

A close-up portrait of a young child with light brown hair and blue eyes, smiling and resting their chin on their hand. The child is wearing a striped shirt.



count

A close-up portrait of a young girl with a warm, joyful smile, resting her chin on her hand. She has dark skin and short, dark hair. The image is cropped closely, focusing on her face and hand. The background is dark and out of focus.

A close-up, vertical photograph of a young child lying down, looking up with their mouth open, showing their tongue and teeth. The child has dark skin and dark hair. The image is oriented vertically, with the child's head at the bottom and feet at the top.

12345678912345678912345
23456789123456789123456
34567891234567891234567

23456789123456789123456
34567891234567891234567
45678912345678912345678





www.ssrc.msstate.edu/mskidscount

The **MISSISSIPPI KIDS COUNT** program is made possible, in part, through grants from the Annie E. Casey Foundation and Mississippi State University's Division of Agriculture, Forestry and Veterinary Medicine. This work is carried out through the Family and Children Research Unit, a division of the Social Science Research Center.

SSRC
<http://www.ssrc.msstate.edu>

Mississippi State
UNIVERSITY®

ADVISORY BOARD

Mary Gayle Armstrong

MS Department of Health

Gary A. Blair

Land Bank South

Mike Clayborne

CREATE Foundation

Neva Penton Eklund

University of MS Medical Center

Yurany Esguerra

Forest School District

Therese Hanna

Center for MS Health Policy

William Hilbun

Pediatrician

Valerie Long

CATCH KIDS, Inc.

Patricia Marshall

MS Attorney General's Office

Dorothy Roberts McEwen

MS Department of Mental Health

Kate McMillin

MS Department of Human Services

Sally Molpus

Operation Shoestring

Arvern Moore

ICS Head Start

Larry Otis

Convening Board Chair

Wade H. Overstreet

Blue Cross & Blue Shield of MS Foundation

Tom Pittman

Community Foundation of Northwest MS

Inez Saum

4-H Club Foundation

Sister Teresa Shields

Jonestown Learning Center

Danny Spreitler

Gilmore Foundation



The Family and Children Research Unit (FCRU) conducts research on issues affecting the health, safety, and well-being of children and families. It employs an interdisciplinary approach for program planning and evaluation while conducting basic and applied research to build effective service systems as well as inform state, local, and national policymakers. FCRU partnerships with public and private agencies allow for the development and implementation of common goals.



TABLE OF CONTENTS

THE STORY

INTRODUCTION	5
EXECUTIVE SUMMARY	11
NATIONAL KIDS COUNT INDICATORS: Mississippi	16
QUICK REFERENCE GUIDE	17

SAFETY

SAFETY BELT USAGE	19
BICYCLE HELMET USAGE	21
DRINKING DRIVER	23
YOUTH VIOLENCE: Carrying a Weapon & Fighting	25

WELL-BEING

SINGLE-PARENT FAMILIES	29
PARENTAL EMPLOYMENT	31
CHILDREN IN POVERTY	33

HEALTH

DIET, OVERWEIGHT & PHYSICAL ACTIVITY	37
TOBACCO, ALCOHOL & MARIJUANA USE	41
ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS	45
LOW BIRTH WEIGHT & INFANT MORTALITY	51
CHILD & TEEN DEATHS	57

EDUCATIONAL SUCCESS

SCHOOL PERFORMANCE	63
EDUCATIONAL ATTAINMENT	67
SCHOOL VIOLENCE	71

ACKNOWLEDGEMENTS	75
------------------	----

APPENDICES

APPENDIX A: References	77
APPENDIX B: Data Sources, Definitions & Notes	86

MISSISSIPPI'S CHILDREN & FAMILIES

INTRODUCTION

“Please think of the children first. If you ever have anything to do with their entertainment, their food, their toys, their custody, their day or night care, their health, their education—listen to the children, learn about them, learn from them. Think of the children first.” -Fred Rogers



Who we are...



Mississippi KIDS COUNT is a research entity that tracks information about Mississippi's children. In doing so, **MS KIDS COUNT** aims to support those who care for and about Mississippi's children by providing data, highlighting evidence-based practices and reporting best return-on-investment strategies pertaining to the well-being of children and, ultimately, the state as a whole.

MS KIDS COUNT is supported, in part, by the Annie E. Casey Foundation (AECF). The AECF was established in 1948 by Jim Casey, founder of United Parcel Service. The national KIDS COUNT program began its state-level work in the early 1990s. **MS KIDS COUNT** is part of a national network of KIDS COUNT state grantees.

Since January 2007, the **MS KIDS COUNT** program has been housed within the Family & Children Research Unit (FCRU) at the Social Science Research Center (SSRC), Mississippi State University (MSU). The work of the stellar **MS KIDS COUNT** Advisory Board, encouragement from individuals and agencies from around the state, support of the Blue Cross & Blue Shield Corporation of Mississippi, and support provided by MSU's Division of Agriculture, Forestry & Veterinary Medicine and the SSRC have been vital to initial efforts during the first year of operation and will continue to be critical in laying a strong foundation for the future work of the **MS KIDS COUNT** program.

APPROXIMATELY

26%

of Mississippi's 2006 population
was under 18 years of age¹

INTRODUCTION

What we do...

The goals of the **MS KIDS COUNT** program are as follows:

- Collect, analyze, and maintain a comprehensive database of indicators concerning the health, education, safety and well-being of Mississippi's children
- Publish and disseminate high-quality data and research reports
- Build a solid reputation as a credible, reliable source of information about Mississippi's children and families

As such, the strong history of the SSRC and FCRU as non-partisan research entities will be advanced. In addition, the work of **MS KIDS COUNT** will assist a wide array of stakeholders in answering the following questions on behalf of Mississippi's children:

- What is required for Mississippi's rankings of child well-being to reflect more positive outcomes?
- What are the most pressing health, education, safety and well-being issues facing children and families in Mississippi?
- What are the economic and social impacts of these issues? What is the capacity for change?
- Where are Mississippi's most vulnerable children located?
- Where are Mississippi's children most likely to thrive?
- What are the markers of success for children, their families and communities? How can Mississippi create more opportunities for success?
- How do we create and maintain a synergy for change across various systems and organizations?
- Who (agencies, individuals, policymakers, communities) can Mississippi's children count on to make long-term, positive changes on their behalf?



Why our work is important...

These questions are challenging and crucial for our state, and they are at the core of improved policy and outcomes for children. Currently, there is no public or private commission, no "think tank," specifically charged to work on behalf of Mississippi's children to holistically formulate evidence-based solutions. Moreover, there is no legislative children's caucus in Mississippi specifically dedicated to addressing children's issues.

MISSISSIPPI'S CHILDREN & FAMILIES

INTRODUCTION

While Mississippians are among the first to reach out to help a neighbor, respond to a tragedy, and volunteer in their community, collectively, one of the state's strongest challenges is planning and carrying out a clear investment strategy for children and youth. By and large, Mississippi's rankings have remained constant for the past 10 years. This of course does not mean that Mississippi has not improved in some categories; it simply means that in order to rise from our last-place rankings, we must improve at a faster rate than other states.

Efforts to improve conditions for Mississippi's children are often confounded by the state's unique set of social and economic variables. Mississippi is rural and—it is well recognized—a very poor state economically. Overall, the poverty rate is 21%,² with a child poverty rate of 30%.² In addition, approximately 26% of Mississippi's 2006 population was under 18 years of age.¹ These circumstances, combined with the fact that early experiences strongly affect children in myriad ways over the life course, indicate a glaring need for information to support early, effective interventions around the state. Douglas W. Nelson, president of the AECF offers the following comment:

Not only does poverty impose short-term hardships on millions of Americans, but it has tragic long-term consequences for children. Overwhelming evidence shows that growing up in poverty—especially deep and sustained poverty—compromises children's health, dims their educational prospects, increases their risk of future arrest and incarceration and lowers their options for future success. (Washington Post, August 29, 2007)

As noted by Mr. Nelson, children's health, education, safety and overall well-being are affected by the contexts in which they grow up. These are the very topics and themes that **MS KIDS COUNT** intends to weave together in order to form a comprehensive picture of the state of childhood in Mississippi, with the idea that synchronized actions around the needs of the state's children will follow. It is the hope of **MS KIDS COUNT** that data collection that targets key indicators of children's well-being and refines areas in need of attention will stimulate the formation of multiple-domain groups and strategies.



Mississippi's 2006 overall
poverty rate was 21% with
a child poverty rate of

30%

INTRODUCTION

How we will communicate our findings...

Once data are collected and analyzed, maps and charts will be assembled to best answer the aforementioned questions, illuminating the geographical locations where Mississippi's children are experiencing the most vulnerability and highlighting the greatest successes around the state. Comparisons will also be made on the regional and national levels, noting trends over time as data are available. This information will be disseminated through various methods: the **MS KIDS COUNT** Web site, periodic data updates, and the annual **MS KIDS COUNT** Data Book and **MS KIDS COUNT** Summit.

The first strategic planning summit, "State of Mississippi's Children Summit: Creating State and Community-Based Action Plans," scheduled for January 2008, will bring together individuals from across the state, region and nation who have expressed a desire to lead and learn from one another. The summit will provide policymakers, parents, health providers, business leaders, educators, faith-based leaders, advocates, the media and other community leaders with the latest available data on Mississippi's children. Equally important, the summit aims to create a policy platform for children's issues that can be monitored over time, linking specific policies to children's outcomes. Strategies that will be used to create this platform include the following:

- Sharing successes and challenges on a variety of children's health and well-being issues in Mississippi
- Educating participants on successful strategies used by various communities in Mississippi and other states to improve specific child health and well-being indicators
- Providing opportunities to begin development of action plans (both community- and state-based) for improving the lives of children and families in Mississippi
- Creating networking opportunities among participants on common areas of interest and/or expertise

With the release of the National KIDS COUNT Data Book (July 2007), the *Northeast Mississippi Daily Journal* endorsed the **MS KIDS COUNT** conception of a Mississippi children's summit, noting, "Healthy children, given an adequate chance, usually become fully functioning, participating and prospering adults. Many of the chronic problems dogging our state get their start in childhood problems, and to say we cannot do something about them is admitting defeat without effort."



MISSISSIPPI'S CHILDREN & FAMILIES

INTRODUCTION

Using the **MS KIDS COUNT** Web site (<http://www.ssrc.msstate.edu/mskidscount>), we plan to point partners to ways in which they can become involved in helping improve outcomes for Mississippi's children.

While **MS KIDS COUNT** is not a direct agent of change, we do have a role in providing foundational information about ways that communities can better understand the landscape in which their children develop and how this landscape can change over time.



In conclusion...

We are a state of hope and continue to demonstrate amazing efforts in less than optimal times and conditions. Our commitment to improvement and excellence is evidenced by the incredible efforts of Mississippians on the Gulf Coast and around the state who are turning the tides of recent devastation through acts of resiliency, rebuilding and restoration. Both pre- and post-Katrina, thousands of citizens across the state of Mississippi have worked and continue to work on behalf of children every day. This fact continues to be demonstrated in programs where dedicated professionals, parents and communities are involved in improving outcomes for children. Through the **MS KIDS COUNT** Web site and other media, we will be highlighting many of these successes.

Over time, these efforts will culminate into a body of information that will allow those who care for and about children to target specific needs more effectively and generate more precise responses. We anticipate that connections made through **MS KIDS COUNT** will springboard action by parents, citizens at large, business leaders, community leaders, legislators, policymakers, agency leaders, faith-based communities, and philanthropic and corporate foundations.

This, the first **MS KIDS COUNT** Data Book to be released from its new home at Mississippi State University's Family & Children Research Unit of the Social Science Research Center, is a *beginning*. Between now and next year's Data Book, we plan to release a series of research briefs to expand topics found in the Data Book and explore topics not yet addressed. Please join us by suggesting topics of interest and reporting successes in your community to the **MS KIDS COUNT** program as we work together to improve outcomes for Mississippi's children and "think of the children first."

