drinking before the age of 15 will meet the criteria for alcohol dependence at some point in their lives.² Each day, 2,000 adolescents ages 12–17 become daily cigarette smokers in the U.S.³ Currently, 10.1 percent of U.S. middle school students and 22.9 percent of high school students are cigarette smokers.³ The use of LSD, amphetamines, and tranquilizers has decreased among high school students and the use of ecstasy has decreased among all students.¹ Parents have an incredible influence on their child's decision to use or not use drugs and research has shown that teens who learn about the risk of drugs from their parents are 54 percent less likely to try drugs.⁴

¹ Teens' Drug Use Declines Dramatically, According to MTF Survey Results. National Institute on Drug Abuse. Available at: www.drugabuse.gov/NIDA_notes/NNvol19N1/tearoff.html

² National Institute on Alcohol Abuse and Alcoholism. Available at: www.niaaa.nih.gov/about/underage.htm#statistics

³ Youth and Tobacco Use: Current Estimates, Center for Disease Control and Prevention. Available at: www.cdc.gov/tobacco/research_data/youth/Youth_Factsheet.htm

⁴ U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. Available at: www.health.org/govpubs/PHD711/lovechild.aspx



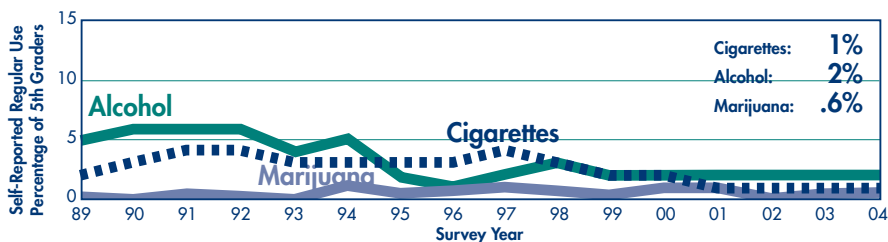
Did you know?

- Research has shown that adolescent children whose parents strongly disapprove of drug use are less likely to report using marijuana. 30.2% of adolescents report using marijuana in the past month when their parents do not strongly disapprove of drug use. In contrast, only 5.5% of teens report using marijuana in the past month when their parents strongly oppose drug use.¹
- 31% of parents believe their teen has been offered drugs versus 52% of teens who say they have been offered drugs.¹
- In Delaware in 2003, the number of 8th graders who reported identifying a “great risk” from drinking everyday increased to 29%, but the 11th graders dropped one point from the previous year to 29%.² In Delaware there was an increase in the number of 5th, 8th, and 11th graders who thought there was a “great risk” from smoking a pack of cigarettes a day, with the change being the most significant for 5th graders.²

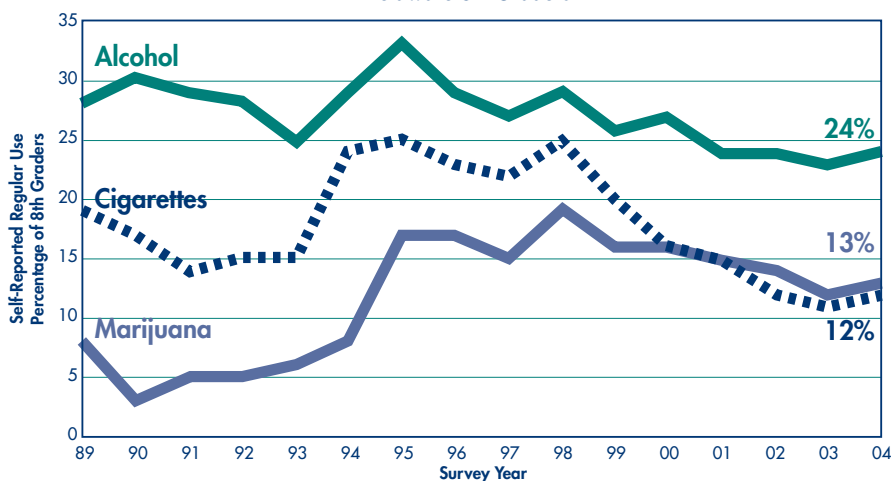
¹ U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. Available at: www.health.org/govpubs/PHD711/lovechild.aspx

² Alcohol, Tobacco, and Other Drug Abuse Among Delaware Students (2003). The Center for Drug and Alcohol Studies, University of Delaware. www.state.de.us.data.htm#atd

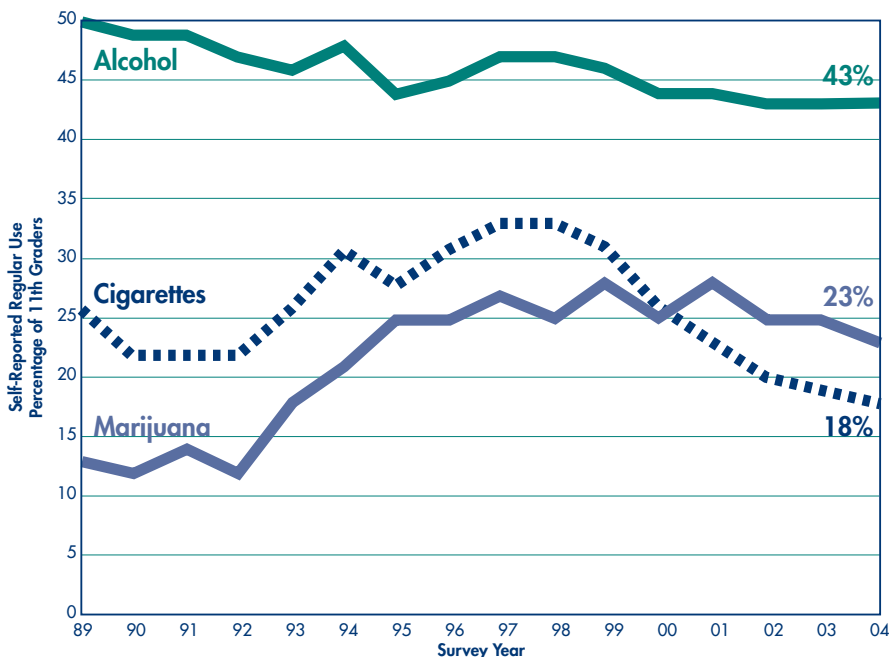
Trends in Cigarette, Alcohol, and Marijuana Use Delaware 5th Graders



Trends in Cigarette, Alcohol, and Marijuana Use Delaware 8th Graders



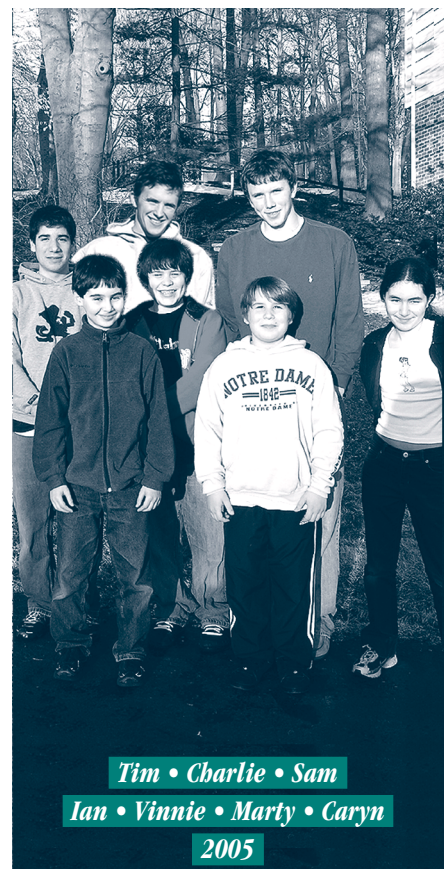
Trends in Cigarette, Alcohol, and Marijuana Use Delaware 11th Graders



Source: 5th graders: 7,788 responses. 8th graders: 6,931 responses. 11th graders: 4,985 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware

Definition

Self-Reported Regular Use – reports of about once a month or more often



Tim • Charlie • Sam

Ian • Vinnie • Marty • Caryn

2005

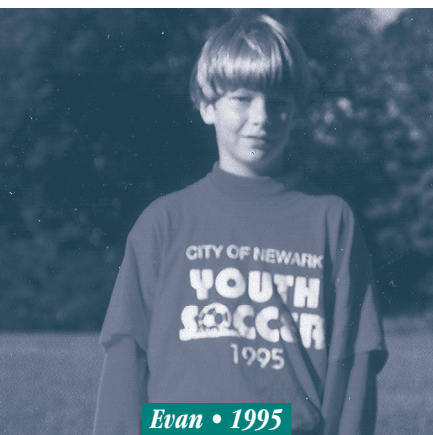
For more information see

Table 39-40 p. 142
www.tobaccofreekids.org
www.state.de.us/drugfree
www.childtrendsdatabank.org/drugs.cfm
www.al-anon-alateen.org
www.udetc.org

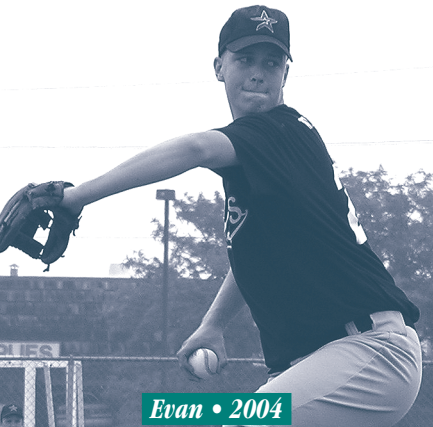
Delaware Children Speak about Health and Health Behaviors

Each year since 1995, the Center for Drug and Alcohol Studies at the University of Delaware has administered a survey for public school students about alcohol, tobacco, and drug use. This study is supported by the Office of Prevention with the cooperation of the Department of Education and the Delaware Drug Free School Coordinators. It has become a valuable tool in assessing trends of drug use among Delaware students. Since 1998 the survey has included new information on school behavior, health habits, and parental interaction. The Center for Drug and Alcohol Studies has provided KIDS COUNT with a wealth of information detailing these issues which are included in each section as Delaware Children Speak. Although these are survey questions of a limited number of Delaware youth, it is useful to examine their comments in light of the increased interest in safety, parental involvement, educational needs, and healthy lifestyles.

Source: Alcohol, Tobacco, Other Drug Abuse among Delaware Students: Final Report to the State Incentive Cooperative Agreement Advisory Committee and the First State Prevention Coalition. September 2002. The Center for Drug and Alcohol Studies, University of Delaware.



Evan • 1995

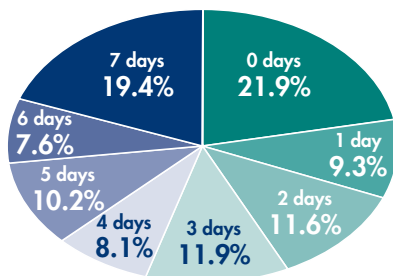


Evan • 2004

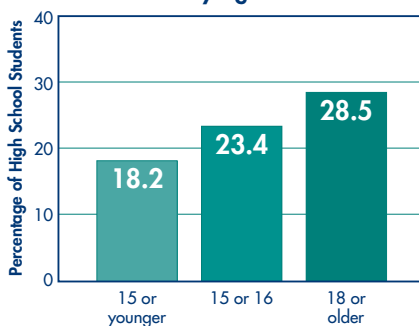
Strenuous Physical Activity

How many days in the past week have you exercised or participated in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing or similar aerobic activity?
Delaware, 2003

9–12th Graders



Students reporting 0 days activity by age

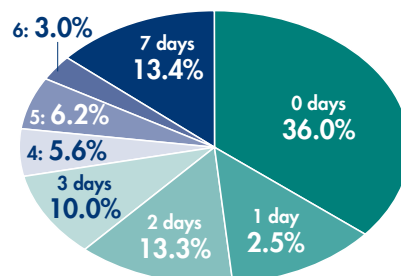


Source: 2,975 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

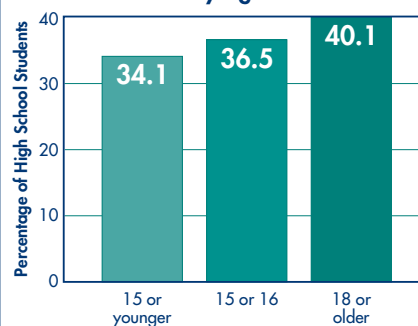
Non-Strenuous Physical Activity

How many days in the past week have you participated in physical activity for at least 30 minutes that did NOT make you sweat or breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors?
Delaware, 2003

9–12th Graders



Students reporting 0 days activity by age

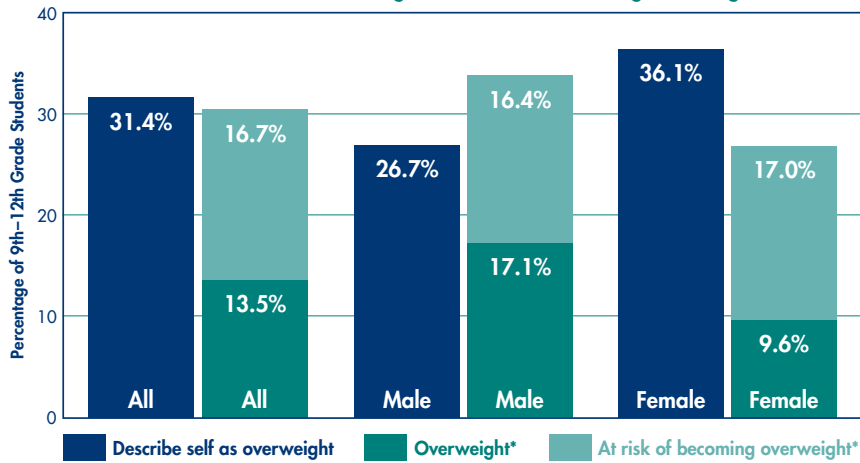


Source: 2,975 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

Individual Physique: Perception vs. Actuality

Delaware, 2003

Teens who describe themselves as slightly/very overweight compared to teens who are overweight or at risk of becoming overweight*