Linda H. Southward, MS KIDS COUNT Coordinator



DATA

SAFETY

WELL-BEING

HEALTH

EDUCATIONAL SUCCESS

DATA

EXECUTIVE SUMMARY

The **MS KIDS COUNT** 2007 Data Book highlights key indicators pertaining to children's safety, well-being, health and education, though these sections are not meant to be all-inclusive. While we recognize that these domains are interrelated and critical to children's ability to flourish, in this—our first—**MS KIDS COUNT** publication, we take a closer look at the areas of children's health and safety. One of the primary goals of the **MS KIDS COUNT** 2007 Data Book is to begin community-level dialogue and examination. Another goal is to capture the "picture" of children and families' well-being within individual communities.

Features of the MS 2007 Data Book include an examination of how this "picture" changes over time, how it compares to the nation as a whole and, occasionally, to other southern states. We also determine whether the trends are statistically significant. Another unique aspect of our Data Book that we believe may be helpful is a comparison of our current standings to the National Healthy People 2010 goals.

It is with great pride that we point out legislation and programs in Mississippi that are successful. Within each section, we also highlight news stories and policy considerations with the realization that other evidence-based practices and policies may be even more promising for Mississippi's children than the ones we note. We hope that this publication, along with the 1st annual **MS KIDS COUNT** Summit, will promote discussion of successful strategies statewide.

Below, please find a summary of our primary findings for each section:

SAFETY

The Mississippi Legislature is to be applauded for enacting Mississippi's primary seat belt law (May 2006), as research has shown primary seat belt laws to save lives. Ongoing safety concerns in the state include the lack of seat belt and bicycle helmet use among adolescents, particularly males. Drinking drivers and adolescents who carry weapons also present tremendous challenges. In each of the following points regarding safety, the percentages of male adolescent reports of unsafe behavior are higher than those of females. Mississippi rates are improving on these issues, but still remain high.



The average number of
people per Mississippi
household is

2.6³

EXECUTIVE SUMMARY

- Mississippi 9th- to 12th-grade males were less likely to report wearing safety belts than their female counterparts. Although Mississippi's percentages of reports of safety belt use improved from 1993 to 2003, the percentage who reported infrequent use still remained significantly higher than the percentage for Alabama, with 23.2% of youth reporting they never or rarely wore one in 2003.
- In 2003, Mississippi 9th- to 12th-grade males were less likely to report wearing a bicycle helmet than females. The percentages of Mississippi adolescent reports of bicycle helmet use improved from 1993 to 2003, but the percentage who reported infrequent use still remained significantly higher than the United States and Alabama, with 95.7% of youth reporting they never or rarely wore one in 2003.
- Ninth- to 12th-grade males in Mississippi were more likely to report driving while drinking than females, but females were equally as likely to ride with a driver who had been drinking. For both topics, percentages of adolescent reports in Mississippi improved from 1993 to 2003. Also, the Mississippi percentages were not significantly different than those of the nation as a whole or Alabama in 2003. However, the percentages were still very high that year: 30.9% stated that they rode with a drinking driver, and 12.8% said they had driven while drinking in the past 30 days.
- Mississippi adolescent males were more likely than their female counterparts to report carrying a weapon. Mississippi percentages improved on this topic from 1993 to 2003, and in 2003 Mississippi was not significantly different from the United States or Alabama, with 20% of 9th-12th graders stating they carried a weapon in the past 30 days.
- Mississippi adolescent males were more likely than females to report fighting, though there was improvement in the percentages of reports of fighting in Mississippi from 1993 to 2003. In 2003, 42.4% of males and 19.5% of females reported fighting in the past year.

WELL-BEING

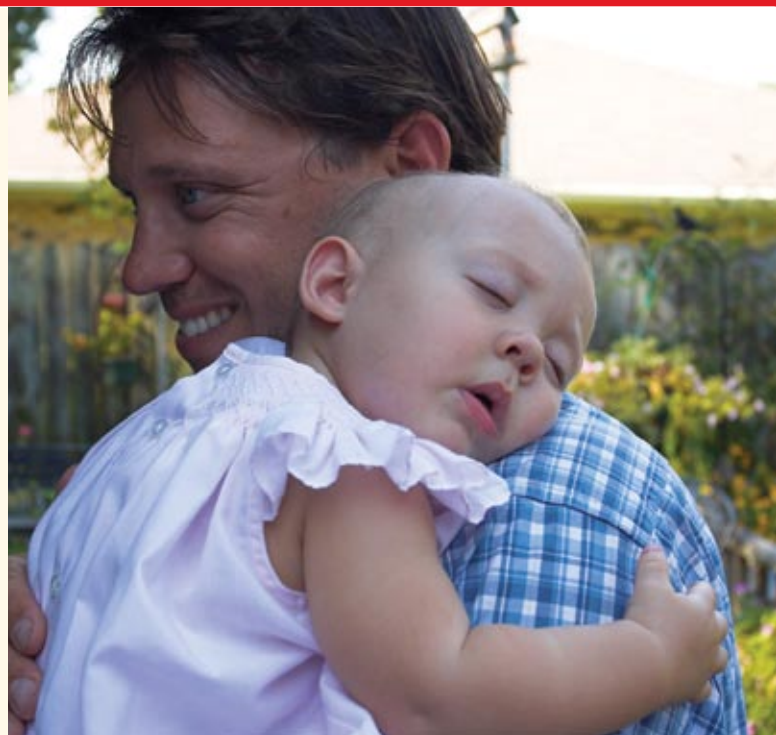
The interconnectedness of family education and structure, full-time employment with a living wage, and child poverty is well-established. These associations are clearly evident in Mississippi, where the interplay of these factors often undermines the economic underpinnings and well-being of children, their families and communities. In this section, we examine Mississippi rates for single-parent families, parental employment and child poverty.

- In 2005, almost half of Mississippi's children lived in single-parent families—more than the surrounding states and the nation as a whole. This number significantly increased from 2000. Mississippi also ranked 49th in 2004 for having a very low percentage of female-headed households receiving child support. Ten percent of Mississippi's children, the highest rate of any state in the country (and twice the national rate of 5%), were being cared for primarily by grandparents in 2005. This equates to approximately 74,000 under the age of 18.

DATA

EXECUTIVE SUMMARY

- Mississippi ranked 50th in the nation in 2005 for having 43% of its children living in a household where no parent had full-time, year-round employment. This percentage was significantly higher than in 2000. Nine percent of children were in low-income homes where no adult held even part-time employment.
- Mississippi leads the nation in child poverty. In 2006, 30% (approximately 220,000 children) were in poverty, compared to 26% in 2000. In 2005, Mississippi had the lowest median family (with child) income of any state in the country.



HEALTH

On many of the health indicators, Mississippi's children are falling far short of the Healthy People 2010 Goals for the nation, as noted throughout this section. Two primary causes are teenage births and the rates of Mississippi babies being born too early and too small. These two important markers need to change in order to improve overall child health. This section also provides an overview of other markers of children's health, including the following: nutritional habits; overweight and obesity; child death and suicide; and alcohol, cigarette and marijuana use. These represent only a sampling of the measures of children's health, but they are nonetheless major influences on the mortality rate of Mississippi's children. Child health is clearly tied to a variety of environmental factors—children's homes and families, schools, peers and communities—and an examination of the impact of each warrants consideration.

- The percentage of babies not seeing their first birthday in Mississippi is the highest in the nation. On average, more than one infant per day is dying in Mississippi. In 2005, 59% of all infant deaths in Mississippi (283 out of 481) occurred during the neonatal period (the first 28 days of an infant's life). Of particular concern is the disparity between rates of Nonwhite infant deaths and White infant deaths, with the Nonwhite infant mortality rate at 15.1 deaths per 1,000 live births (for years 2001-2005), compared to an infant mortality rate of 6.7 for White infants during the same time period. In addition, the percentage of infants being born with low birth weight increased in Mississippi from 2000 to 2004, and Mississippi's percentage was significantly higher than the nation as a whole in 2004.

EXECUTIVE SUMMARY

- There was no significant change in the Mississippi child and teen death rates from 2000 to 2004. In Mississippi, from 1992 to 2001, “other” injuries (including those caused by accidents, fire and burns, and drowning, but not including those caused by motor vehicle crashes) accounted for 31% of all deaths among children ages 1 to 4, followed by motor vehicle crashes (17%). For children ages 5 to 14, other injuries accounted for 28% of all deaths, and motor vehicle crashes accounted for 26%. By the time Mississippi children reach driving age (15 to 19 years old), 43% of deaths are caused by motor vehicle crashes, with homicide (16%), other injuries (12%), and suicide (9%) also claiming lives. In 2004, Mississippi had 181 child deaths and 220 9th- to 12th-grade student deaths, equating to higher than average child and teen death rates in the country. For self-inflicted deaths, in 2003, Mississippi had a significantly lower percentage of 9th- to 12th-grade students than the national average reporting that they had seriously considered suicide (13.5%) and/or made a suicide plan (11.6%).
- Mississippi percentages of reports of tobacco use in 2003 were higher than the nation as a whole on a number of measures. However, recent Mississippi data reveal that current cigarette use among students is on the decline. From 1999 to 2006, the prevalence of current smokers decreased by 43% among Mississippi public high school students and decreased by 65% among public middle school students. In 2003, Mississippi was not significantly different than the nation on a number of measures of alcohol use, with the exception of a higher percentage of students reporting drinking before the age of 13. In 1993, the Mississippi percentage of student reports of recent marijuana use was significantly lower than that of the United States, but by 2003, there was not a significant difference.



- In the years of 1993 and 2003, Mississippi had significantly higher percentages than the United States of 9th- to 12th-grade students reporting they had been sexually active with one or more people in the last three months or that they had been sexually active with four or more people in their lifetime. However, teenage pregnancy rates declined in Mississippi from 1999 to 2005. The Nonwhite pregnancy rate was higher than the White pregnancy rate. Teen births decreased in Mississippi from 2000 to 2004, but in 2004 the state was significantly higher than the United States, Alabama and Georgia. There were 6,543 teen (15-19) births in 2004 in Mississippi.
- Mississippi has the highest percentage of obese citizens in the nation. A lower percentage of Mississippi 9th- to 12th-grade students reported exercising to lose weight or to keep from gaining weight than the nation as a whole in 1999 and 2001, but not in 2003.

MISSISSIPPI'S CHILDREN & FAMILIES

EXECUTIVE SUMMARY

EDUCATIONAL SUCCESS

While Mississippi's schools have shown improvement in recent years, a number of Mississippi's children still attend low- and under-performing schools. The educational attainment of children and youth is a critical and necessary component for improving overall community and economic development, particularly in Mississippi where the percentages of children and adults experiencing poverty are persistently high. In addition, schools must be a safe harbor for optimal learning—free from bullying, violence and weapons. The differences between males and females with respect to fighting and carrying a weapon on school property need to be considered in school programming.

- The overwhelming majority of Mississippi school districts are accredited (95%). In addition, there was an increase between 2003-2004 and 2007 in the percentage of schools classified as superior-performing (Level 5).
- Mississippi had a significantly higher percentage of high school dropouts (9%) than the nation as a whole (7.3%) in 2005. In that same year, Mississippi ranked 45th in the nation for its percentage of children (20%) who lived in a household where the household head was a high school dropout.
- Percentages of student reports of carrying a weapon or fighting at school declined in Mississippi from 1993 to 2003. Males were more likely than females to report carrying a weapon or being in a physical fight on school property. Percentages of students reporting that they had property stolen or damaged at school declined in Mississippi from 1993 to 2003.



In each section, we highlight specific policy considerations for these issues. While some considerations are issue-specific, clearly some cut across multiple domains of child well-being: expanding early education options for Mississippi's families with a public pre-Kindergarten program, expanding earned income tax credits for working families, and increasing opportunities and workforce training for Mississippi adults. In addition, in each section, we mention specific legislation and a number of promising programs around the state that are addressing the needs of Mississippi's children.

Full funding of the Mississippi Adequate Education Program in the 2007 Legislative Session is a step in the right direction, as is the appointment of a commission to address funding for at-risk student populations. Furthermore, Governor Haley Barbour's appointment of an Infant Mortality Task Force (November 2007) is indeed needed and welcomed.

NATIONAL KIDS COUNT INDICATORS: Mississippi

Mississippi consistently faces a number of challenges for improving the overall well-being of children in the state. For the years indicated, Mississippi had the lowest ranking in the nation for 5 of the 10 indicators listed in Figure 1, indicating the highest prevalence of these conditions in the United States. These indicators were low-birth-weight babies; teens not attending school or working; children living in families where no parent has full-time, year-round employment; children in poverty; and children in single-parent families.⁴ For four of the remaining five indicators, Mississippi was still near the bottom, and preliminary estimates using cohort data suggest that the state's dropout rate may be higher than previously reported.^{5,6} Underlying many of the other difficulties for children, poverty is prevalent in Mississippi, with almost one-third of children living in poverty in 2006.⁴ While Mississippi showed improvement from 2000-2004 for teen births, the majority of the statistics reveal an unchanging or worsening situation for children since 2000.*

KIDS COUNT Data Book Indicators: Mississippi

Indicator	Year	Number	Rate of Percentage	Change since 2000*	Rank	Data Book Location
Low-birth-weight babies (less than 5.5 pounds)	2004	4,956	11.6%	Worse	50	Page 53
Infant mortality (per 1,000)	2004	420	9.8	Same	49	Page 53
Child deaths, ages 1-14 (per 100,000)	2004	181	31	Same	45	Page 59
Teen deaths, ages 15-19 (per 100,000)	2004	220	102	Same	48	Page 59
Teen births, ages 15-19 (per 1,000)	2004	6,543	62	Better	49	Page 50
Teens (16-19) who are high school dropouts [∞]	2005	14,000	9%	Better	36	Page 70
Teens (16-19) not attending school and not working	2005	18,000	11%	Same	45 [†]	Page 68
Children living in families where no parent has full-time, year-round employment	2005	321,000	43%	Worse	50	Page 32
Children in poverty	2006	220,000	30%	Worse [‡]	50	Page 34
Children in single-parent families	2005	317,000	47%	Worse	50	Page 30

FIGURE 1

Notes:

The values reported in Figure 1 were taken from the Annie E. Casey Foundation's KIDS COUNT Web site. State-level data are available online at: <http://www.kidscount.org/sld/compare.jsp>. Refer to Appendix B for further information on data sources, definitions and applicable notes for each indicator.

*Change since 2000 judgments were based on statistical significance calculations from the Population Reference Bureau (2007).

[∞]Preliminary estimates from Mississippi cohort analyses are available on pg. 69.

[†]MS tied with 5 other states for the highest % on this indicator.

[‡]Comparisons for this indicator were between 2000 and 2005 percentages (not 2006).

DATA

QUICK REFERENCE GUIDE

Information related to Mississippi child, family and community indicators has been organized for **quick reference**. Look for these key sections throughout the Data Book.

Healthy People 2010 Goals:

Look for this tab

containing relevant national Healthy People 2010 Goals for each indicator. Healthy People 2010 is a set of health objectives for the nation to achieve over the first decade of the new century.

facts:

Look for this section containing state- and national-level facts related to each indicator. Sources for these facts include state and national organizations devoted to providing news and research-based information related to topics featured in this Data Book. See Appendix A for a full listing of specific sources.

key findings:

Look for this section containing an overview of the key data findings for each indicator. Sources for key findings include entities that collect primary and secondary data at the state and national levels on issues related to children. Appendix B provides additional information, including specific data sources, definitions and notes for topic.

NOTE: For the MS KIDS COUNT 2007 Data Book, *statistical significance* was either established by the primary data collection agency or by MS KIDS COUNT using available confidence intervals. Statistical significance indicates that it is statistically unlikely that the relationship occurred by chance. For additional notes about statistical significance determinations, please see the relevant sections of Appendix B.

policy considerations:

Look for this tab containing relevant policy considerations for each indicator. These researched considerations are intended to open discussion and are not exhaustive.



MISSISSIPPI INDICATORS OF CHILD, FAMILY AND COMMUNITY

SAFETY



SAFETY

SAFETY BELT USAGE



Graduated driver
licensing programs can
reduce fatal crashes of
16-year-olds by up to

21%

"In 2007, Mississippi's children, teens, and young adults continue to be overrepresented in traffic crash fatalities, due in part to the low seat belt usage rate among this population."

-Kim Proctor, Director
MS Office of Highway Safety²

Healthy People 2010 Goals:

The national health goal for 2010 is 92% safety belt usage for all ages, which would be up from 69% in 1998. (Objective 15-19)³

"When a crash occurs, unbelted occupants frequently injure other occupants and drivers have more difficulty controlling their vehicle. In addition, children riding with unbelted adults are much less likely to be buckled up, as compared to children riding with belted adults. And the cost of increased deaths and injuries associated with failure to use a safety belt is borne by everyone."

-National Highway Traffic Safety Administration¹

facts:

- For children and young people ages 5 to 24, motor vehicle crashes are the number one cause of death.⁴
- "Of the children ages 0 to 14 years who were killed in motor vehicle crashes during 2005, nearly half were unrestrained." -National Highway Traffic Safety Administration⁵
- Drivers in rural areas are especially vulnerable to motor vehicle fatalities, with twice the death rate from car crashes than urban drivers.⁶
- Enacted by the 2006 Mississippi Legislature, a primary safety belt law went into effect in Mississippi on May 27, 2006. According to the National Highway Traffic Safety Administration, primary safety belt laws allow a citation to be issued if a law enforcement officer simply observes an unbelted driver or passenger. Secondary safety belt laws require an officer to stop or cite a violator for another infraction before issuing a citation for not buckling up.⁶
- Mississippi had 911 traffic fatalities in 2006.⁷
- In 2003, the percentage of Mississippi 9th- to 12th-grade students who reported infrequent seat belt use as passengers was significantly higher than percentages of students in the surrounding states of Alabama, Georgia, and Tennessee.^{8,a,b}

When a safety belt is used,
the risk of fatal injury in a
motor vehicle crash can be
reduced by approximately

50%⁹

SAFETY BELT USAGE

key findings:

SAFETY BELT USAGE

A significantly higher percentage of Mississippi males in the 9th-12th grades reported infrequent use of seat belts as passengers compared to females. Though reported seat belt use rose from 1993 to 2003 in general, 28.3% of males and 18.4% of females still reported in 2003 that they never or rarely wore a seat belt as a passenger.^{8,a,b} [FIGURE 2]

Comparing 1993 and 2003 percentages, Mississippi had a significant improvement in seat belt use among 9th-12th graders. Also, in 1993, the percentage of Mississippi students reporting infrequent seat belt use was significantly higher than the U.S. average; however, in 2003, the percentages were not significantly different, indicating that Mississippi's reports were more closely aligned with those of the nation as a whole. The 2003 national percentage of 9th- to 12th-grade students reporting that they never or rarely wore seat belts as passengers was 18.2%, compared to 23.2% in Mississippi.^{8,a,b} [FIGURE 3]

Notes:

Figures 2 and 3 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbs/

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^b

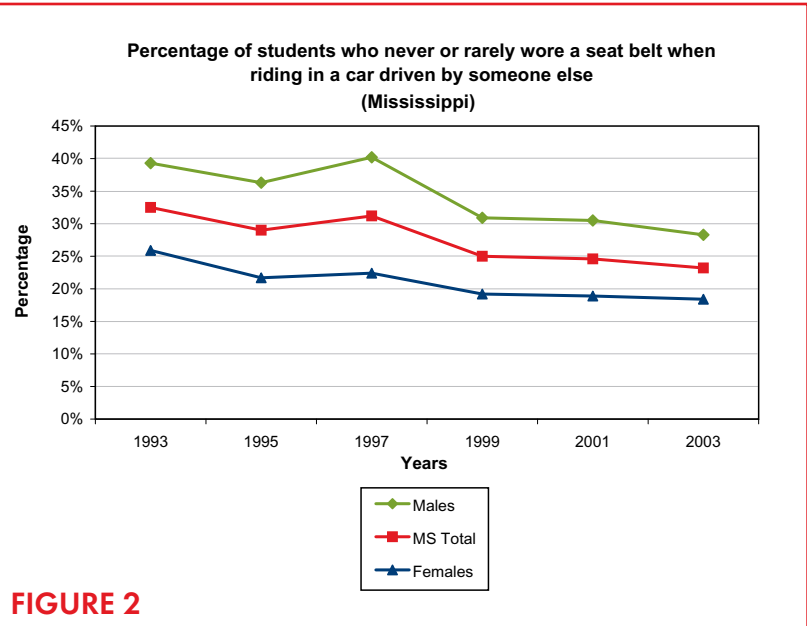


FIGURE 2

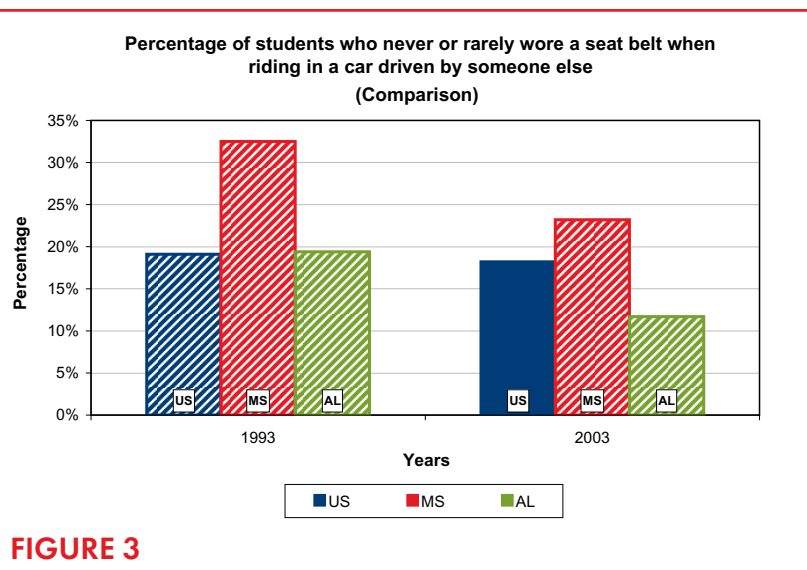


FIGURE 3

policy considerations:

Mississippi's primary seat belt law, enacted May 2006, is saving lives. Seat belt use was already increasing in Mississippi and has increased even more since its enactment. Seat belt use in Mississippi jumped from 60.8% in 2005 to 73.6% in 2006.¹⁰ This is encouraging because approximately 268 lives are saved annually for every percentage point increase.¹¹ Another important step that could be taken to save teen lives would be revisiting Mississippi's graduated driver license law. According to a recent study by Johns Hopkins University, comprehensive graduated driver licensing programs can result in up to a 21% reduction in fatal crashes of 16-year-old drivers.¹² One national health goal is that all states and the District of Columbia adopt a graduated driver licensing model law. (Objective 15-22)³

SAFETY

BICYCLE HELMET USAGE



“Bicycling is a popular recreational activity and a principal mode of transportation for children in the United States, yet about 300 children die and 430,000 are injured annually.”

-Centers for Disease Control and Prevention¹³

facts:

- Wearing a bicycle helmet reduces the risk of serious brain injury by up to 85% and is one of the most important safety measures a child can take.^{13, 14}
- In 2003, the Associate Director of the Brain Injury Association of Mississippi, Freda Arender, noted that Mississippi had 212 child deaths in 2001 from brain injuries resulting from various causes, including bicycle accidents.¹⁵
- Parents' use of helmets and mandatory helmet use laws are two factors that are strongly associated with helmet use by children.¹⁴

Healthy People 2010 Goals:

The national health goal is for 76% of all children aged 1 to 15 years to regularly wear a bicycle helmet by 2010, which would be up from 69% in 1998. (Objective 15-23a)³

A related national health goal is for all states to have laws that require bicycle helmets for bicycle riders. (Objective 15-24)³

“Because children cannot conceptualize what a brain injury is and what it could mean for them and because they are not in control of their surroundings, making helmet use second nature is critical. [Also,]...children often wear helmets that are too big or small or that sit back on their heads, providing little protection. Hopefully, through safety education provided by Safe Routes to School and other prevention programs, the number of children wearing helmets—and wearing them properly—will increase.”