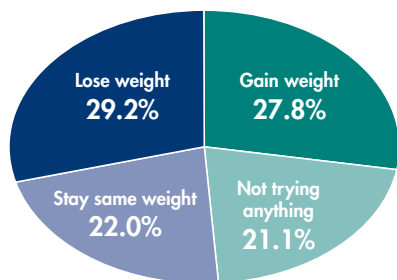
* Calculated body mass index from reported height and weight

Source: 2,975 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

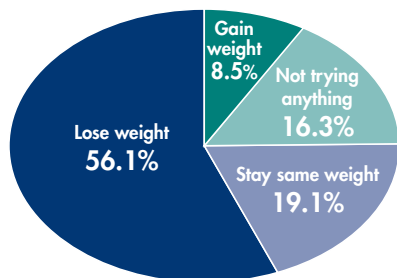
Concern about Weight

Which of the following are you trying to do about your weight?
Delaware, 2003

9-12th Grade Males



9-12th Grade Females



Source for all graphs on this page:
Responses from 2,975 9th-12th grade students.
CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

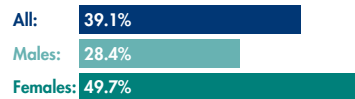
Weight Control

Step taken in the last 30 days to lose weight or keep from gaining weight
Delaware, 2003

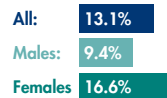
Exercised



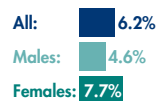
Ate less food, fewer calories or low-fat food



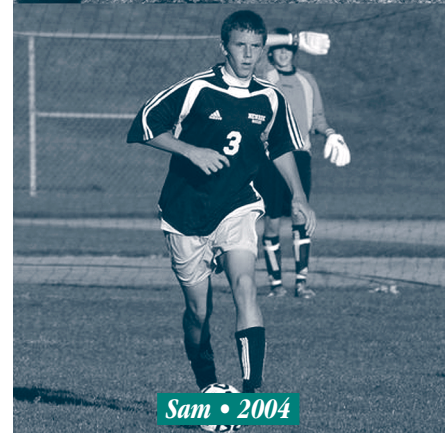
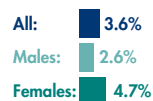
Went without eating for 24 hours or more



Took diet pills, powders, or liquids without doctor's advice



Vomited or took laxatives



For more information see

www.state.de.us/drugfree/data.htm

Delaware Children Speak about Health and Health Behaviors

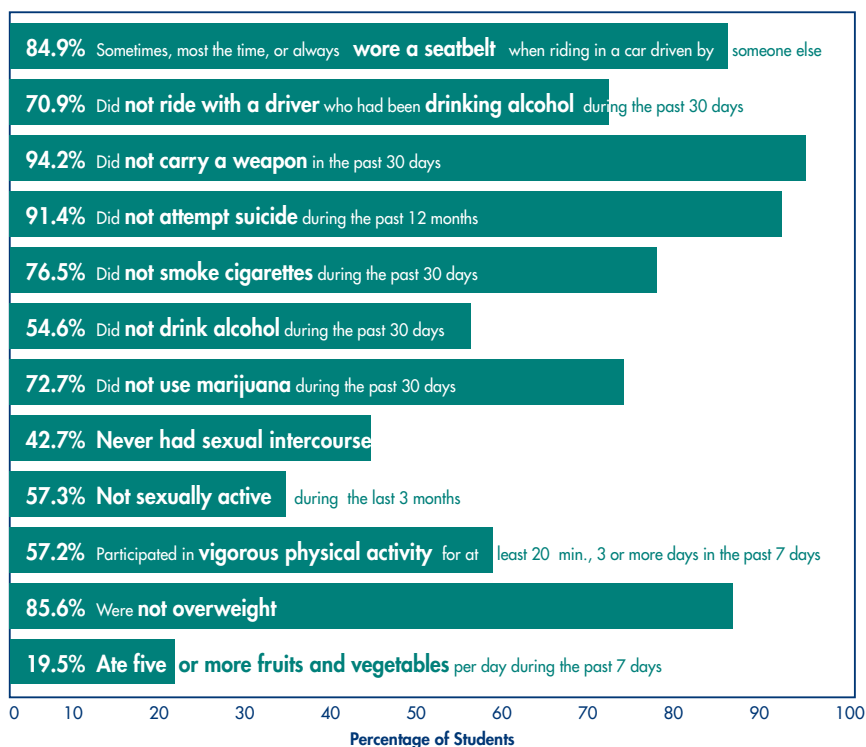
Youth today are developing healthier lifestyles. Too often data presented reflect negative aspects of youth behavior, but it is important to consider the more positive attributes of our youth. This helps to identify the areas in which our children are succeeding and provides insight into programs and characteristics that are associated with success.

Today's teens are actively participating in positive behaviors that may promote their well-being. Through Delaware Team Nutrition projects, the University of Delaware was able to document that fifty percent of the student participants increased their level of physical activity and seventy percent of the participants showed improvements with weight training and reduction of body fat. Moreover, eighty-eight percent said that they wanted to continue exercising after the program ended.¹

¹ On the Table; Delaware small in size, big in nutrition. USDA, Food and Nutrition Service. Fall 2002.



Lifestyle Choices Delaware High School Students, 2003



Source: CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

Note: The Youth Risk Behavior Survey (YRBS) was administered to 3,048 students in 32 public high schools in Delaware during the spring of 2003. The results are representative of all students in grades 9–12. The sample was comprised of the following students: Female: 49.5%, Male: 50.5%; 9th grade: 29.9%, 10th grade: 25.5%, 11th grade: 23.3%, 12th grade: 21.4%; African American: 28.9%, Hispanic/Latino: 5.7%, White: 63.1%, All other races: 1.3%, Multiple races: 1.0%. Students completed a self-administered, anonymous questionnaire.

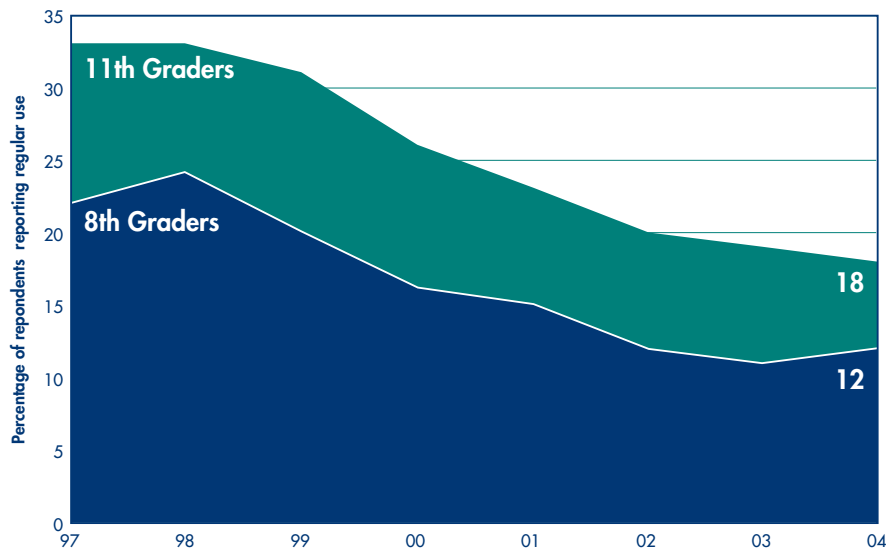
Did you know?

- Youth participation in physical activity decreases the risk of developing heart disease, type two diabetes, high blood pressure, and colon cancer.
- In 2003, the proportion of adolescents in the U.S. who engaged in vigorous exercise dropped from 69 percent in ninth grade to 55 percent by twelfth grade. Females showed the greatest difference, dropping from 64 percent in ninth grade to 46 percent by twelfth grade.
- For adolescents, participation in sports, physical education classes, or any other type of regular exercise helps to build and maintain healthy bones and muscles, controls weight, and has positive psychological benefits.

Source: Vigorous Physical Activity By Youth (2004). Child Trends Databank. Available at: <http://www.childtrendsdatabank.org>

Declining Cigarette Use

Delaware 8th and 11th Graders

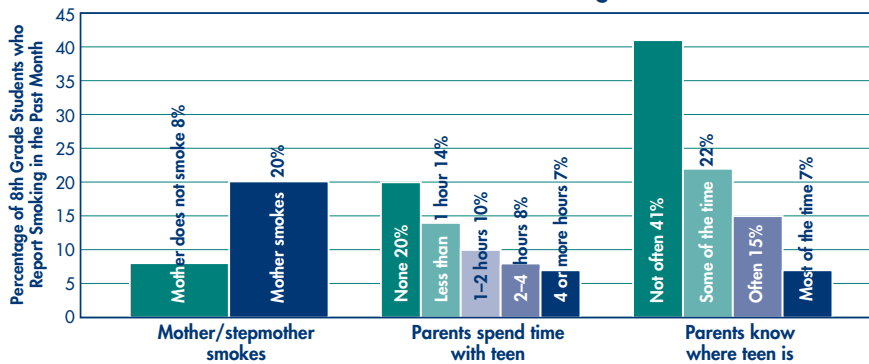


Source: 5th graders: 7,788 responses. 8th graders: 6,931 responses. 11th graders: 4,985 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware

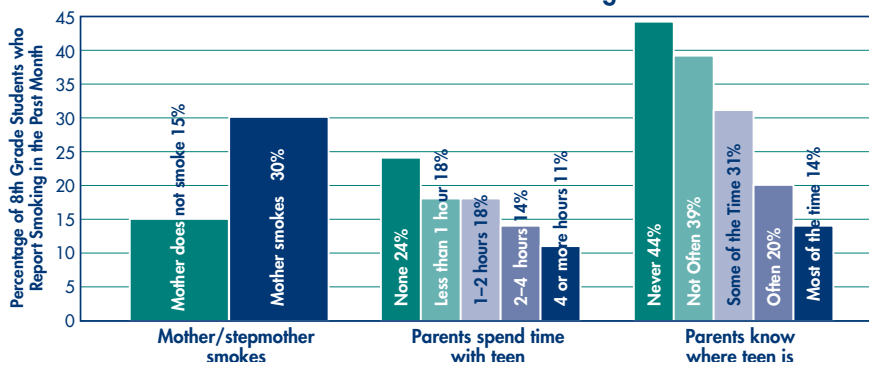
Parents Influence Teen Smoking

Delaware, 2004

8th Graders who Smoke Cigarettes



11th Graders who Smoke Cigarettes



Source: 8th graders: 6,931 responses. 11th graders: 4,985 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware



For more information see

www.state.de.us/drugfree/data.htm

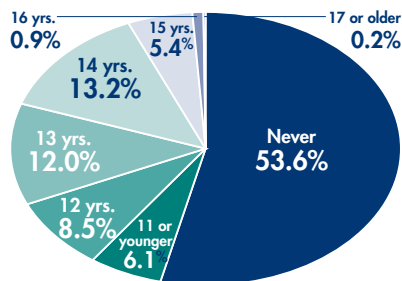
<http://childnutrition.doe.state.de.us/>



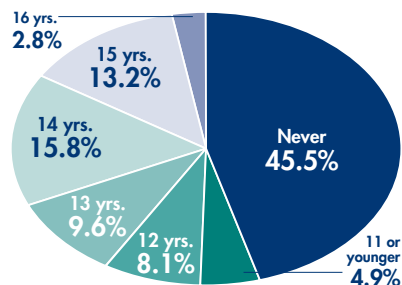
Sexual Activity

How old were you when you had sexual intercourse for the first time?
Delaware, 2003

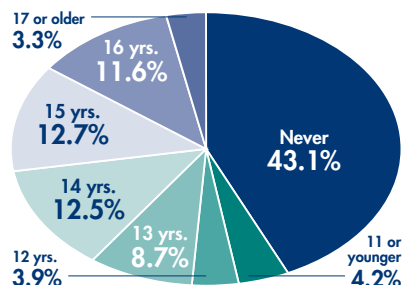
9th Graders



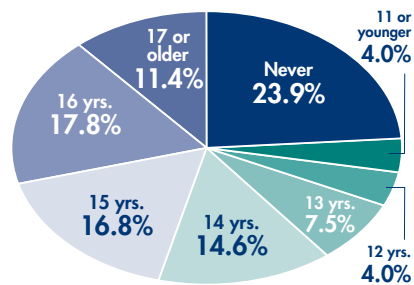
10th Graders



11th Graders

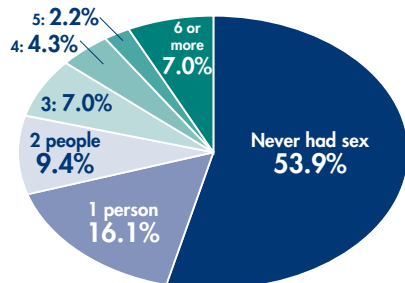


12th Graders

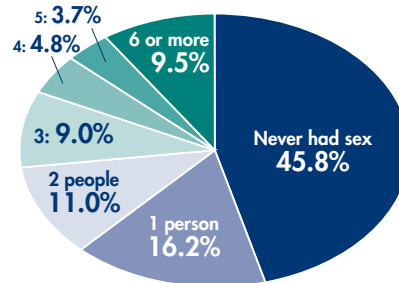


During your life, with how many people have you had sexual intercourse?
Delaware, 2003