- Cookie Leffler, Safe Routes to School Coordinator
Mississippi Department of Transportation¹⁶

Wearing a bicycle helmet
reduces the risk of serious
brain injury by up to

85%

BICYCLE HELMET USAGE

key findings:

BICYCLE HELMET USAGE

Comparing percentages for 1993 to those for 2003, reported helmet use improved significantly for females, but very little for males. In 1993, 98.5% of females and 97.7% of males reported that they never or rarely wore a bicycle helmet during the past 12 months. In other words, approximately 2% of Mississippi 9th-12th graders reported that they wore a bicycle helmet at least sometimes while cycling. In 2001, the percentage of females who reported infrequent helmet use continued to decrease while the percentage for males increased, leading to a significant difference between the genders in 2003. By 2003, 93.1% of females and 97.4% of males reported infrequent helmet use; therefore, approximately 3% of males and 7% of females reported that they wore helmets at least sometimes. There was a significant difference between the Mississippi 1993 and 2003 percentages overall: 98.0% of 9th-12th graders reported that they never or rarely wore a helmet in 1993, compared to 95.7% in 2003.^{8,a,b} [FIGURE 4]

Comparing Mississippi to Alabama and the nation as a whole, a significantly higher percentage of Mississippi's 9th-12th graders reported infrequent helmet use in both 1993 and 2003, indicating a consistent trend and safety problem.^{8,a,b} [FIGURE 5]

Notes:

Figures 4 and 5 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/^a

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^b

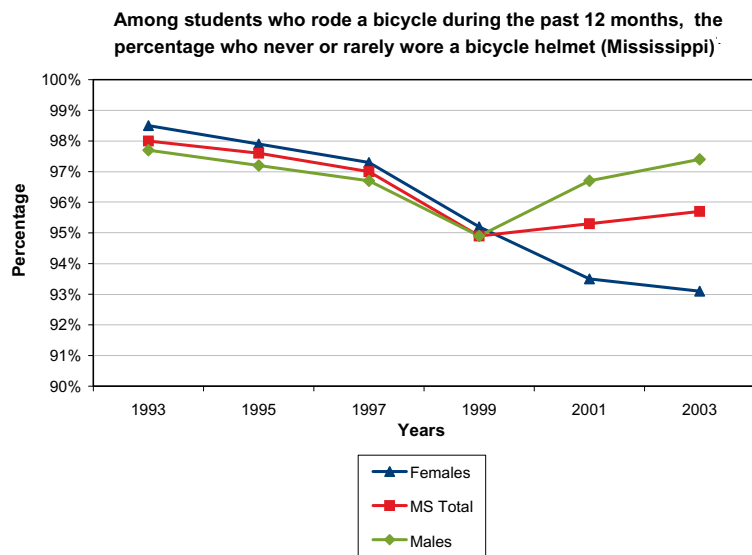


FIGURE 4

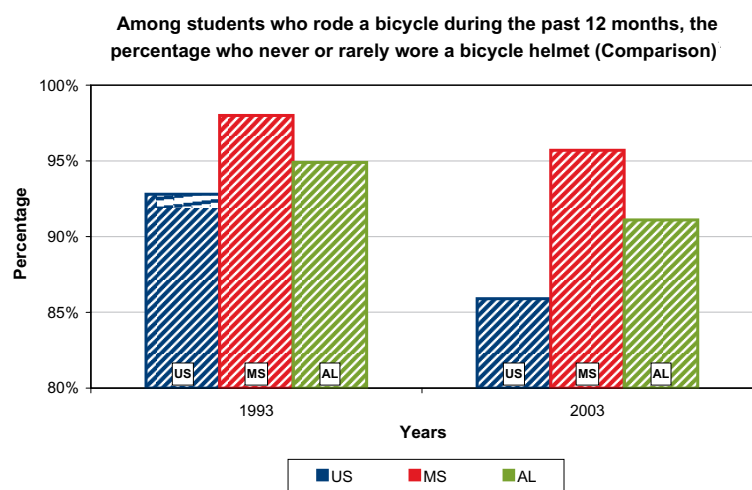


FIGURE 5

policy considerations:

Although Mississippi has a motorcycle helmet law, we do NOT have a bicycle helmet law. While parents and adults may understand the implications of children not wearing bicycle helmets, continued education is important, and studies have noted that this must be coupled with both state and city ordinances.¹⁷

SAFETY

DRINKING DRIVER

"All alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks."

—American Medical Association¹⁸

65%

of underage youth
who drink alcohol
report that they obtain
it from friends or family

Healthy People 2010 Goals:

The national health goal for 2010 is to reduce the proportion of adolescents who report riding with a drinking driver to 30%, which would be down from 33% in 1999. (Objective 26-6)³

facts:

- Sixty-five percent of underage youth who drink alcohol report that they obtain it from friends or family. Only 7% report that they obtain alcohol from retailers, according to research by The Century Council.¹⁹

Children and youth pay a high price for drinking and driving in the United States:

- "In 2002 [nationally], 24% of young drivers who were killed in an automobile accident had been drinking and were legally intoxicated." —Child Trends²⁰
- Older students are more likely to drive while drinking: nationally, the percentage nearly triples from 9th to 12th grade.²⁰
- Nationally, for children ages 0 to 14, 25% of all motor vehicle deaths involve a drinking driver.²¹
- Consistently, from 1993 to 2003, a significantly higher percentage of Mississippi 9th- to 12th-grade males reported driving while drinking compared to females. In 2003, 18.5% of males reported driving while drinking, compared to 7.3% of females. Interestingly, females did not significantly differ from males in the percentage who reported riding with someone who had been drinking.^{8,a,b}

25% of U.S. motor vehicle deaths
for children ages 0 to 14
involve a drinking driver

DRINKING DRIVER

key findings:

DRINKING DRIVER

Comparing reports in 1993 to those in 2003, the percentage of Mississippi 9th-12th graders who drove while drinking or rode with a drinking driver in the past 30 days decreased, and the Mississippi percentages for 2003 were not significantly higher than either Alabama or the nation as a whole. In 1993, 42.6% of Mississippi's youth reported that they rode with a drinking driver, compared to 30.9% in 2003. In 1993, 19.7% of Mississippi's youth reported that they drove while drinking, compared to 12.8% in 2003.^{8,a,b}

[FIGURES 6, 7]

Notes:

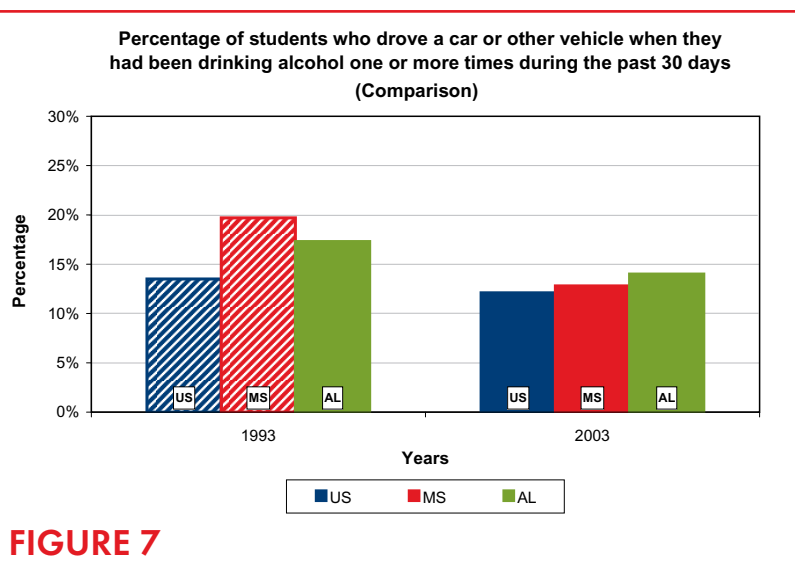
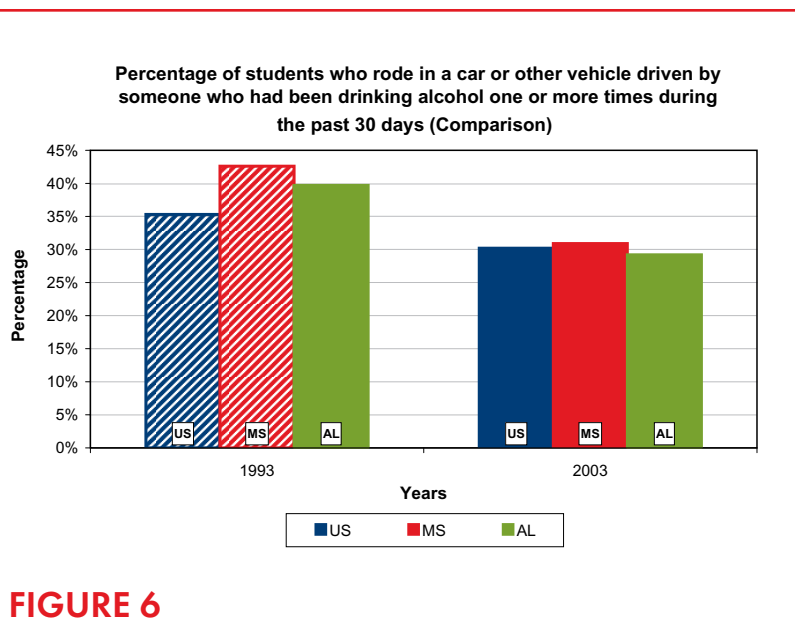
Figures 6 and 7 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbs/

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.⁹

"The power of parenting is the most potent, least appreciated and most underutilized resource available in the struggle to raise children free of drugs and alcohol abuse."

– Joseph A. Califano, Jr., in a May 2007 National Center on Addiction and Substance Abuse Press Release²²



policy considerations:

While it is important to recognize that percentages have progressively decreased over the last decade, the stark reality is that, in 2003, almost one-third of Mississippi's adolescents reported riding with someone who had been drinking alcohol one or more times within the previous month. This is a call for alarm. Revisiting Mississippi's graduated driver licensing legislation and increasing public health and media campaigns to educate parents, communities and professionals are important considerations in saving young lives.

SAFETY

YOUTH VIOLENCE: Carrying a Weapon & Fighting

“Violence is a significant—but largely preventable—cause of death and injury for young Americans and contributes to stark health disparities for racial and ethnic minorities.”

-CDC, Public Health Law Program²³

14%

of deaths for U.S. teens
ages 15 to 19 in 2003
were homicides

Healthy People 2010 Goals:

The national health goal for 2010 is to reduce physical fighting among adolescents to 32%, which would be down from 36% in 1999. (Objective 15-38)³

facts:

- Mississippi is one of 12 states that has enacted laws preventing persons from intentionally, knowingly, and/or recklessly providing firearms to minors. However, in Mississippi, this law applies to handguns only.²⁴
- Despite a downward trend (Figure 8), clearly too many weapons are in the hands of Mississippi's young people, increasing the danger associated with minor disagreements and common accidents.
- Nationwide, for teens 15-19 years of age, 14% of all deaths in 2003 were homicides.²⁵
- In 2005, Hispanic and Black youths were more likely to report being in a physical fight than White youths.²⁶
- In 2005, approximately one-third of U.S. students who reported carrying a weapon stated it was a gun.²⁵

20%

of Mississippi 9th- to 12th-grade students in 2003 reported that they carried a weapon on one or more of the past 30 days

YOUTH VIOLENCE: Carrying a Weapon & Fighting

key findings:

CARRYING A WEAPON

From 1993 until 2003, the percentage of Mississippi males in the 9th-12th grades who reported carrying a weapon in the past 30 days was much higher than the percentage of females. In 2003, 34.2% of males made such a claim, compared to 6.8% of females. In 1993, a higher percentage of Mississippi students (28.1%) reported carrying a weapon, compared to the U.S. average (22.1%). However, between 1993 and 2003, there was a significant decline in the percentage of Mississippi students who reported carrying a weapon (28.1% to 20.0%), and in 2003, the Mississippi percentage was not significantly different than the national average.^{8,a,b} [FIGURES 8, 9]

Notes:

Figures 8 and 9 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^b

"Risk factors that predict violence by youth include substance abuse by the youth, conflict and abuse in the home, harsh or inattentive parenting, antisocial and delinquent peers, and neighborhoods where crime and drug use are prevalent. Youth who are involved in physical fighting are also often engaged in other high risk activities such as illegal drug use, binge drinking, carrying weapons, and having unsafe sex."