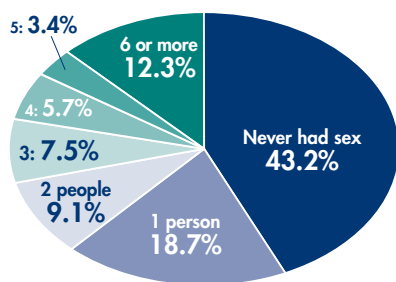
9th Graders



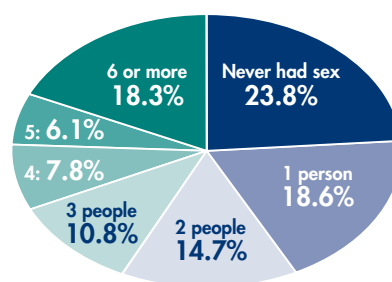
10th Graders



11th Graders



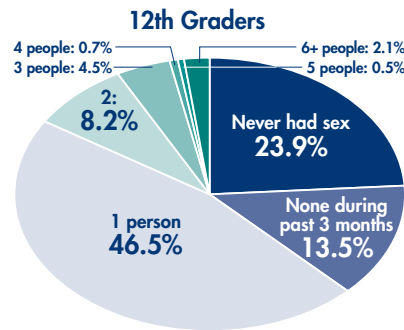
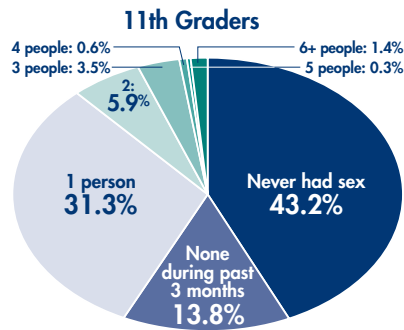
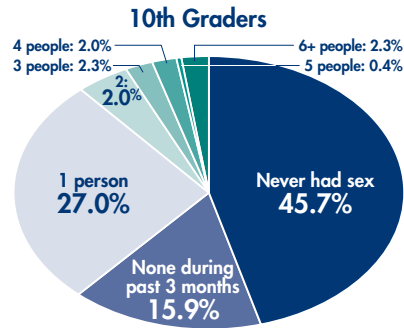
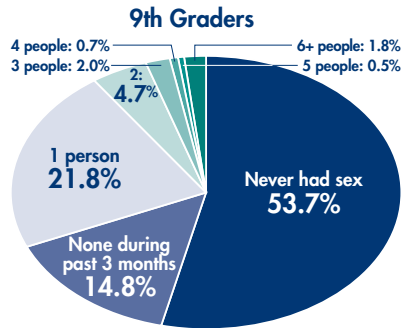
12th Graders



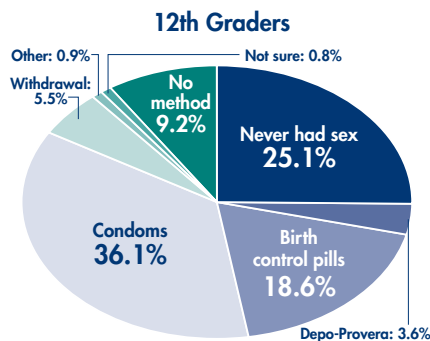
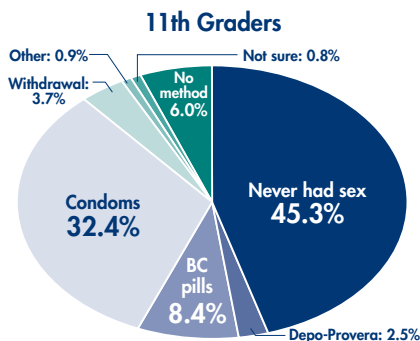
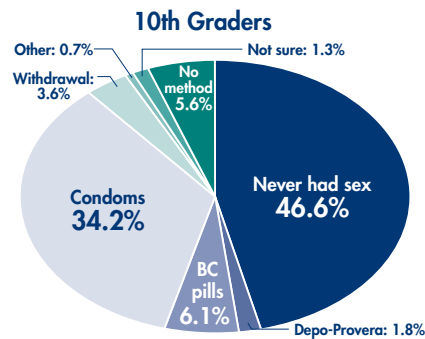
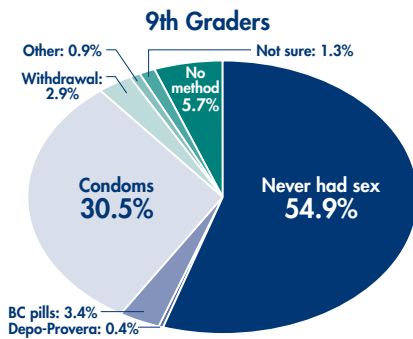
Note: All students did not answer every question, causing percentages to vary.
Source: 3,048 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

Sexual Activity

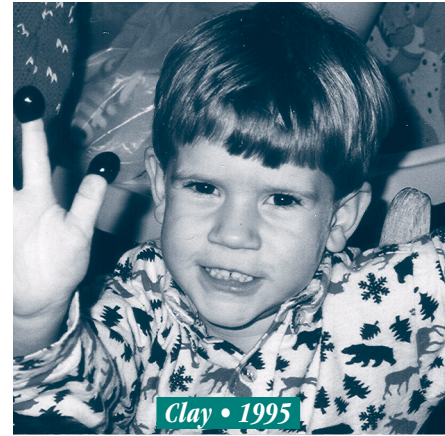
During the past 3 months, with how many people did you have sexual intercourse?
Delaware, 2003



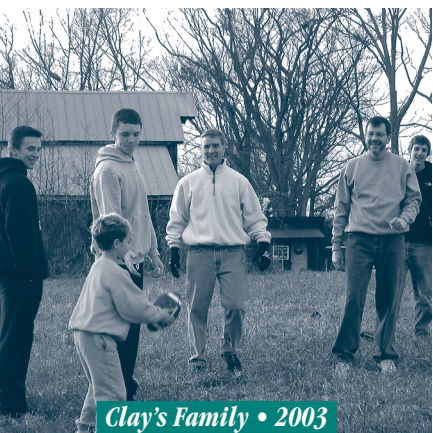
The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy?
Delaware, 2003



Note: All students did not answer every question, causing percentages to vary.
Source: 3,048 responses. CDC Youth Risk Behavior Survey 2003, Center for Drug and Alcohol Studies, University of Delaware

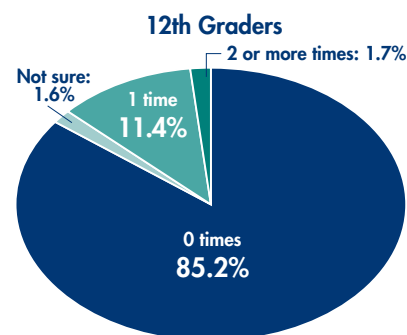
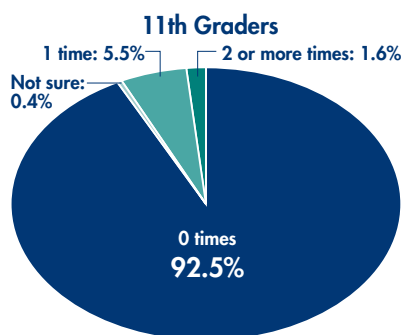
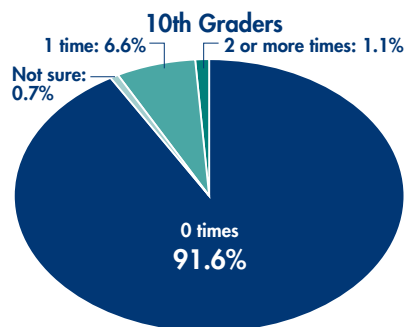
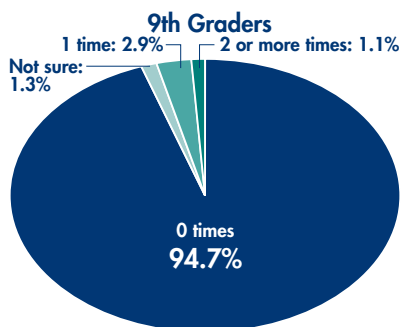


For more information see
www.state.de.us/drugfree/data.htm

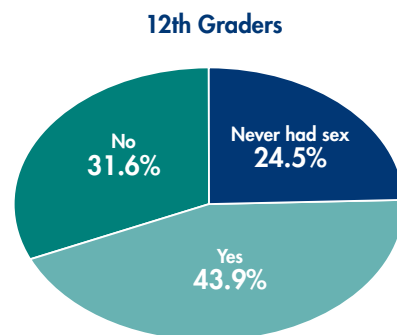
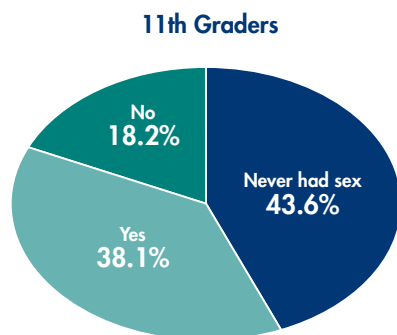
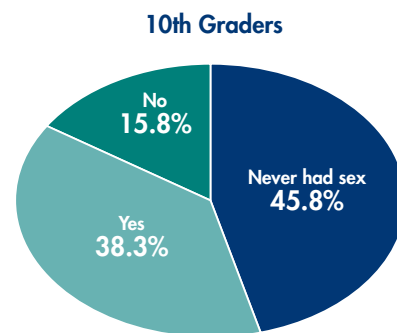
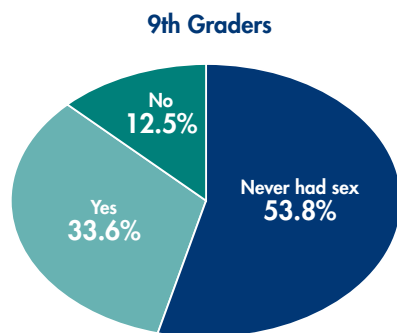


Sexual Activity

How many times have you been pregnant or gotten someone pregnant?
Delaware, 2003



The last time you had sexual intercourse, did you or your partner use a condom?
Delaware, 2003



Note: All students did not answer every question, causing percentages to vary.
Source: 3,048 responses. CDC Youth Risk Behavior Survey 2001, Center for Drug and Alcohol Studies, University of Delaware

For more information see

www.state.de.us/drugfree/data.htm

Educational Involvement & Achievement

Early Intervention	56
Head Start/ECAP	57
Student Achievement	58
Advanced Placement	62
Children Receiving Free and Reduced-Price School Meals	64
High School Dropouts	65
Teens Not in School and Not Working	68
Delaware Children Speak about Education	70



Marty
Vinnie • Timmy
Sam • Justyn • Charlie
1998



Justyn • Charlie • Sam • Tim
Vinnie • Marty
2005

Early Intervention

Research has shown that early experiences, caregiving relationships, and environment have a significant impact on early childhood development. From birth through age five, children are developing the cognitive, physical, emotional, and social skills that they will need for the rest of their lives.¹ It is therefore critical that children with delays and disabilities be diagnosed and provided with quality intervention as early as possible.

In Delaware, Child Development Watch is a statewide early intervention program for children ages birth to 3. The program's mission is to enhance both the development of infants and toddlers with disabilities or developmental delays and the capacity of their families to meet the needs of their young children.²

1. Helping your Preschool Child (2002). U.S. Department of Education. Available at: <http://www.ed.gov/parents/earlychild/ready/preschool/index.html>

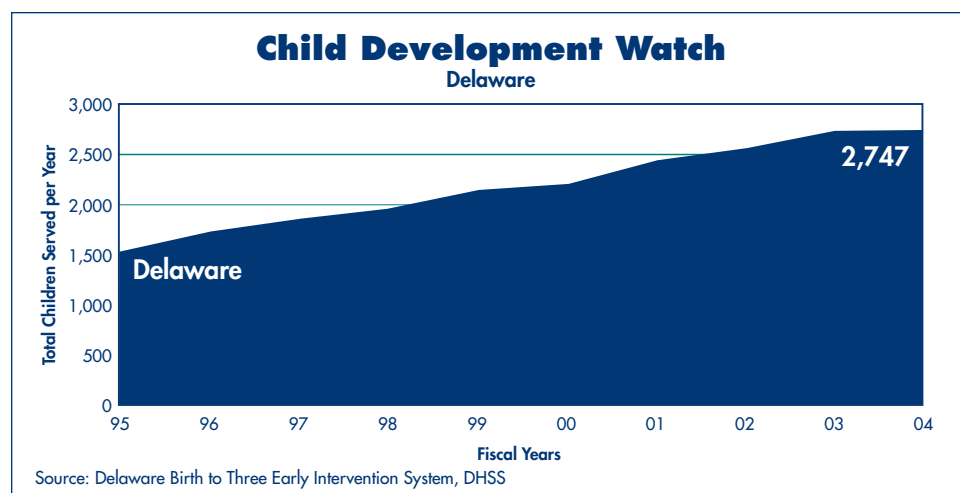
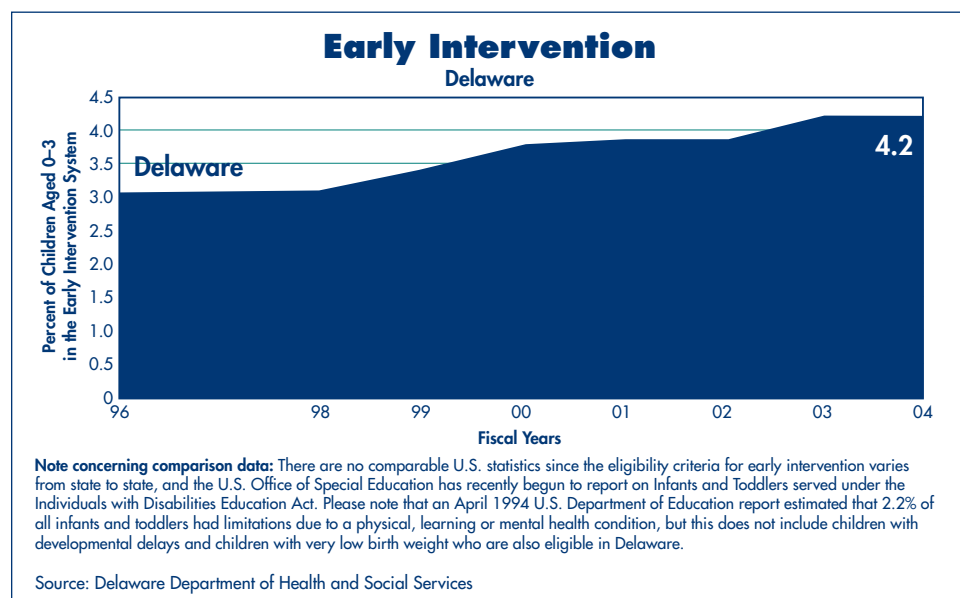
2. Child Development Watch. Division of Public Health DHSS. Available at: <http://www.state.de.us/dhss/dph/chs/chscdw.html>



Anya • 2003



Anya • 2005



For more information see

www.state.de.us/dhss/dms/epqc/birth3/directry.html

www.kidscount.com/kidscount/content/earlyintervention.html

Did you know?

- 94% of the families whose children are receiving services through Child Development Watch reported that their family's quality of life had improved since beginning participation in the program.
- 93% of the families felt overall satisfaction with the services they and their children received.
- 93.5% of the families reported that Child Development Watch gave information helpful to use with their children on a daily basis.

Source: IRMC 2003 Annual Report. Interagency Resource Management Committee. Available at www.doe.state.de.us

Head Start/ECAP

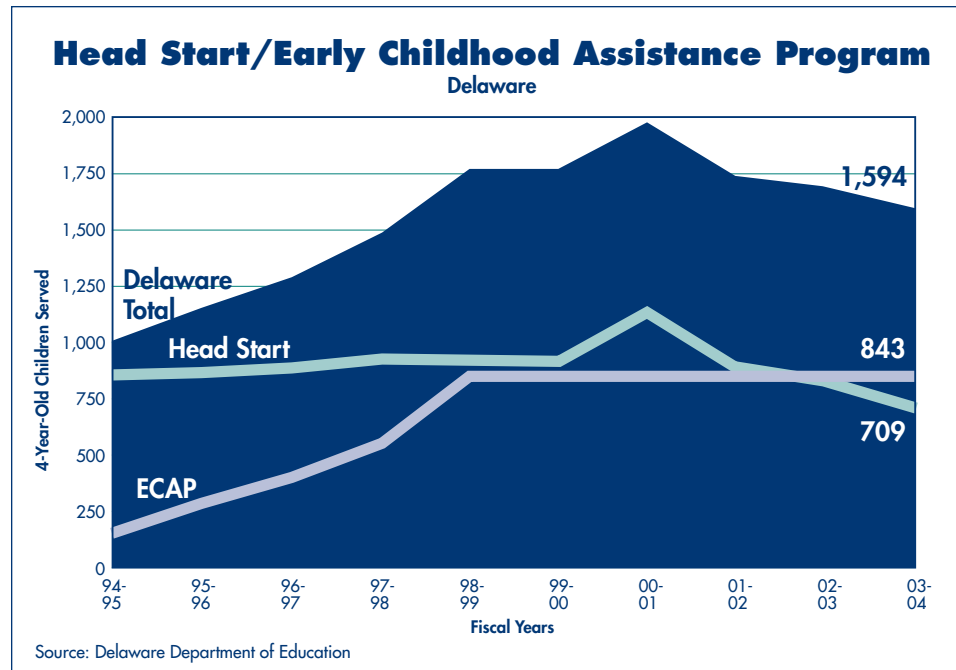
Head Start and Early Head Start are comprehensive child development programs which serve children from birth to age 5, pregnant women, and their families. They are child-focused programs and have the overall goal of increasing the school readiness of young children in low-income families.

The Head Start program has a long tradition of delivering comprehensive and high quality services designed to foster healthy development in low-income children. Head Start grantees and delegate agencies provide a range of individualized services in the areas of education, early childhood development, health (medical, dental, and mental), nutrition, and parent involvement. In addition, the entire range of Head Start services is responsive to each child's as well as his or her family's developmental, ethnic, cultural, and linguistic heritage and experience.¹

¹ About Head Start. US Department of Health and Human Services. Available at: www.acf.dhhs.gov

Definition:

ECAP – The Early Childhood Assistance Program (ECAP) is a comprehensive early childhood development program for four year olds whose families are below 100% of poverty. Linking with the federally funded Head Start programs throughout the state, these Department of Education programs provide a full-range of preschool, health, developmental, and other family support services.



Did you know?

According with the Delaware Early Childhood Longitudinal Study, children living in poverty who participated in Early Childhood Assistance Programs (ECAP) or Head Start programs when they were four years old:

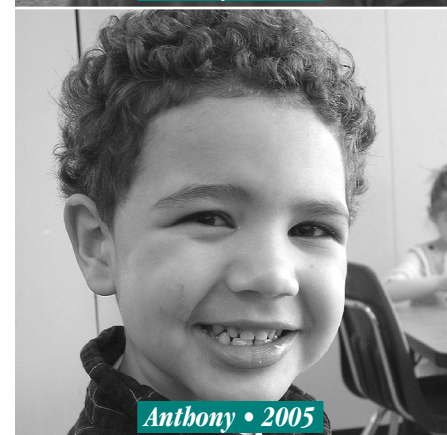
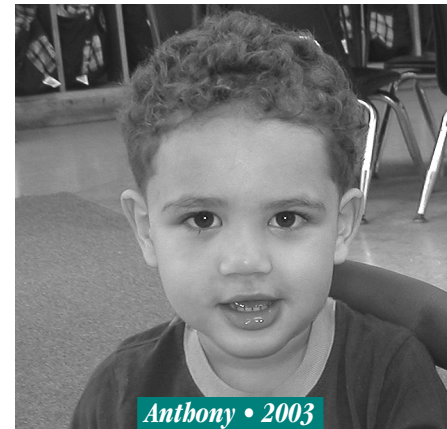
- were significantly more likely to earn passing performance scores on the reading and math sections of the Delaware Student Testing Program (DSTP) than those students who did not receive ECAP or Head Start services.
- earned passing performance scores on the math and reading DSTPs at about the same rate as those students not living in poverty and who did not have a disability.
- had significantly higher grades than did their peers who live in poverty and did not participate in ECAP or Head Start programs.

Source: IRMC 2003 Annual Report. Interagency Resource Management Committee. Available at www.doe.state.de.us

put data into action

Reading aloud to young children is important because it helps them acquire the information and skills they need to succeed in school and life. Reading also helps them know printed letters and words, the relationship between sound and print, the meaning of many words, a variety of writing styles, the difference between written language and everyday conversation, and the pleasure of reading.

Source: Teaching Our Youngest: A Guide for Preschool Teachers and Child Care and Family Providers (2002). U.S. Department of Education. Available at: www.ed.gov



For more information see

Tables 79-83

p. 162-163

Student Achievement

Student achievement, which can be measured in part by reading and math proficiency, is associated with future success in the labor market. On average, students with higher test scores will earn more and be unemployed less often than students with lower scores.¹

The ability to read proficiently is a fundamental skill that affects the learning experiences and school performance of children and adolescents. Students who are competent readers, as measured by their performance on reading tests, are more likely to perform well in other subjects, such as math and science. Reading achievement also predicts student's likelihood of graduating from high school and attending college.²

Competence in mathematics is essential for functioning in everyday life, as well as for success in our increasingly technological workplace. Students who take higher level mathematics and science courses which require strong fundamental skills in mathematics are more likely to attend and to complete college.³

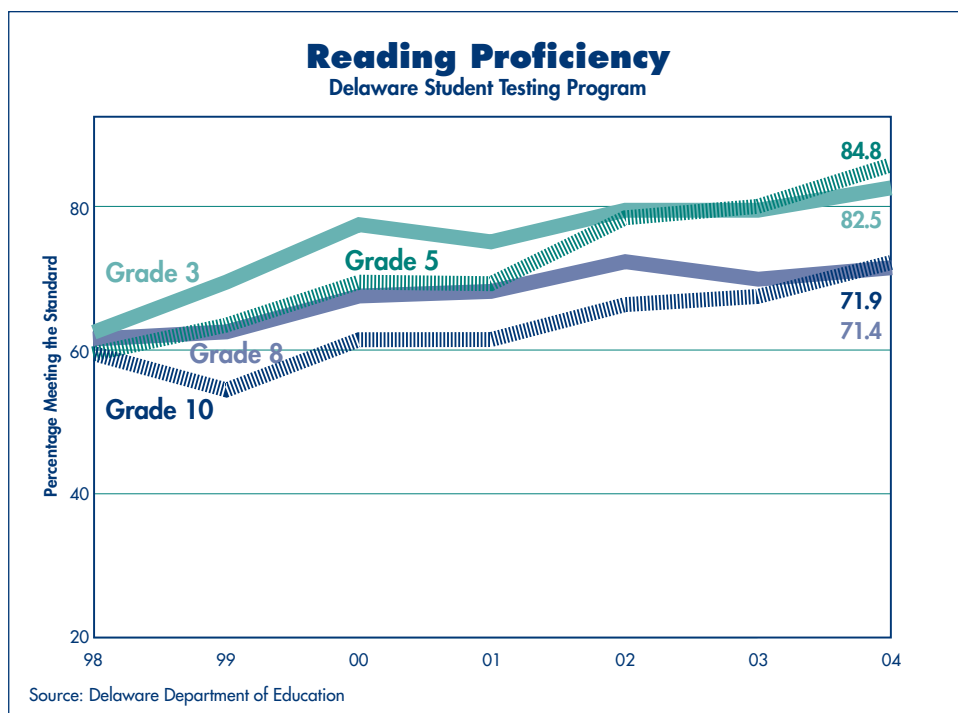
1. America's Children: Key National Indicators of Well-Being 2003 (2003). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

2. Reading Proficiency. Children Trends DataBank. Available at: www.childtrendsdatabank.org

3. Mathematics Proficiency. Children Trends DataBank. Available at: www.childtrendsdatabank.org



Matthew & Krista • 1999

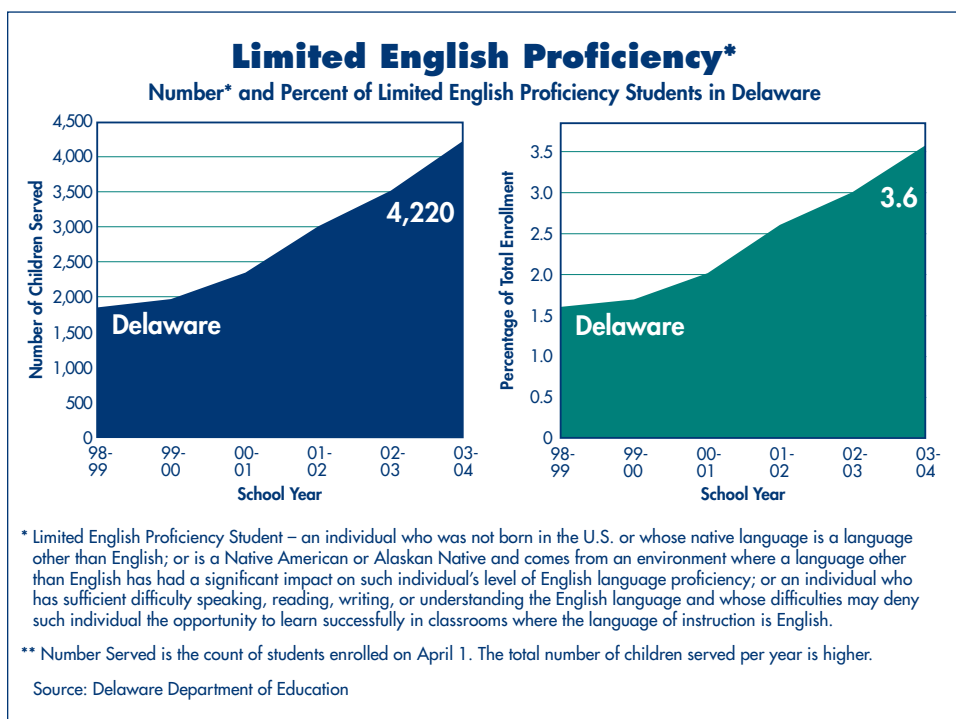
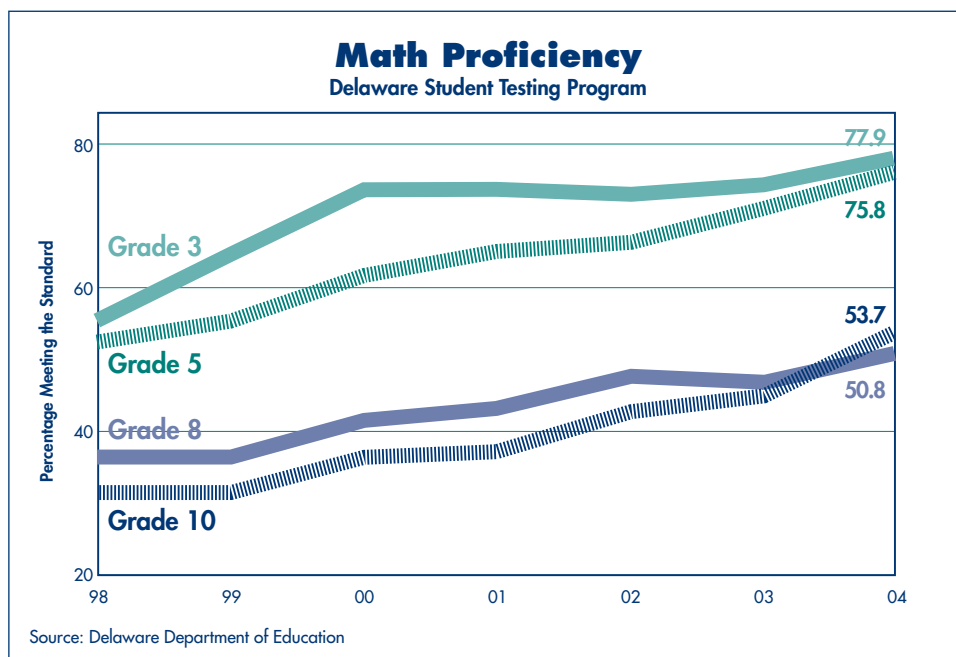


put data into action

Building a strong math and science foundation can start at home. Here are some tips to help children of any age become good problem solvers:

- 1 Encourage questions, particularly those that have more than one possible answer, and preferably ones to which you don't know the answer yourself.
- 2 Ask open-ended questions and welcome innovative responses.
- 3 Help your child to tolerate some uncertainty—effective thinkers can delay the best solution to a problem until they have thought about possible options.
- 4 Provide toys and games that encourage a variety of types of play that the youngster must create himself; praise and admire innovative uses of play construction or game materials.
- 5 Show your child how to estimate.
- 6 Practice “guess and test”.
- 7 Work hard on helping your child feel secure enough to take sensible risks.