-Child Trends²⁶

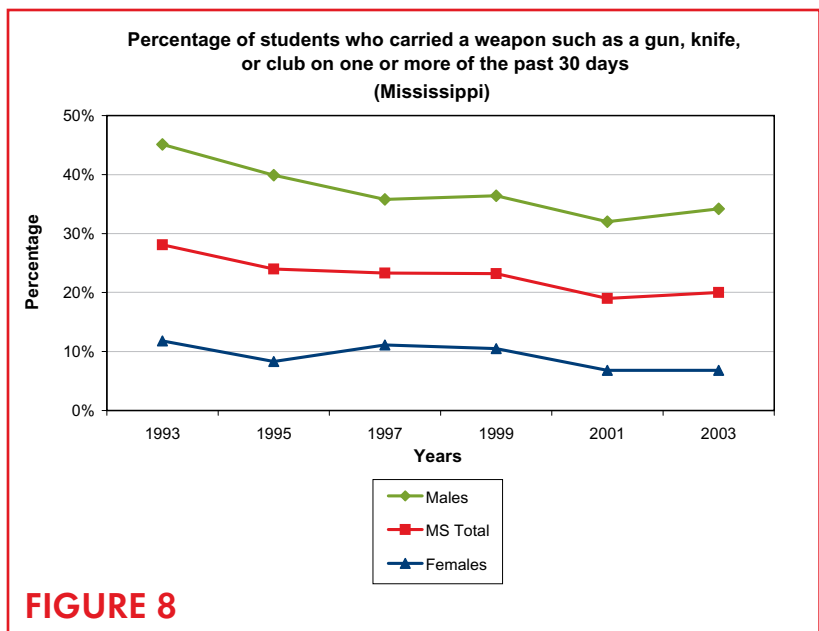


FIGURE 8

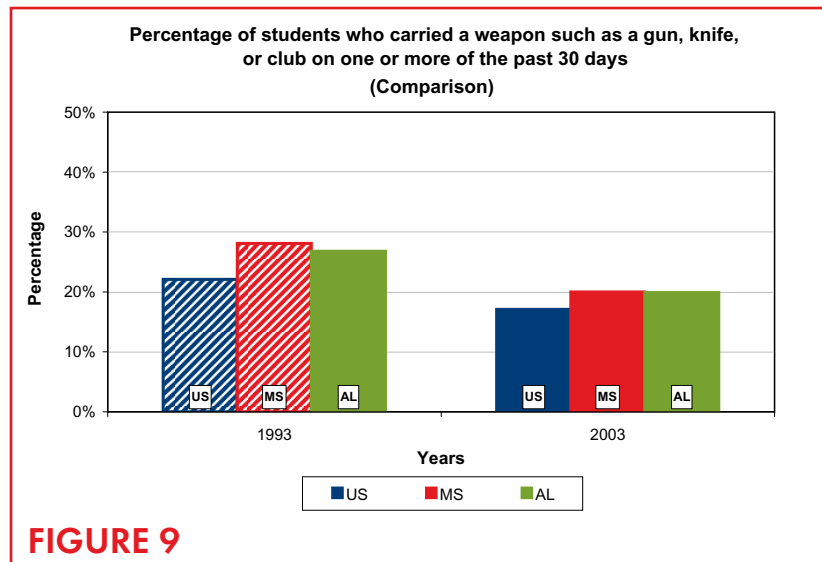


FIGURE 9

SAFETY

YOUTH VIOLENCE: Carrying a Weapon & Fighting

key findings:

FIGHTING

Gender differences were also observed among Mississippi students for the percentage who reported being involved in physical fights during the past 12 months. A higher percentage of males than females reported being in a physical fight each year they were surveyed between 1993 and 2003. Overall, Mississippi student reports of physical fighting have decreased between 1993 (39.3%) and 2003 (30.6%). However, these numbers still remain high: in 2003, 42.4% of males and 19.5% of females reported being involved in a physical fight, indicating the potential danger if weapons were introduced. Percentages for reported fighting among youth in the United States as a whole were not significantly different than those for Mississippi in 1993 or 2003.^{8,a,b}

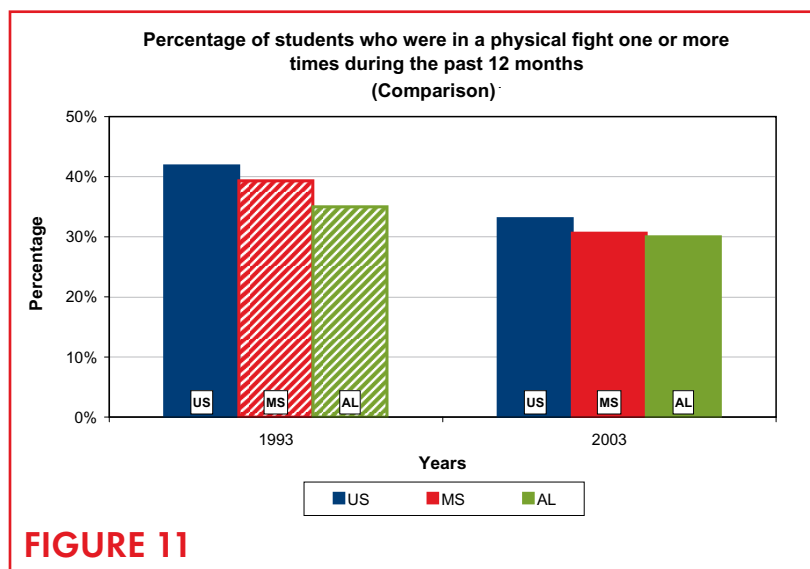
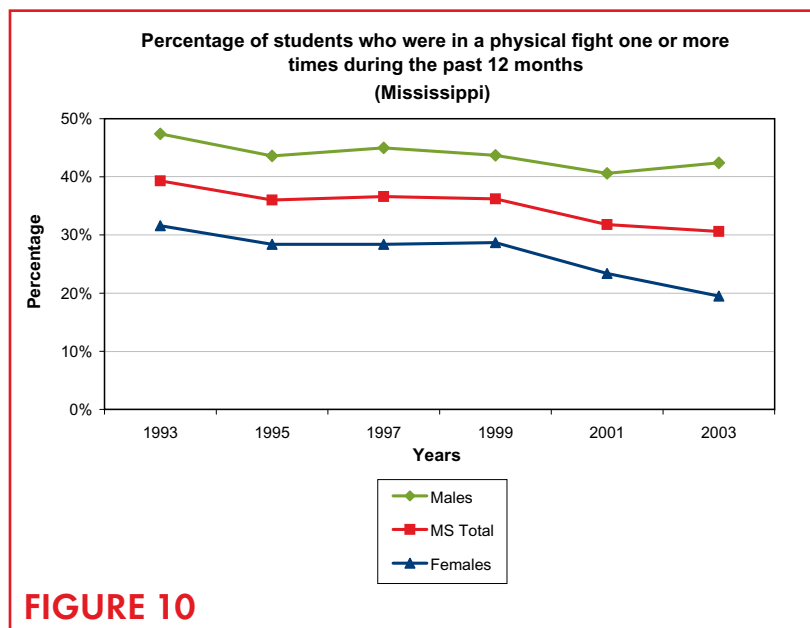
[FIGURES 10, 11]

Notes:

Figures 10 and 11 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^b



policy considerations:

As there are multiple determinants of the dangers of firearms to children, such as firearm storage, types of firearms owned (i.e., handgun vs. shotgun), ages of children in the home, and family members' histories of gun ownership, accordant manifold interventions are needed.²⁷ Public health, mental health and health care providers, as well as educators, are all important resources to parents, families and communities for information regarding gun safety and firearm access restrictions for children of all ages. Research is needed on the types and locations of fatalities and firearm-related injuries among all Mississippi children and on approaches to tailored messages for parents and caregivers, particularly focusing on gender differences.



WELL-BEING

SINGLE-PARENT FAMILIES



Family composition has been changing in America for many years. Several types of families are particularly vulnerable to financial and emotional burdens, as the responsibility for the care of children falls on one parent or even a grandparent. Many families struggle to raise their children without the benefit of child support, increasing strain. Due to time and physical constraints, single parents and grandparents may find it difficult to supervise children, offer support, arrange activities, and take an active part in their child's or grandchild's education.^{1, 2}

In 2005,
Mississippi
had the
highest
percentage
of children in
single-parent
families in the
nation

facts:

- Single-mother families in the United States are in poverty at 4 to 5 times the rate of families with married couples.³
- Nationally, in 2004, 88% of children living in two-parent households had at least one parent who was employed full-time, year-round; this was true for only 47% of children living in single-mother households.⁴
- Children of single-parent families fare worse than those of two-parent families on a number of measures of child well-being, including academic achievement, teen pregnancy, and emotional health.⁵
- When Mississippi's percentage of children in single-parent families in 2005 is compared to other states', we rank 50th, indicating that we had the highest percentage of children in single-parent families in the nation.^{6, a, e}

policy considerations:

Given the link between a family's single-parent status and its income level, strategies for reducing the incidence and prevalence of poverty among single-parent families are important, particularly in Mississippi where so many children and families are affected. Mississippi currently ranks 50th nationally on unemployment, with 6.4% of the labor force being unemployed.⁷ Among Mississippi counties, the monthly rate (October 2007) ranged from a low of 3.9% (Rankin) to a high of 12.7% (Clay).⁸ The recognized link between economic opportunity and earnings, for males in particular, has been shown to affect marriage rates, and in turn, potentially offer more economic stability to many children.

47% of Mississippi's children lived in single-parent families in 2005

SINGLE-PARENT FAMILIES

key findings:

SINGLE-PARENT FAMILIES

In 2005, Mississippi led other southern states and the nation as a whole in its percentage of children living in single-parent families. In that year, Mississippi had 47%, almost half, of its children living in families headed by one parent, as compared to a national average of 32%. The percentage of children living in single-parent families in Mississippi significantly increased from 2000 (43%) to 2005 (47%). In 2005, Mississippi had a significantly higher percentage of children living in single-parent families than Alabama and Georgia, as well as the nation as a whole.^{6,a,e,l} [FIGURE 12]

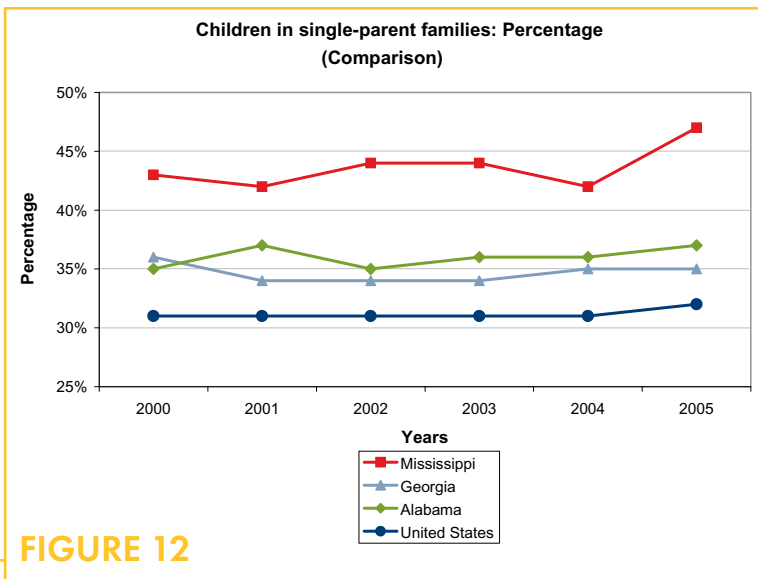


FIGURE 12

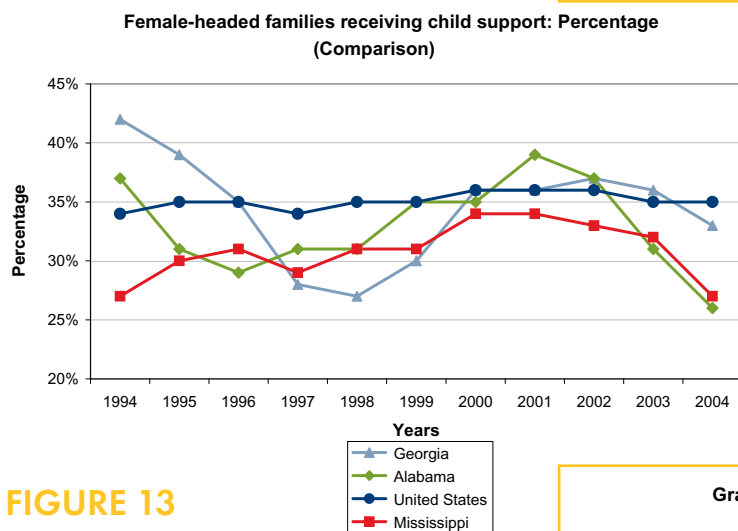


FIGURE 13

In 2004, Alabama ranked 50th for having the lowest percentage of female-headed families receiving child support of any state in the nation; Mississippi ranked 49th. In 2004, just 26% of Alabama's female-headed families received child support, as did 27% of Mississippi's. Georgia, at 33%, was closer to the national average of 35%.^{6,b,f} [FIGURE 13]