Source: Parent Portal. University of California at Berkeley's Lawrence Hall of Science. Available at <http://lhp.parent.org/foundation.html>



Did you know?

The No Child Left Behind Act may provide free tutoring for children if the state says his or her school needs to improve and the child is eligible. These services offer students extra help in academic subjects such as reading, language arts, and mathematics. Supplemental Education Services (SES) services are provided outside the regular school day—before or after school, on weekends, or in the summer.

Source: SES: The Basics. SESQ Center. Available at: www.tutorsforkids.org/basics.asp



Definition:

DSTP – The Delaware Student Testing Program (DSTP), designed by Delaware educators, measures how well students are progressing toward the state content standards. The program is one part of a much larger and richer effort by the educational community to ensure a high quality education for all students in Delaware. The DSTP assists Delaware educators in determining students' strengths and weaknesses to help identify academic issues.

Student Achievement



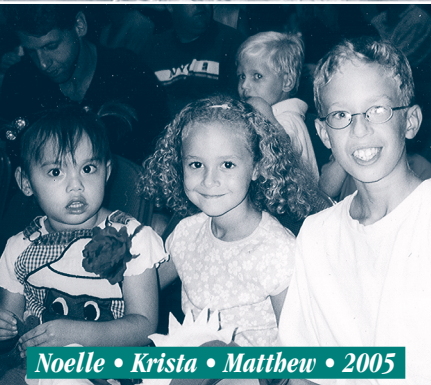
Krista • 1999



Matthew • 1999

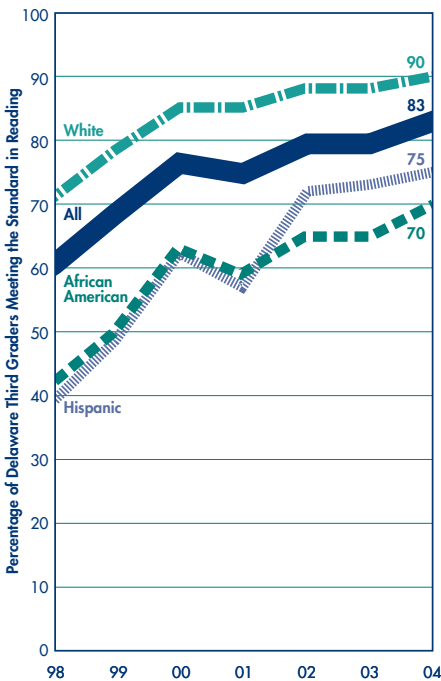


Noelle • 2003

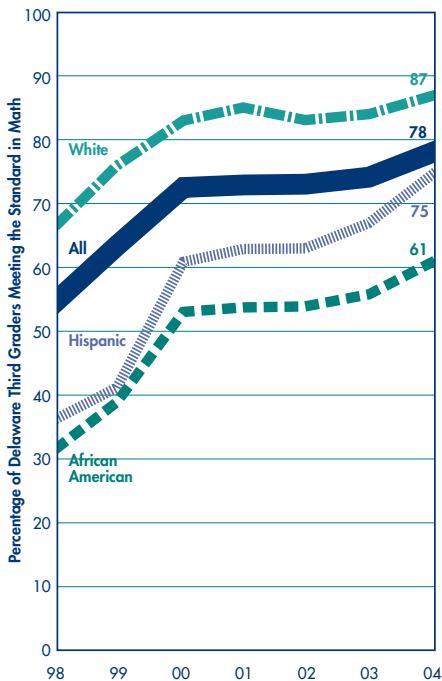


Noelle • Krista • Matthew • 2005

Grade 3 Meeting the DSTP Standard

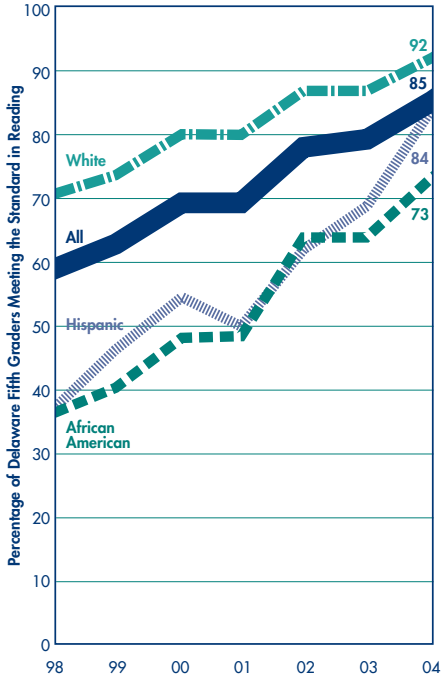


Source: Delaware Department of Education

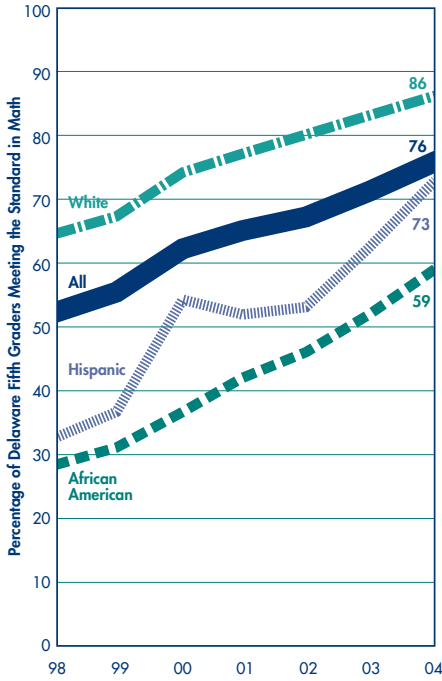


Note: All includes Native American and Asian.

Grade 5 Meeting the DSTP Standard



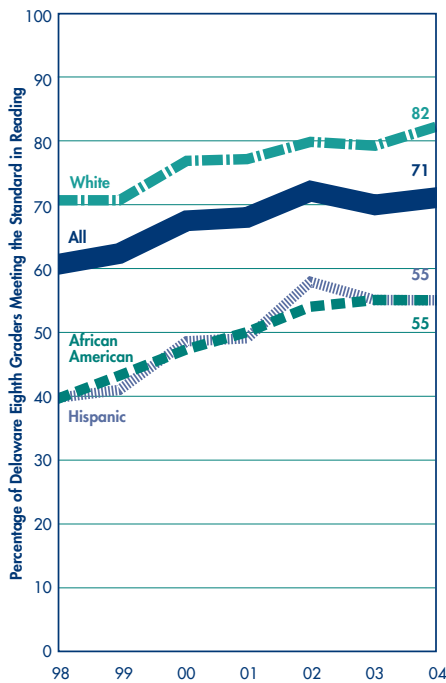
Source: Delaware Department of Education



Note: All includes Native American and Asian.

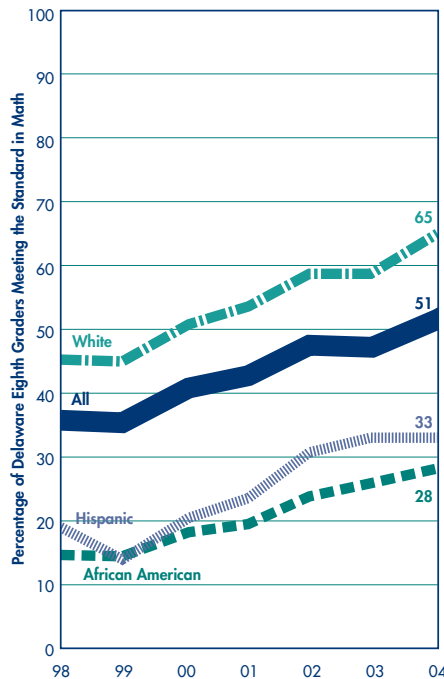
Grade 8 Meeting the DSTP Standard

Reading



Source: Delaware Department of Education

Math



Note: All includes Native American and Asian.

DSTP Proficiency Levels – Delaware Student Testing Program

Students receive scores categorized as follows:

Level	Category/Description
5	Distinguished: Excellent performance
4	Exceeds the standard: Very good performance
3	Meets the standard: Good performance
2	Below the standard: Needs improvement
1	Well below the standard: Needs lots of improvement

DSTP Accountability

Student accountability began with the 2002 DSTP. Students in grades 3 and 5 are promoted if their DSTP reading is at level 3 or above. Students in grade 8 are promoted if their DSTP reading and math are at level 3 or above.

Level 2 – Students Below the Standard

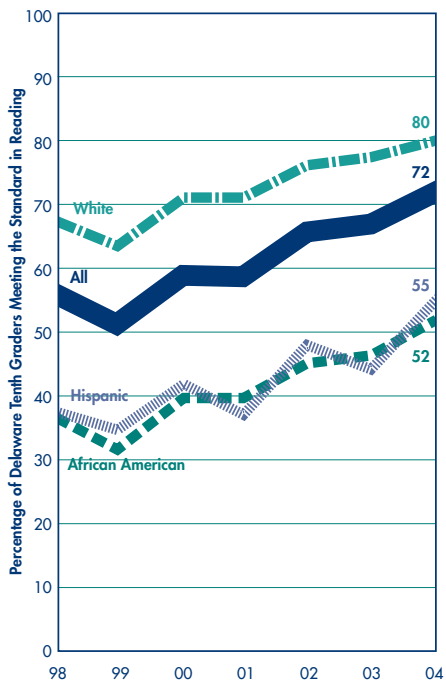
- Promoted with an Individual Improvement Plan (IIP)
- IIP must be agreed to by the parents of the student
- IIP may include summer school and/or extra instruction during the school year

Level 1 – Students Well Below the Standard

- Must attend summer school
 - Must retake DSTP at the end of summer school
 - School must have an IIP in place for a student at the end of summer
- * If the student is still below the standard, the student will only be promoted after an Academic Review Committee determines that the student has demonstrated proficiency relative to the standards using additional indicators of performance.

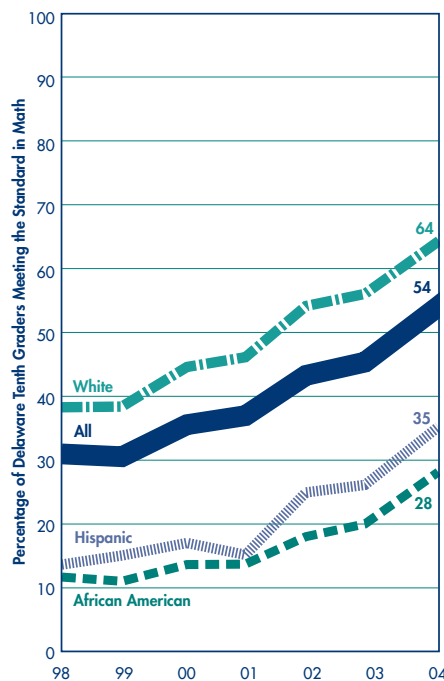
Grade 10 Meeting the DSTP Standard

Reading



Source: Delaware Department of Education

Math



Note: All includes Native American and Asian.

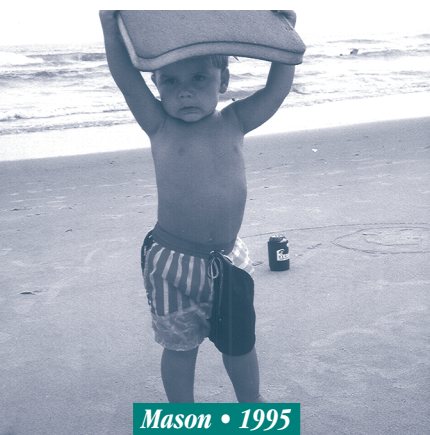
For more information see

Tables 46-53 p. 146-149
www.doe.state.de.us
www.doe.state.de.us

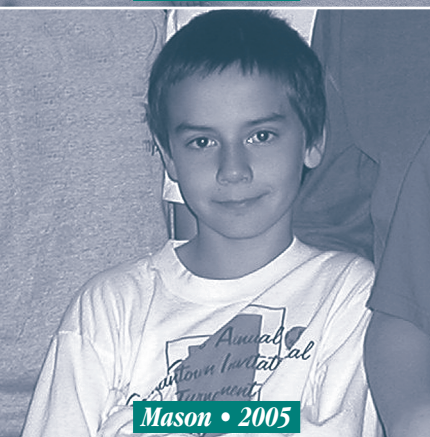
Advanced Placement

The Advanced Placement (AP) program gives students an opportunity to take college-level courses and exams while still in high school. Based on their performance on rigorous AP Examinations, students can earn credit, advanced college class placement, or both, for college. Research conducted by the U.S. Department of Education indicates a direct positive correlation between AP classes taken in high school and the likelihood of earning a college degree.

In 2001, there was great disparity in the availability of advanced placement courses in the state's 31 public high schools and some districts offered no AP courses. In 2001, Delaware received an Advanced Placement Incentive (API) grant from the U.S. Department of Education. The professional development and increased AP course offerings made possible by the API grant has enabled students (many of them disadvantaged) to attend a more rigorous academic curriculum, perform better in the tenth grade assessment, and pursue a college preparatory career. In the 2003-2004, Delaware high schools offered 255 AP courses with an enrollment of 2,779 students.



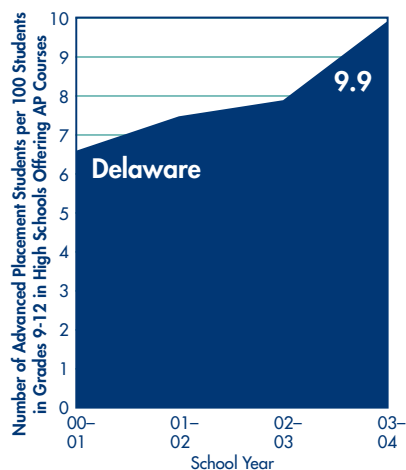
Mason • 1995



Mason • 2005

Advanced Placement Participation

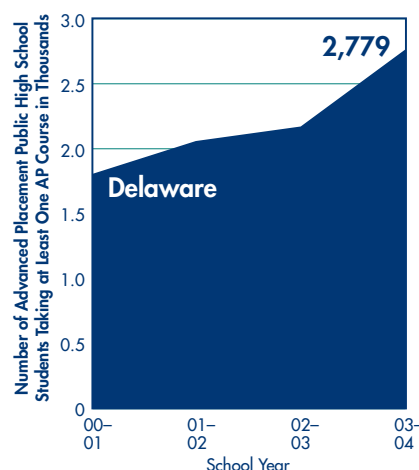
Delaware



Source: Delaware Department of Education

Advanced Placement Students

Delaware



Source: Delaware Department of Education

Did you know?

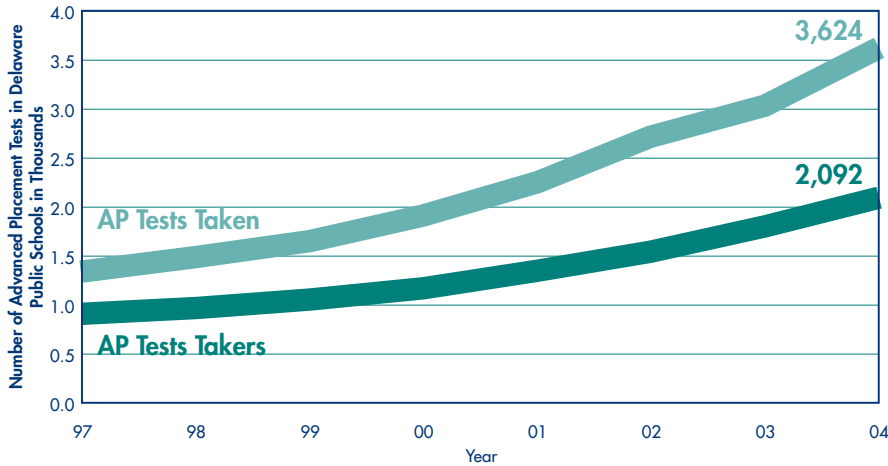
Advanced Placement (AP) exams, developed by Educational Testing Systems (ETS), are administered every spring. The purpose is to assess a student's achievement in a particular course and, with a high enough score, allow the student to earn college credit, advanced placement, or both, for college.

The highest score possible is a "5." A score of "3" is considered average and most colleges and universities will grant credit or advanced placement, or both, with this score.

The Delaware Department of Education (DDOE) as part of the Advanced Placement Incentive program (APIP) reimburses a major portion of the cost for low-income students. In Delaware public schools, students took 3,237 tests in the spring of 2004. During the three years of the APIP from 2002 through 2004, the number of public school test fee refunds increased from 43 to 133.

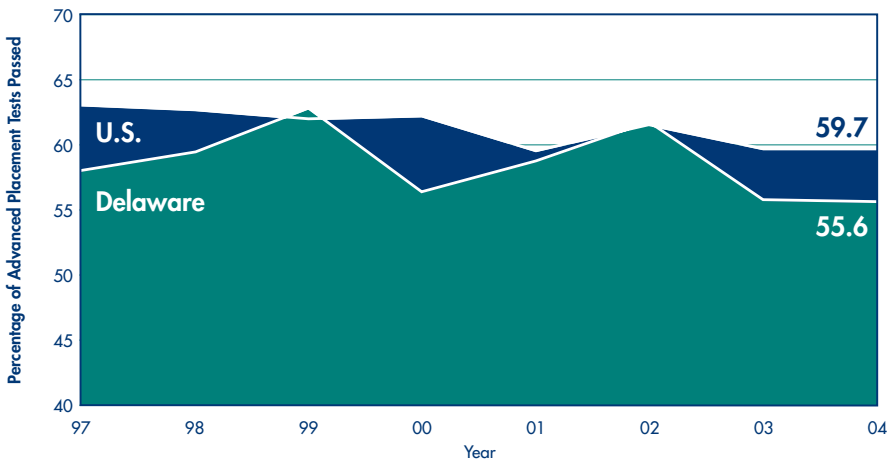
Of 31 Delaware public high schools, 25 offer AP courses. Nationally, over 34 courses and exams are available across 19 subject areas for AP Programs. For more information about AP testing please contact an AP teacher at a local school or visit the Delaware Department of Education web site: www.doe.state.de.us/AdvPlacementProgram/APGoals.htm or www.collegeboard.com. Both websites contain valuable information for parents and educators.

Advanced Placement Tests Delaware



Source: Delaware Department of Education

Advanced Placement Tests Passed Delaware Compared to U.S.



Source: Delaware Department of Education



Charlie • 1995



Charlie • 2004

put data into action

Below are several reasons listed as to why high school students should enroll in AP programs.

- Gain an edge in college preparation.
- Get a head start on college-level work.
- Improve writing skills and sharpen problem-solving techniques.
- Develop the study habits necessary for tackling rigorous course work.
- Stand out in the college admissions process.
- Demonstrate maturity and readiness for college.
- Show willingness to push oneself to the limit.
- Emphasize commitment to academic excellence.
- Broaden intellectual horizons.
- Explore the world from a variety of perspectives, most importantly the student's own.
- Study subjects in greater depth and detail.
- Assume the responsibility of reasoning, analyzing, and understanding.

For more information see

Table 44–45

p. 145

www.doe.state.de.us/AdvPlacementProgram/APGoals.htm

www.collegeboard.com/student/testing/ap/about.html

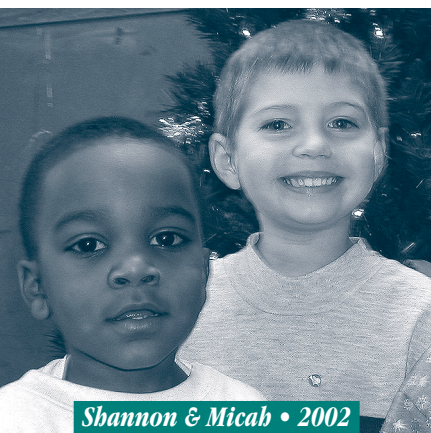
Children Receiving Free & Reduced-Price School Meals

More than 25 million children participate in the National School Lunch Program (NSLP) daily, helping them to reach proper nutrition, which is imperative for the growth and educational achievement of children. The NSLP was created in 1946 and since then has served more than 187 billion lunches.¹

Children participating in NSLP are more likely than nonparticipants to consume more vegetables, milk products, and meat or meat substitutes, and fewer soft drinks and fruit drinks. Also, school lunches provide 35% of the daily total energy intake.²

1 Program Fact Sheet. Food and Nutrition Services. USDA Available at: www.fns.usda.gov/cnd/Lunch/AboutLunch/NSLPFactSheet.htm

2 Position of the American Dietetic Association: Dietary Guidance for Healthy Children Ages 2 to 11 Years. American Dietetic Association. Available at: [www.eatright.org/Member/Files/dietary\(1\).pdf](http://www.eatright.org/Member/Files/dietary(1).pdf)



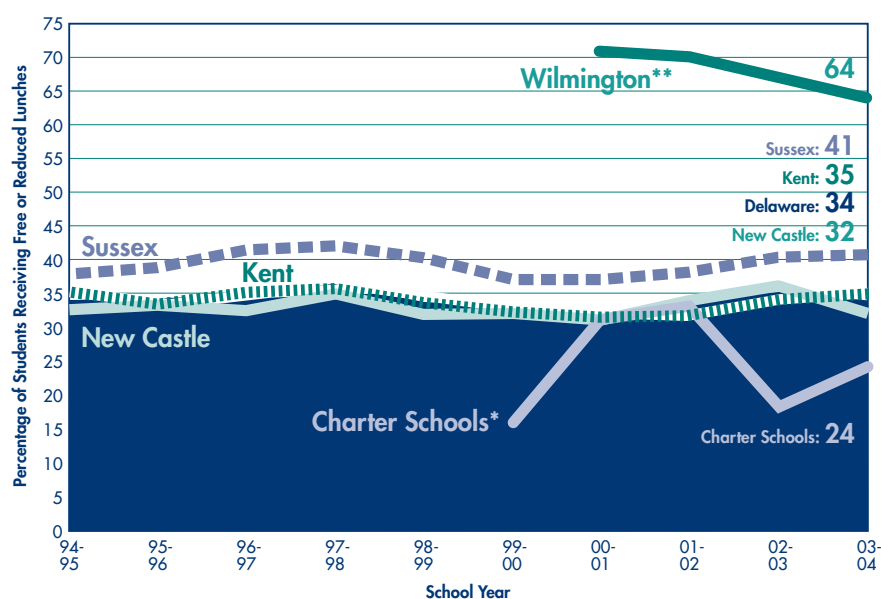
Shannon & Micah • 2002



Micah & Shannon • 2005

Free and Reduced-Price Lunches

Delaware, Counties, Charter Schools*, and Wilmington**



* Charter School data were not available before the 1999-2000 school year.

** Wilmington data are available only for the 2000-01 and 2001-02 school years

Source: Delaware Department of Education

Did you know?

- Hungry children, even those who experience only mild malnutrition during the critical stages of their development, may suffer irreparable harm.
- Hungry children have a harder time learning in school, shorter attention spans, and suffer more absences due to illness.
- A child who is unequipped to learn because of hunger and poverty is more likely to be poor as an adult.

Source: Fact & Statistics. ConAgra Foods' Feeding Children Better Foundation. Available at: www.feedingchildrenbetter.org

put data into action

The Delaware Action for Healthy Kids Coalition, a group of public health care workers, educators, and nutrition experts, is trying to change eating behaviors among children that lead to obesity and chronic diseases. The coalition is helping schools to adopt policies that ensure that all foods and beverages available on Delaware public school campuses and at school events are consistent with USDA lunch guidelines. Specific focus is being given to adopting a proposed voluntary nutritional standard for snacks which would have no more than 8 grams of fat per serving and get less than 35 percent of their calories from sugar or other sweeteners.

For more information see

Table 46

p. 146

www.feedingchildrenbetter.org

High School Dropouts

Education has always played a role in determining children's future economic and occupational success, but its influence has never been greater than it is today. Young people who drop out of high school are unlikely to have the minimum skills and credentials necessary to function in today's increasingly complex society and technological workplaces. Over the last two decades, people without high school diplomas have suffered an absolute decline in real income and have dropped further behind individuals with more education.¹

Interestingly, however, many youth who drop out of high school eventually earn a diploma or General Education Diploma (GED). One study found that 63 percent of students who dropped out had earned a diploma or GED within eight years of the year they would have originally graduated.²

1 KIDS COUNT Indicator Brief Reducing the High School Dropout Rate (2003). Annie E. Casey Foundation. Available at <http://www.kidscount.org>

2 High School Dropout (2004). Child Trends DataBank. Available at <http://www.childtrendsdatabank.org>

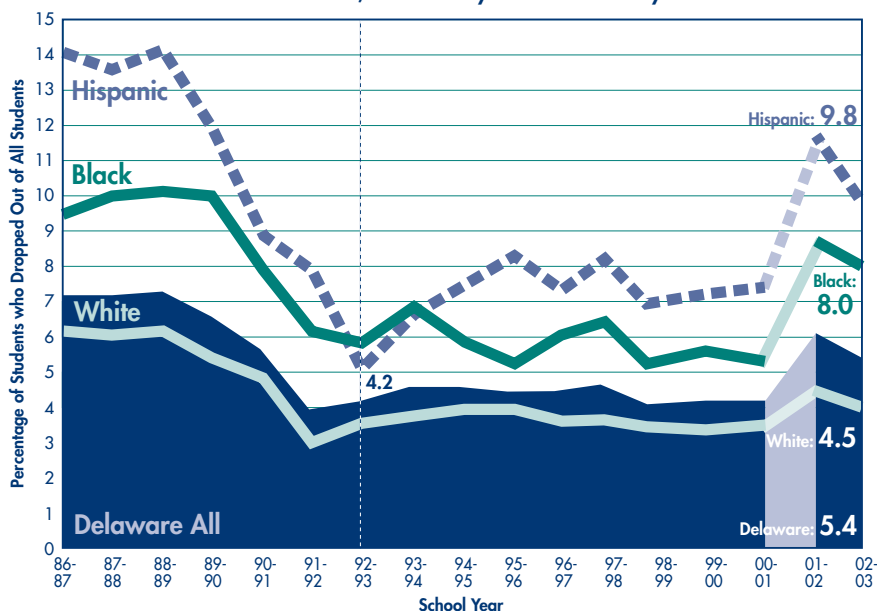
RECENT TREND
IN DELAWARE
**GETTING
BETTER**

H.S. DROPOUTS • 10 YEARS



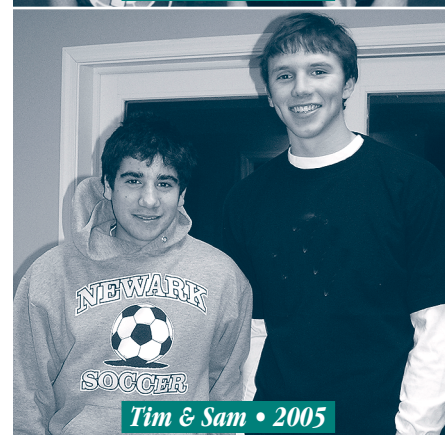
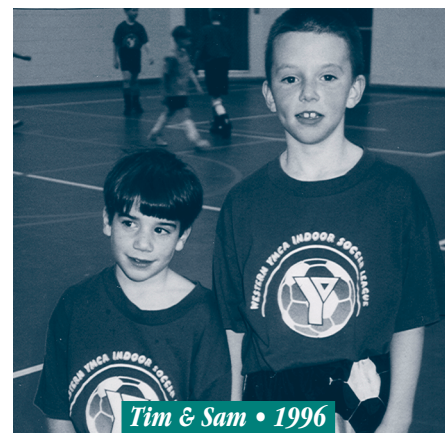
Public High School Dropouts

Grades 9–12, Delaware by Race and Ethnicity



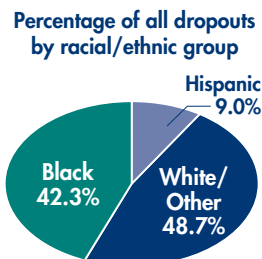
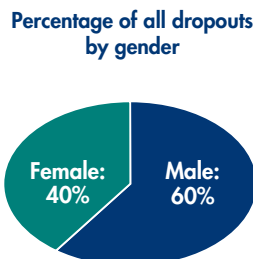
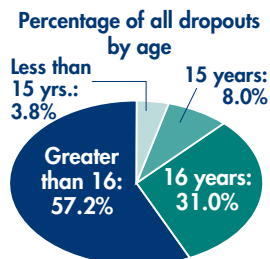
The percentage after 2000-02 reflects an improvement in data acquisition and reporting. There has not been a significant increase in the number of dropouts; those students added to the dropout data were previously listed as "Missing," and not reported. Missing students have been tracked and placed in correct categories.