In 2005, Mississippi had the highest percentage of children under 18 whose primary care was provided by grandparents. Ten percent, or 74,000, of Mississippi's children lived in this arrangement, compared to 8% in Alabama, 6% in Georgia, and 5% in the United States as a whole.^{6,a,g}

[FIGURE 14]

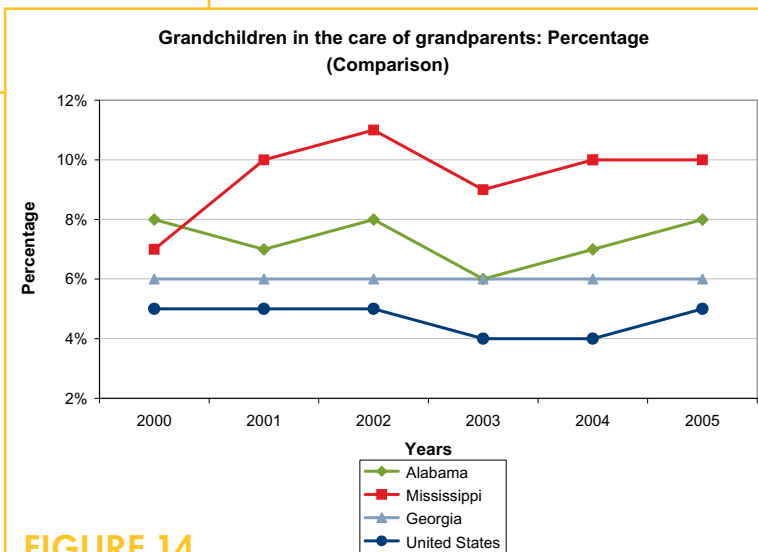


FIGURE 14

WELL-BEING

PARENTAL EMPLOYMENT

Secure employment, though not always sufficient to lift a family out of poverty, is an important predictor of children's stability and well-being. Family income is often associated with children's success in school, overall health, access to health insurance, and financial future.⁴

69,000
children in
Mississippi lived
in a **low-income**
household with
no working
adult in 2005

facts:

- Nationally, 87% of children at or above the poverty line in 2004 lived with at least one parent who was employed full-time, year-round, compared to 33% of children who were below the poverty line.⁴
- In 2004, Black children in the U.S. were more likely than White or Hispanic children to not have at least one parent with full-time, year-round employment.⁴
- Parental unemployment may predispose children to physical and mental health problems.⁹ Furthermore, adolescents who have an unemployed parent are less likely to plan for college after high school and are less likely to hold a part-time job while in school.¹⁰

43%

of children in Mississippi in 2005
lived in a family where no parent had
full-time, year-round employment

PARENTAL EMPLOYMENT

key findings:

PARENTAL EMPLOYMENT

In 2005, Mississippi had the highest percentage in the nation of children living in families where no parent had full-time, year-round employment. Forty-three percent of children in Mississippi lived in a family where no parent had full-time, year-round employment; this compares to a national percentage of 34%. A significantly higher percentage of children in Mississippi lived in households where no parent had full-time, year-round employment in 2005 (43%) than in 2000 (36%).^{6,c,h,i} [FIGURE 15]

In 2005, Mississippi and West Virginia had the highest percentages (9%) of children living in low-income households where no adult held even part-time employment, compared to a national average of 5%. Nine percent equates to 69,000 children in Mississippi in 2005 who were living in a low-income household without a working adult.^{6,a,i} [FIGURE 16]

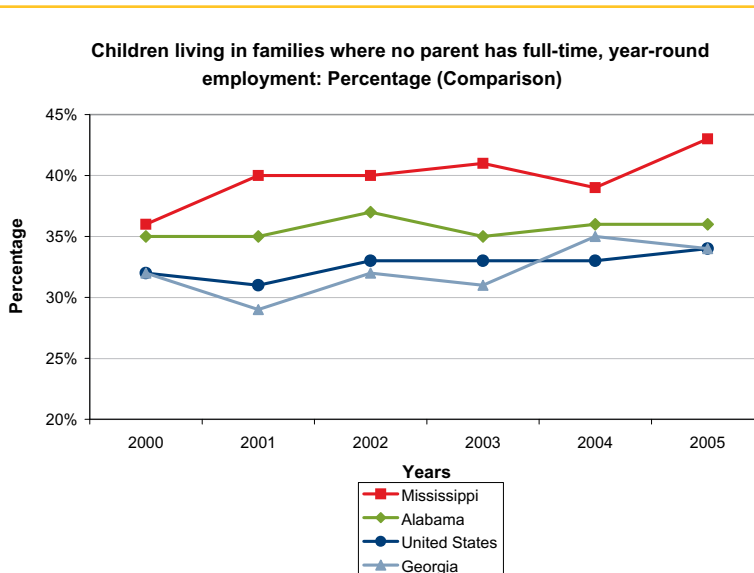


FIGURE 15

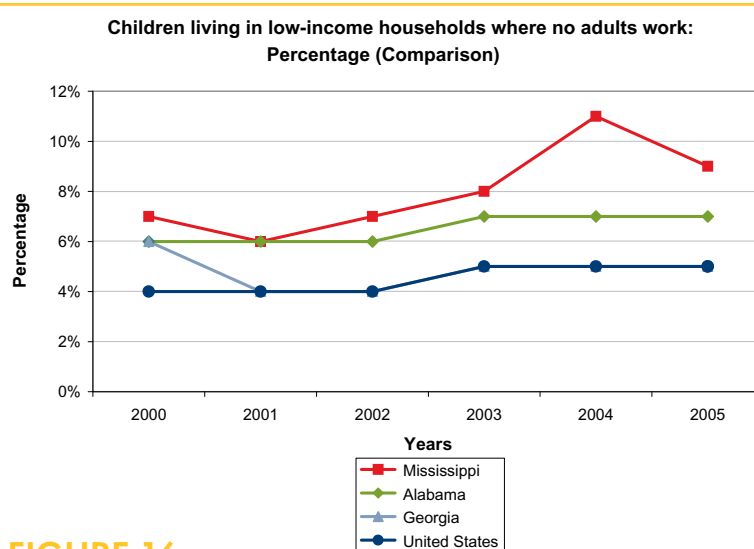


FIGURE 16

policy considerations:

In 2005, Mississippi had the highest rate in the nation of children living in families where no parent had full-time, year-round employment. With family income so profoundly affecting the development and well-being of children, policies are needed that link economic development with job availability and job stability for low-skill workers. Furthermore, child care options must be expanded for working families.¹¹ Mississippi is one of just a few states that does not have a public pre-kindergarten program, despite the evidence-based benefits of providing quality early education, particularly among disenfranchised populations.¹² School readiness is another evidence-based way to decrease the achievement gaps of Mississippi's children at the beginning of their educational path.

WELL-BEING

CHILDREN IN POVERTY



"Nearly 13 million children in the United States—17% of all children—live in families with incomes below the federal poverty level—\$20,650 a year for a family of four. Research shows that, on average, families need an income of about twice that level to cover basic expenses. Using this standard, 39% of children live in low-income families. Most of these children have parents who work, but low wages and unstable employment leave their families struggling to make ends meet. Poverty can impede children's ability to learn and contribute to social, emotional, and behavioral problems. Poverty also can contribute to poor health and mental health. Risks are greatest for children who experience poverty when they are young and/or deep and persistent poverty."*

- National Center for Children in Poverty
Columbia University Mailman School of Public Health¹³

facts:

- Many rural children, particularly in the South, live in poverty. From 2005 to 2006, U.S. metropolitan areas experienced a 2.7% decrease in the number of people living in poverty, whereas nonmetropolitan areas experienced a 6.2% increase over the same time period.¹⁴
- Not only did Mississippi lead the southern states in 2006, it had the highest child poverty rate of any state in the nation.^{6,c,j}
- "The child poverty rate is widely used as an indicator of child well-being since growing up in poverty often compromises the future health status and educational attainment of children. Changes in child poverty signal important changes in children's quality of life and future outcomes." -The Carsey Institute¹⁴
- In 2006, children in poor families were most likely under age 6, living with a single mother, and Black or Hispanic.¹⁵
- Children who are raised in poverty are more often exposed to environmental risk factors that may affect social, emotional and biological development. Consequently, overall health, mental health, and academic outcomes for children in poverty are not as good, and poor children more often engage in dangerous health-related behaviors as adolescents.¹⁵
- The effects of poverty are the most profound when children experience it while they are young and/or if they experience continual poverty. Nationally, approximately 20% of Black children ages 0 to 5 in 1987 lived in poverty for at least nine years during the years of 1987-1996.^{13, 16}
- The State Children's Health Insurance Program (SCHIP) provides health insurance for children in working families whose income is too high to qualify for Medicaid but too low to afford private insurance. Mississippi set the maximum SCHIP eligibility level at 200% of the federal poverty level and identified 129,547 low-income families with 256,177 children. Yet, only 60,000 are currently enrolled. - *The Clarion Ledger*, May 9, 2007¹⁷

*Estimates range from 17% to 18%, depending on the survey. The Current Population Survey estimates the U.S. child poverty rate at 17%, while the American Community Survey estimates it at 18%. Reference is made to both percentages in this section.

220,000

children under 18 in Mississippi in 2006 were living in poverty

CHILDREN IN POVERTY

key findings:

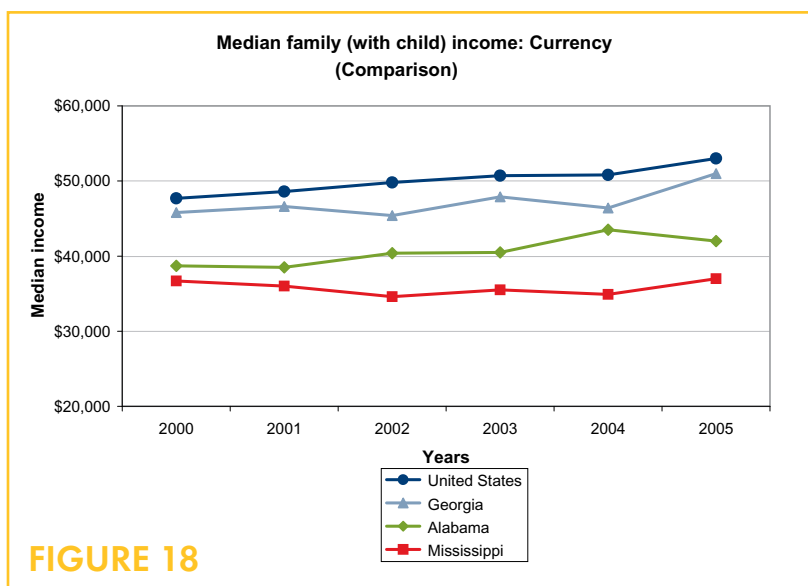
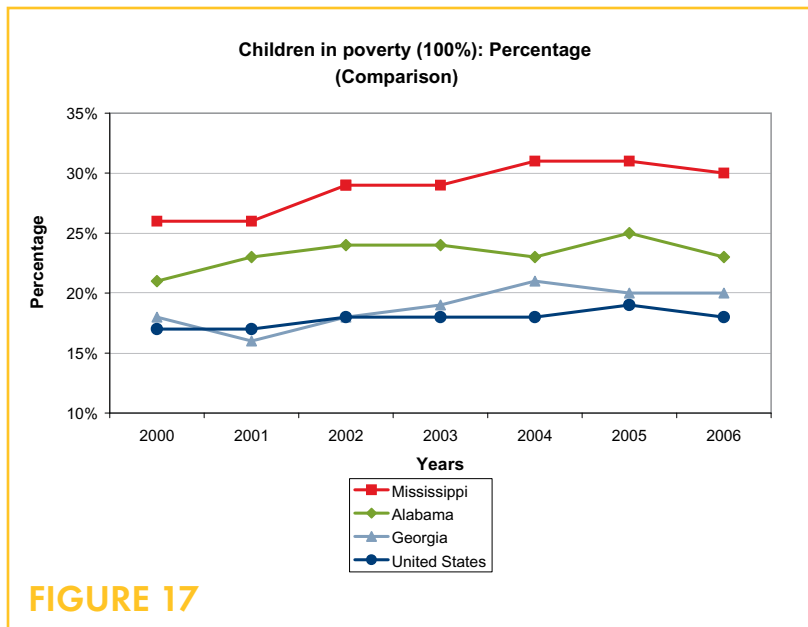
CHILDREN IN POVERTY

Mississippi leads other southern states and the nation as a whole in its percentage of children living in poverty. In 2006, 30% (220,000) of Mississippi's children under the age of 18 were in poverty, compared to a national average of 18%. While 2006 data were available online, calculations obtained from the Population Reference Bureau were for 2005. Therefore, we provide comments for the year of 2005. In 2005, Mississippi had a significantly higher percentage of children in poverty than Alabama, Georgia, and the United States as a whole. Furthermore, there was a significant increase between 2000 and 2005 in the percentage of Mississippi children in families below the poverty level. Twenty-six percent, or 199,000 children, were living in poverty in Mississippi in 2000, compared to 31%, or 226,000 children, in 2005.^{6,c,j,l} [FIGURE 17]

Mississippi had the lowest median family (with child) income of all 50 states in 2005, \$37,000 compared to a U.S. median of \$53,000.^{6,a,k} [FIGURE 18]

"Research is clear that poverty is the single greatest threat to children's well-being."