Source: Delaware Department of Education



Dropouts

by Age, Gender, and Racial/Ethnic Group, School Year 2001–2002



Source: Delaware Department of Education

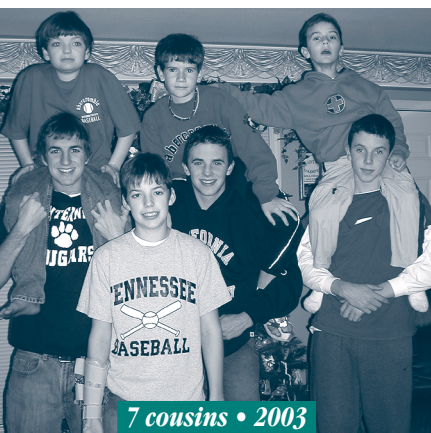
Definitions

Dropout – A 2002-2003 dropout is an individual who was enrolled at the end of the 2001-2002 school year; or at any time during the 2002-2003 school year; and has not graduated from high school or completed a state- or district-approved educational program; and does not meet any of the following exclusionary conditions:

- Documentation proving transfer to another public school district, private school, or state- or district-approved education program;
- Temporary absence due to suspension or school-approved illness; or
- Death.

Definition

Graduation Rate – The graduation rate is a cohort rate that reflects the percent of 9th grade students who graduated within four years from a Delaware public school. The rate takes into account dropouts. For example, the rate for 2000–2001 reflects the percent of incoming 9th graders in September of 1997 who graduated in June of 2001.



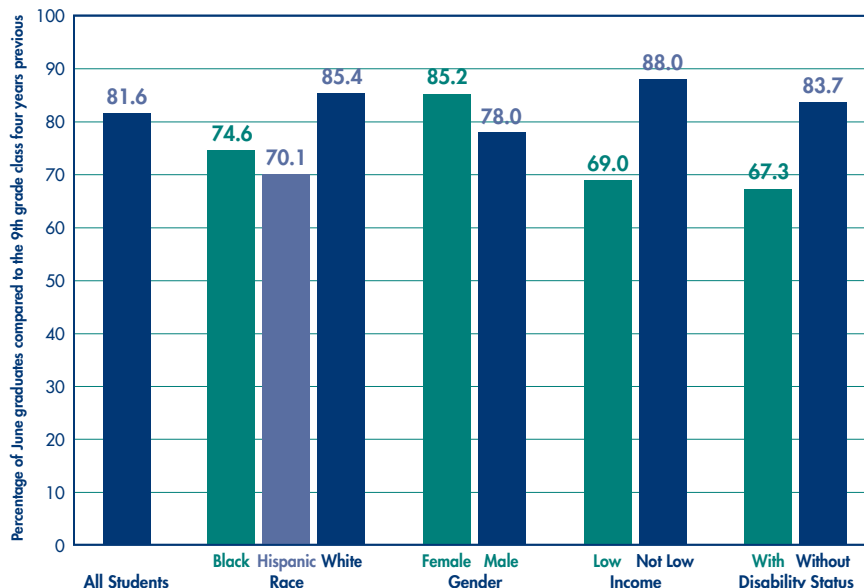
7 cousins • 2003



7 cousins • 2005

Graduation Rates

Delaware, School Year 2002–03



Source: Delaware Department of Education

Did you know?

- High school dropouts are four times as likely to be unemployed as those who completed four or more years of college.
- High school graduates earn \$143 more per week than high school dropouts. College graduates earn \$336 more per week than high school graduates.
- Dropouts are more likely to apply and receive public assistance than graduates.
- Dropouts comprise a disproportionate percentage of the nation's prison and death row inmates. 82% of prisoners in America are high school dropouts.

Source: Top 5 Reasons to Stay in School. National Dropout Prevention Center/Network. Available at: <http://www.dropoutprevention.org/resource/famstud/reasons.htm>

put data into action

The National Dropout Prevention Center/Network (NDPC/N) has identified 15 effective strategies that have the most positive impact on the dropout rate. These strategies have been implemented successfully at all education levels and environments throughout the nation. For program descriptions, resources and contacts, please visit: www.dropoutprevention.org/effstrat/effstrat.htm

Dropout Rates

by Racial/Ethnic Group
School Year 2002–03

Delaware

All – 5.4

White/Other – 4.0

Hispanic – 9.8

Black – 8.0

New Castle County

All – 5.9

White/Other – 3.9

Hispanic – 11.5

Black – 8.9

Kent County

All – 4.4

White/Other – 3.8

Hispanic – 3.4

Black – 5.9

Sussex County

All – 5.1

White/Other – 4.5

Hispanic – 7.3

Black – 6.9

Delaware Average: 5.4

Source: Delaware Department of Education

For more information see

Table 17 p. 131

Tables 47–55 p. 147–150

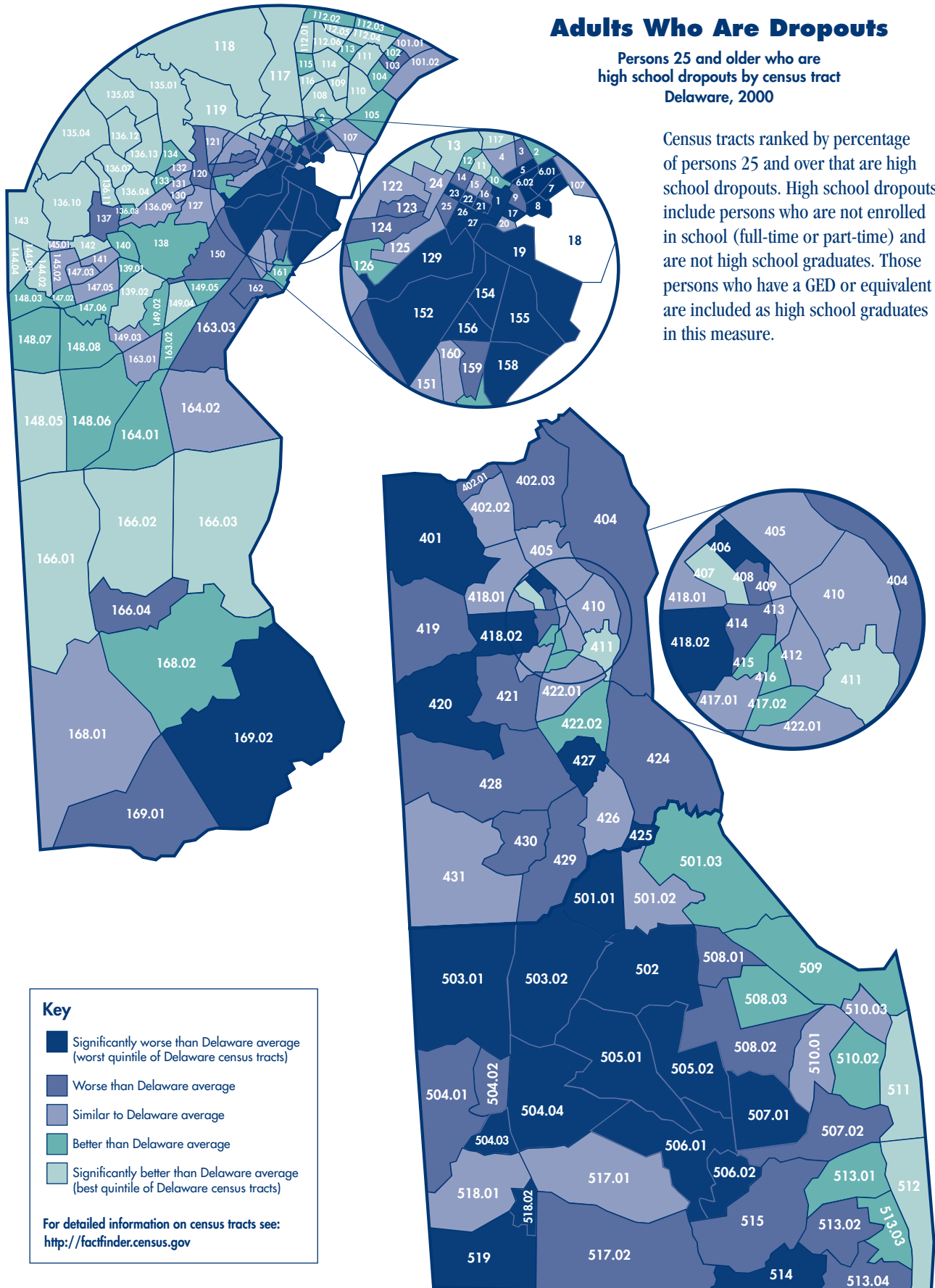
www.dropoutprevention.org

<http://jobcorps.doleta.gov>

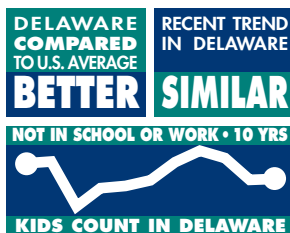
Adults Who Are Dropouts

Persons 25 and older who are
high school dropouts by census tract
Delaware, 2000

Census tracts ranked by percentage of persons 25 and over that are high school dropouts. High school dropouts include persons who are not enrolled in school (full-time or part-time) and are not high school graduates. Those persons who have a GED or equivalent are included as high school graduates in this measure.



Teens Not in School and Not Working

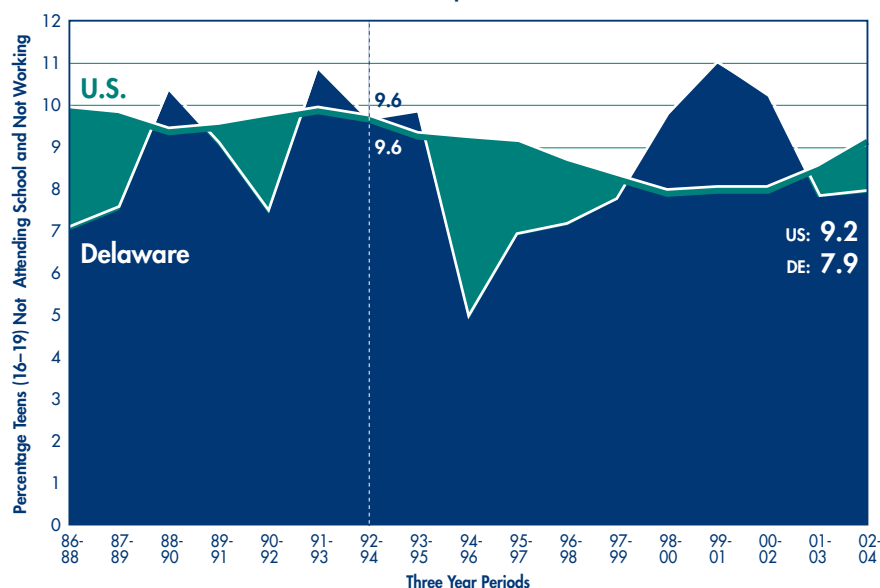


As they move toward adulthood, most young Americans are either in school, the workforce, or the military. In whichever setting they are involved, their lives are shaped by the challenges and routines of an important societal institution and by the social networks they encounter there. However, a persistent minority, nearly one in ten teens between the ages of 16 and 19, are neither studying nor working. They are disconnected from the roles and relationships that set most young people on pathways toward productive adult lives. Their detachment, especially if it lasts for several years, increases the risk that a young person will have lower earnings and a less stable employment history than peers who stayed in school or found jobs. Disconnected young women are more likely than other young adult women to rely on welfare, while disconnected young men are more likely than other young men to spend time in jail.¹

¹ KIDS COUNT Indicator Brief: Reducing the Number of Disconnected Youth (2003). Annie E. Casey Foundation. Available at <http://www.kidscount.org>



Teens Not in School and Not Working Delaware Compared to U.S.



Note: Variations in the Delaware graph are due to sampling size of the data collection. Data are collected through a sample size too small for county breakout. This measure is based on an analysis of the Current Population Survey, representing a nationwide sampling. Like all estimates derived from sampling, these figures do contain sampling errors. The Bureau of Labor Statistics suggests that state rankings based on these figures should be used with caution.

Source: Center for Applied Demography and Survey Research, University of Delaware

Did you know?

- American Indian and non-Hispanic black youth are more likely than other youth to be neither enrolled in school nor working. In 2003, 28 percent of American Indian youth and 20 percent of non-Hispanic black youth were neither enrolled in school nor working, compared with 9 percent of Asian youth, 10 percent of non-Hispanic white youth, and 18 percent of Hispanic youth.
- Older youth are more likely than younger youth to be neither working nor enrolled in school. For example, in 2003, 18 percent of youth ages 23 to 24 were neither working nor enrolled in school compared with 4 percent of youth ages 16 to 17.
- Young adults ages 23 to 24 are more likely to be neither working nor enrolled in school than youth ages 16 to 17. For example, in 2003, 18 percent of persons ages 23 to 24 were neither working nor in school compared with 4 percent of 16 to 17 year olds.

Source: Youth Neither Enrolled in School nor Working (2004). Child Trends DataBank. Available at <http://www.childtrendsdatabank.org>

Definition

Teens Not in School and Not Working
– teenagers 16–19 who are not in school and not employed

The State of Delaware's Department of Education keeps track of out-of-school suspensions and expulsions in all regular, vocational/technical, and special public schools for each school year. The duration of out-of-school suspensions is influenced by district policy, district procedure, severity of the incident, frequency of a particular student's involvement in disciplinary actions, and the availability of disciplinary alternatives.

Expulsions and Suspensions

Delaware Public Schools, 2002–03

County	Enrollment	Number of Expulsions	Number of Suspensions*
Delaware	116,429	96	29,736
New Castle	68,636	74	22,324
Kent	24,975	5	3,827
Sussex	21,939	17	3,585

*Suspensions are total number of suspensions, not students suspended. A student may have multiple suspensions.

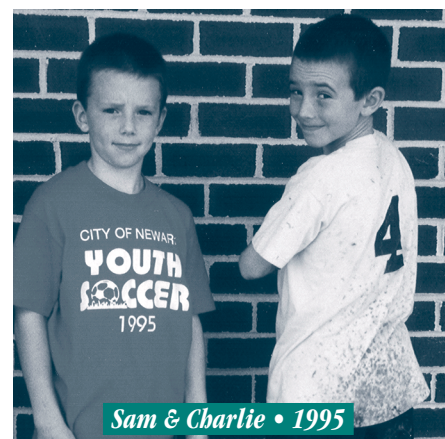
Note: Most frequent infractions resulting in Suspensions were Defiance of School Authority, Fighting, General Disruption. Most frequent infractions resulting in Expulsion were Drug Use or Possession, Assault/Battery.

Source: Delaware Department of Education

Did you know?

According to the National League of Cities, engaging disconnected youth is important for the following reasons:

- **Education and training for young people builds strong communities.** Cities that want to cultivate a skilled workforce can achieve this goal by expanding opportunities for disconnected youth to return to school, enroll in training programs, and find paid employment.
- **Investments now can save money down the road.** Reconnecting young people to school, work, and their communities allows them to develop their talents, serve as leaders, and stay out of trouble, reducing the need for future public expenses. Many of these reconnected teens and young adults will also make positive contributions to the cities in which they live, such as: paying taxes, purchasing goods and services, serving as role models in their neighborhoods, and engaging in civic activities.
- **A “second chance” for disconnected youth promotes equity.** The chance to bounce back and overcome youthful mistakes is a routine part of growing up for most Americans. Disconnected youth who lack the social and financial supports of their more advantaged peers often are not as fortunate, but they deserve the same opportunity to get back on their feet.



Sam & Charlie • 1995



Sam & Charlie • 2004



The KIDS COUNT Indicator Brief: Reducing the Number of Disconnected Youth identifies five broad strategies for policy makers and the public at large to use to reduce the number of teens neither enrolled in school nor working:

- Aim for comprehensive system reform, not just the provision or expansion of direct services.
- Start with schools.
- Create well-structured school-to-career (STC) programs.
- Address impediments to employment.
- Meet adolescents' intense need for nurturing, guidance, and protection.

Source: KIDS COUNT Indicator Brief: Reducing the Number of Disconnected Youth (2003). Annie E. Casey Foundation. Available at <http://www.kidscount.org>

For more information see

Tables 47-54 p. 147-150

Table 93 p. 168

www.dropoutprevention.org

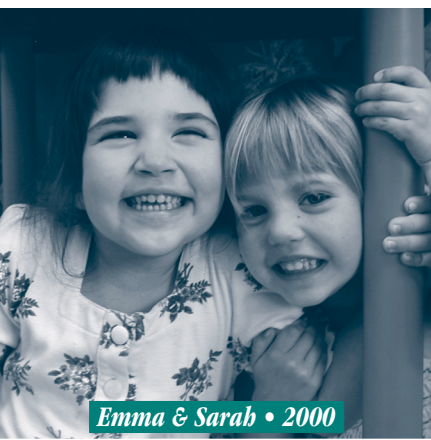
www.childrensdefense.org



The drive to raise academic standards in education has been in the forefront of the American public for the past decade. However, there is more to educational achievement than testing and standards. People are deeply concerned about issues beyond the academic arena. National surveys consistently show that drugs, crime, safety and discipline are considered important problems facing education.

Students learn best and achieve their full potential in safe and orderly classrooms. This positive academic environment begins with safe and involved families and communities. Studies show that all children in a school—not just the children of parents who are involved—develop better attitudes about school and schoolwork when parent volunteers are in the classroom. The general presence of parents in the classroom communicates that schools and schoolwork are valued and important in the community.¹

¹ How Your Involvement Makes a Difference. University of California at Berkeley's Lawrence Hall of Science. Available at <http://lhsparent.org/InvolvementatSchool.html>



Emma & Sarah • 2000

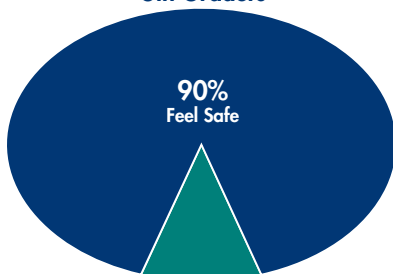


Emma & Sarah • 2005

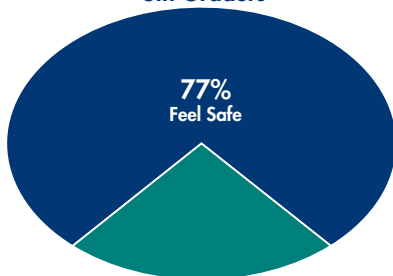
School Safety

I feel safe in my school.
Delaware, 2004

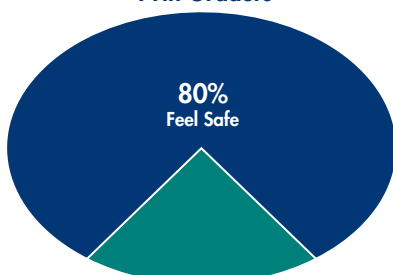
5th Graders



8th Graders



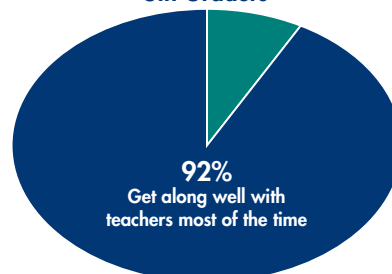
11th Graders



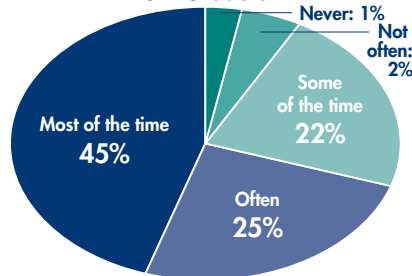
Teachers

I get along well with teachers at school.
Delaware, 2004

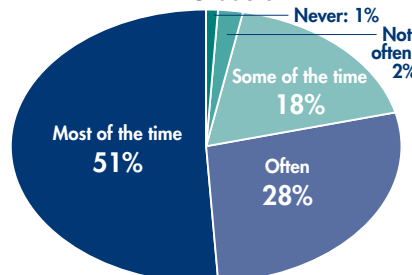
5th Graders



8th Graders



11th Graders



Source for all graphs on this page: 5th graders: 7,788 responses. 8th graders: 6,931 responses. 11th graders: 4,985 responses. Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware

Did you know

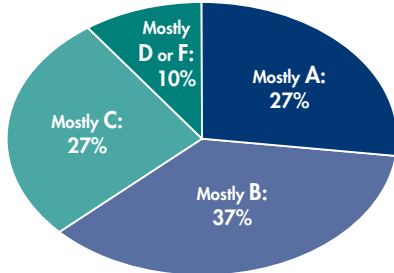
The percentage of youth who feared attack at school or on the way to and from school decreased significantly from 12% in 1995 to 6% in 2003.

Source: Child Trends DataBank. Available at <http://www.childtrendsdatabank.org>

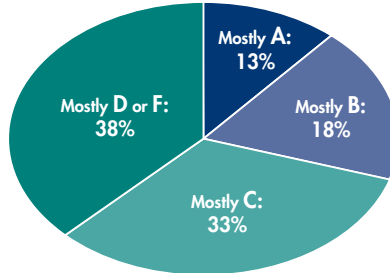
Grades and Parental Concern

How often do your parents know where you are?
What grades do you usually make?
8th Graders, Delaware, 2004

Parents know most of the time



Parents never know

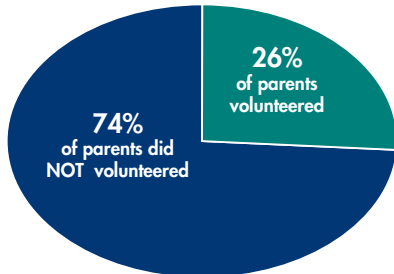


Source: 8th graders: 6,931 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware

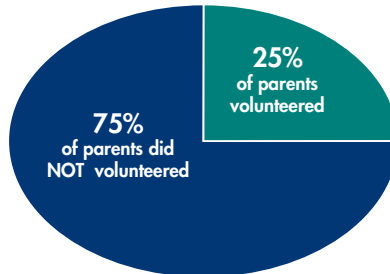
Parents Volunteer

This school year, did one or both of your parents volunteer to come to the school to help the school in any way?
Delaware, 2004

8th Graders



11th Graders

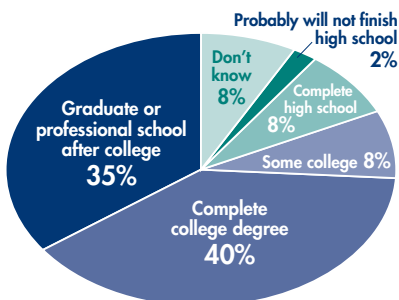


Source: 8th graders: 6,931 responses. 11th graders: 4,985 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware

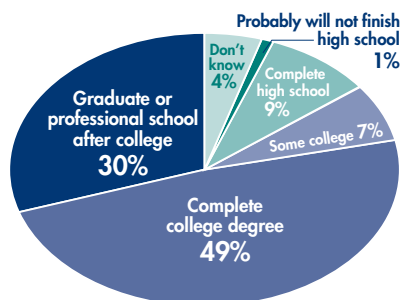
Finishing School

How much schooling do you think you will complete?
Delaware, 2004

8th Graders



11th Graders



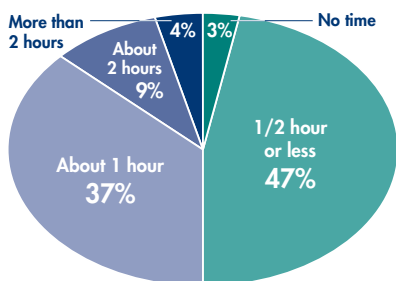
Source: 8th graders: 6,931 responses. 11th graders: 4,985 responses.
Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware



Studying

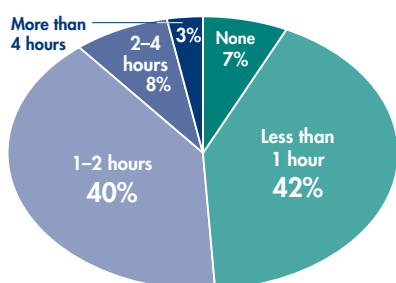
How much time do you spend on a school day (before or after school) doing schoolwork at home?
Delaware, 2004

5th Graders

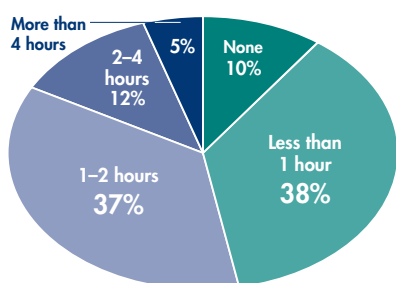


How much time do you spend on a school day (before or after school) studying or doing homework outside of school?

8th Graders



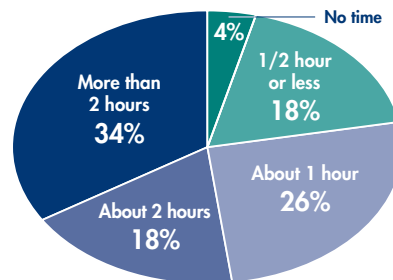
11th Graders



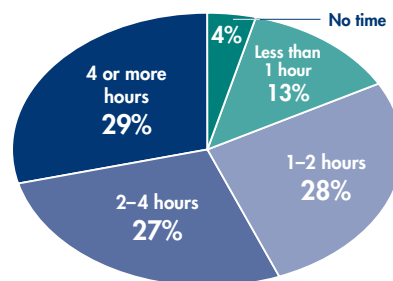
Television

How much time do you spend on a school day watching TV?
Delaware, 2004

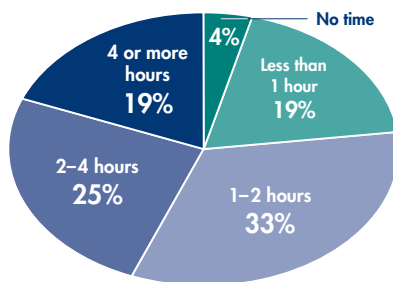
5th Graders



8th Graders



11th Graders



Source for all graphs on this page: 5th graders: 7,788 responses. 8th graders: 6,931 responses. 11th graders: 4,985 responses. Delaware School Survey 2004, Center for Drug and Alcohol Studies, University of Delaware



Did you know

Black students are much more likely than white students to watch four or more hours of television per day on the average weekday. Among eighth graders in 2003, for example, 61% of black students watched four or more hours of television, compared with 24% of white students.

Source: Child Trends DataBank. Available at <http://www.childtrendsdatabank.org>

put data into action

Practical ways in which parents can support their child's school:

- Asking the teachers how they can help.
- Sharing their knowledge, skills, or interests with their child's class.
- Calling the local newspaper to get news coverage for school events or unusual class projects.
- Volunteering to help office staff conduct school mailings.
- Organizing community "appreciation events" for teachers, such as cooking and serving a meal on a day when teachers need to stay late, or organizing a "thank you brunch."

Source: How Your Involvement Makes a Difference. University of California at Berkeley's Lawrence Hall of Science. Available at <http://lhsparent.org/InvolvementatSchool.html>

For more information see

www.state.de.us/drugfree/data.htm