- National Center for Children in Poverty
Columbia University
Mailman School of Public Health¹³



policy considerations:

There are 3,141 counties in the United States. Of the 100 U.S. counties with the highest child poverty rates, 22 are located in Mississippi.¹⁸ Of the 82 counties in Mississippi, only 2 have lower child poverty rates than the national average of 17%. Forty Mississippi counties have child poverty rates over 30%; of these, 10 have child poverty rates over 40%.^{19,d,m} Consequently, Mississippi ranks 50th in the nation on child poverty.⁶ Expansion of the Earned Income Tax Credit has been shown to be an effective means of assisting low- and moderate-income families and decreasing poverty rates at both the state and national levels.²⁰ In addition, bringing together public, private, and faith-based leaders from the state and local levels to determine specific policies for decreasing child poverty is a first step. Furthermore, an examination of where poverty exists and what services families may be eligible for, but not receiving, is crucial for improving outcomes for children and their families.

WELL-BEING

CHILDREN IN POVERTY



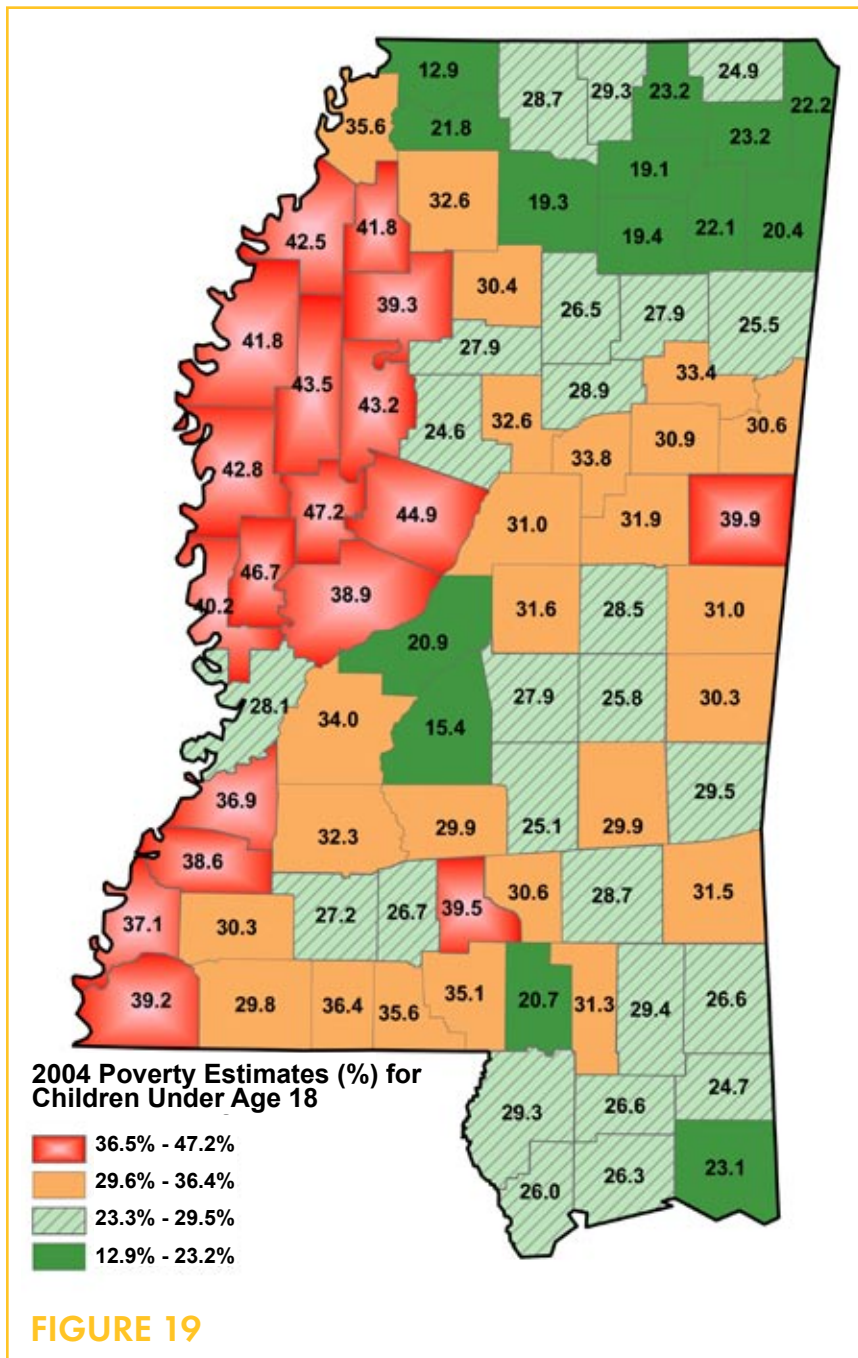
"Whenever there is money-related stress in a family unit, the child is always the first to suffer. Poverty is a crippling thing for Mississippi. Many times it is the reason children do not have a higher self-esteem, contributing to their ability to have poor attendance in schools, which contributes to their making poor grades and leads them to develop poor health habits. Through education this paradigm can be broken."

-Joel B. Waters

Executive Director

Big Brothers/Big Sisters
of Mississippi

as quoted in *The Clarion Ledger*
December 4, 2005²¹



Source:

U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE).^d

Nearly **13 million children** in the United States—17% of all children—live in families with incomes **below the federal poverty level**¹³



HEALTH

789123456789123456789
891234567891234567891
912345678912345678912



HEALTH

DIET, OVERWEIGHT & PHYSICAL ACTIVITY



As noted by the American Academy of Pediatrics, reductions in the consumption of fruits, vegetables and fiber, coupled with increases in the consumption of foods high in fats and sugar, are part of the problem that has now become known as the “obesity crisis.” These trends are affecting children at younger ages each year. Furthermore, engagement in physical activity, an important counterbalance to overweight and obesity, has waned among children.¹

Only **20%**
of high school students
nationwide **consume**
5 or more servings of
fruits and vegetables
per day

“It is impossible to ignore the fact that a childhood obesity epidemic looms large and food-related battles are being waged in virtually every household in America.

Given that our children’s nutritional fortitude is at risk, it’s high time we focus our efforts on planting the seeds of nutritional success early and start teaching the youngest of children healthy eating habits.”

-Dr. Laura Jana, MD, FAAP²

facts:

- Participation in school sports may be linked with parental education. Forty-two percent of 10th graders whose parents did not complete high school participated in school sports in 2004, compared with 73% of 10th graders whose parents attended graduate school.³
- Of children born in 2000, 1 in 3 will develop diabetes in their lifetime. As a result of overweight and obesity, Type 2 diabetes has become more prevalent among children. Other health problems associated with childhood obesity include high blood pressure, high cholesterol, and adult obesity.⁴
- Just 20% of high school students nationwide consume 5 or more servings of fruits and vegetables per day.⁴
- “Children ages six to 11 were more than two and a half times as likely to be overweight in 2003-2004 as they were in 1976-1980 (19 percent versus 7 percent, respectively). During the same time period, the percentage of adolescents ages 12 to 19 who were overweight tripled from 5 percent in 1976-1980 to 17 percent in 2003-2004.” -Child Trends⁵
- Ninety-one percent of the 3,048 parents who participated in a *Consumer Reports* magazine poll said that childhood obesity is a problem. However, half of the parents whose children’s body mass indices indicated they were overweight stated that their children were an appropriate weight.⁶
- In spring of 2007, Mississippi enacted a law to ensure 150 minutes

1 in 3

children born in 2000
will develop diabetes
in their lifetime

DIET, OVERWEIGHT & PHYSICAL ACTIVITY



Healthy People 2010 Goals:

The national goal is to increase the proportion of senior high schools that require daily physical education for all students from 5.8% (2000) to 14.5% (2010). (Objective 22-8b)⁹

Another national goal is to reduce the proportion of children and adolescents, aged 6 to 19 years, who are overweight or obese from 11% (1988-1994) to 5% by 2010. (Objective 19-3c)⁹

Another national goal is to increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables from 3% (1994-1996) to 50% by 2010. (Objective 19-6)⁹

of exercise and 45 minutes of health education per week for elementary and junior high students, effective fall 2007. Furthermore, food preparation regulations that promote health and fitness must be adopted by the Mississippi Department of Education by March 2008. - *The Clarion Ledger*, April 16, 2007⁷

- The percentage of Mississippi students who reported that they ate less food, fewer calories, or foods low in fat to lose weight or to keep from gaining weight during the past 30 days was significantly lower than the U.S. percentage in 2003.^{8,a,q}
- In 2003, there was a significantly lower percentage of Mississippi 9th- to 12th-grade students reporting that they engaged in the following dietary behaviors than for the nation as a whole: drinking 100% fruit juice in the past week; eating fruit, green salad, carrots or other vegetables during the past week; or drinking three or more glasses of milk during the past week.^{8,a,q}
- In 2003, compared to the national average, a significantly higher percentage of Mississippi 9th- to 12th-grade students reported they had 1) not participated in any vigorous or moderate physical activity during the past seven days or 2) watched three or more hours per day of TV on an average school day.^{8,a,q}
- In 2003, compared to the national average, a significantly higher percentage of Mississippi 9th- to 12th-grade students reported they had attended physical education classes on one or more days in an average week when they were in school.^{8,a,q}

HEALTH

DIET, OVERWEIGHT & PHYSICAL ACTIVITY

key findings:

OVERWEIGHT

Southern states struggle most with obesity, and Mississippi is the most obese state in the nation. In 1999, 2001 and 2003, Mississippi had a significantly higher percentage of 9th-12th graders who were overweight (based on self reports of height and weight) compared to the nation as a whole. However, Mississippi and Alabama did not significantly differ on the percentage of students who were overweight in those years. For the same years, a significantly higher percentage of Mississippi 9th- to 12th-grade males were overweight than females.^{8,a,q} [FIGURES 20, 21]

Notes:

Figures 20-23 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/^a

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^q

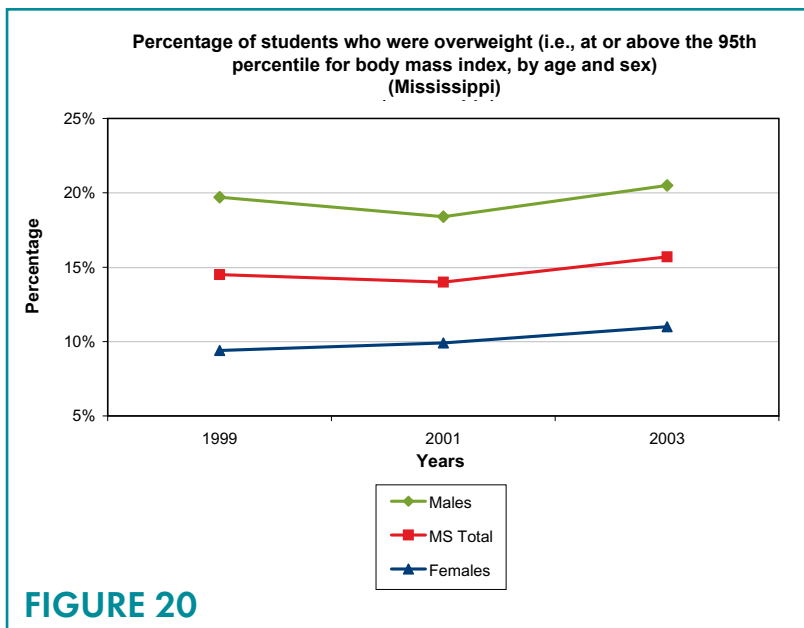


FIGURE 20

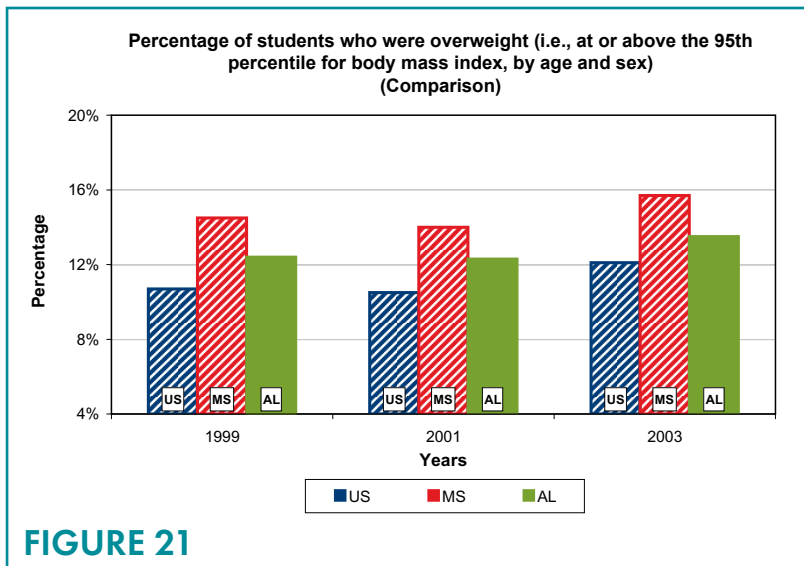


FIGURE 21

policy considerations:

The interconnectedness of diet and exercise are well established as strong determinants of overweight and obesity. The dimensions influencing diet and exercise must be addressed early in a child's life in order to lay a foundation for healthy life choices and to sustain these throughout the life course.

According to a 2006 survey of Mississippians by Kolbo et al., approximately 95% think childhood obesity is a serious problem in Mississippi. In addition, Mississippians display stronger support for the following public policies than do adults nationally: laws requiring BMI assessments for school-age children, increased physical activity for school children, and limited vending machines in schools.¹⁰

17% of adolescents ages 12 to 19 in 2003-2004 were overweight⁵

DIET, OVERWEIGHT & PHYSICAL ACTIVITY

key findings:

DIET

In 1999, Mississippi had a significantly lower percentage of 9th- to 12th-grade students than the nation as a whole reporting that they had eaten five or more servings of fruits and vegetables each day for the past seven days. Mississippi had a higher percentage than Alabama in 1999, 2001, and 2003, but was no longer significantly different than the United States in 2001 and 2003. During the time period of 1999-2003, there were no significant changes in the percentage of Mississippi students reporting daily consumption of five or more servings of fruits and vegetables.^{8,a,q} [FIGURE 22]

PHYSICAL ACTIVITY

In 1999 and 2001, there was a significantly lower percentage of Mississippi 9th- to 12th-grade students reporting that they had exercised to lose weight or keep from gaining weight during the past 30 days, compared to the national average. Mississippi was not significantly different than Alabama in 1999, 2001, or 2003, and Mississippi was not significantly different than the United States as a whole in 2003.^{8,a,q} [FIGURE 23]

"A child with one obese parent has a 3-fold risk of becoming obese...and a 13-fold risk if both parents are obese."

-Child Obesity Action Network¹¹

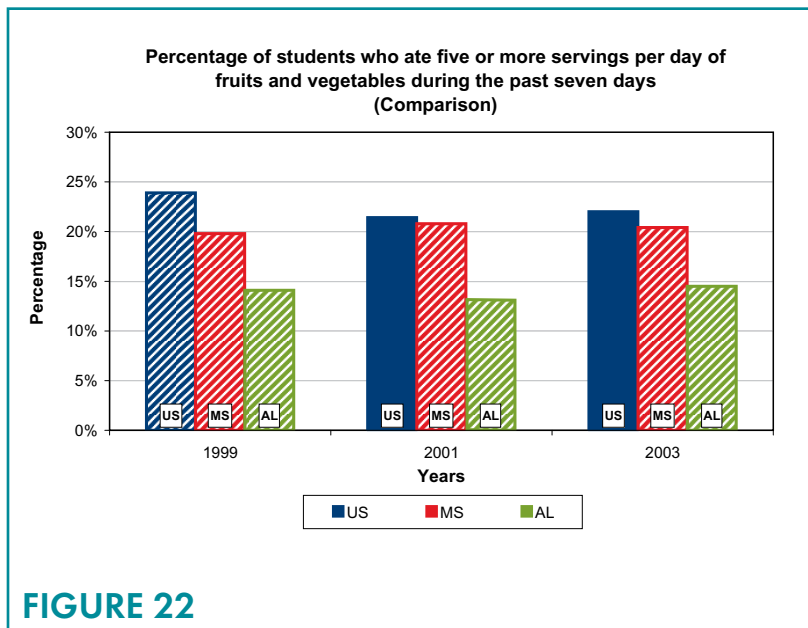


FIGURE 22

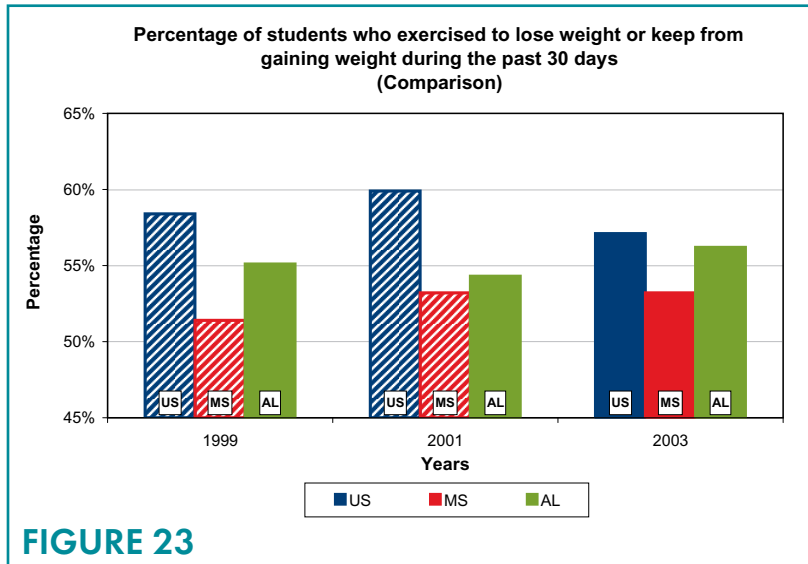


FIGURE 23

Wellness programs/campaigns for parents, teachers and staff who care for children in K-12 and preschool environments should be considered. Promoting healthy habits (i.e., nutrition and exercise) in the environments where children are likely to spend most of their waking hours (schools, child care and neighborhood facilities) is crucial. The "Let's Go Walkin' Mississippi" campaign is clearly a step in the right direction. Campaigns specifically targeted to Mississippi's children and adolescents are important as well, whether through Facebook, YouTube, My Space, blogs, radio, concerts, churches or other venues.

Mississippi should also avail itself of federal dollars to combat childhood obesity. The Centers for Disease Control and Prevention's program for state-based initiatives and physical activities does not have a grant in Mississippi, despite our high rates of childhood obesity and overweight.¹²

HEALTH

TOBACCO, ALCOHOL & MARIJUANA USE



*The use of marijuana, alcohol, or cigarettes is illegal for youths under the age of 18, and each of the three substances poses a health hazard for children. The use of one of these substances is often associated with the use of additional prohibited substances, as well as other risky behaviors. All three substances are especially worrisome because of the risk of addiction. Each carries potentially lethal risks and is associated with long-term health problems. Exposure to any of these substances at an early age increases the likelihood for harm.*¹³⁻¹⁸

“In 1998, Mississippi initiated one of the few well-funded tobacco prevention programs in the nation. During the past seven years, this state has experienced profound reductions in the prevalence of youth cigarette smoking. Given that almost 90% of adult smokers smoked their first cigarette before the age of 18, these and continuing improvements will greatly reduce the short- and long-term health impacts of cigarette smoking in Mississippi.”

—Robert McMillen, PhD
Social Science Research Center
and Department of Psychology
Mississippi State University¹⁹

facts:

- From 1993 to 2003, the percentage of Mississippi students reporting that they had at least one drink of alcohol on one or more of the past 30 days significantly decreased from 47% to 41.8%.^{8,a,q}
- Alcohol abuse has been linked with fighting, impaired driving, academic problems, liver disease, cancer, cardiovascular disease, and psychiatric problems.²⁰
- Mississippi, Tennessee, and Utah tied for the lowest percentage of “binge drinking” among 12- to 17-year-olds (8%) in 2003-2004. This rate can be compared to the national average of 11%. Montana had the highest (17%).²¹
- The percentage of Mississippi 9th- to 12th-grade students who reported that they had ever tried cigarette smoking—even one or two puffs—significantly decreased from 1993 (75.9%) to 2003 (65.6%).^{8,a,q}
- Smoking cigarettes is associated with increased blood pressure, respiratory problems, tooth decay, gum disease, poor immune function, and cancer.²²
- Children are more responsive than adults to tobacco advertising, which has often contained cartoon characters, such as Joe Camel. As much as one-third of underage smoking can be attributed to tobacco marketing.²²

The prevalence of current smoking
among Mississippi public middle
school youth decreased by

65%
from 1999 to 2006^{23,b}

TOBACCO, ALCOHOL & MARIJUANA USE

Healthy People 2010 Goals:

The national goal is to reduce tobacco use (cigarettes in the past month) by students in grades 9 through 12 from 35% (1999) to 16% by 2010. (Objective 27-2b)⁹

Another national goal is to increase the number of states that suspend or revoke retail licenses for violations of laws prohibiting the sale of tobacco to minors from 34 states (1998) to all states and the District of Columbia by 2010. (Objective 27-15)⁹

A related national goal is to increase the average age of first use of alcohol in adolescents ages 12 to 17 from 13.0 years old (2002) to 16.1 years old (2010). (Objective 26-9a)⁹

Another national goal is to reduce the proportion of adolescents (aged 12 to 17 years) who reported marijuana use in the past 30 days from 8.2% (2002) to 0.7% by 2010. (Objective 26-10b)⁹

- "...More than 5 million children alive today will die prematurely from smoking-related illnesses." –Campaign for Tobacco-free Kids²⁴
- To date, smoke-free ordinances have been enacted in 14 Mississippi communities, including Tupelo, Hattiesburg, Oxford and Starkville. Such ordinances have been shown to reduce the likelihood that adolescents will become established smokers. Approximately 69% of Mississippi adults favor smoke-free indoor work areas, and approximately 72% favor smoke-free indoor areas in restaurants.²⁵
- In spring 2007, Mississippi enacted a law requiring school districts to add education for tobacco and illegal drug abstinence to their wellness plans by the 2008-2009 school year. –*The Clarion Ledger*, April 16, 2007⁷
- Marijuana has numerous possible health effects including memory problems, anxiety attacks, impaired driving, respiratory problems, and cognitive and immune system deficits.^{26, 27}
- "In a study at the Annenberg Public Policy Center of the University of Pennsylvania, researchers found that young people connect cigarette smoking and alcohol and illegal drug use with popularity." –Substance Abuse and Mental Health Services Administration²⁸

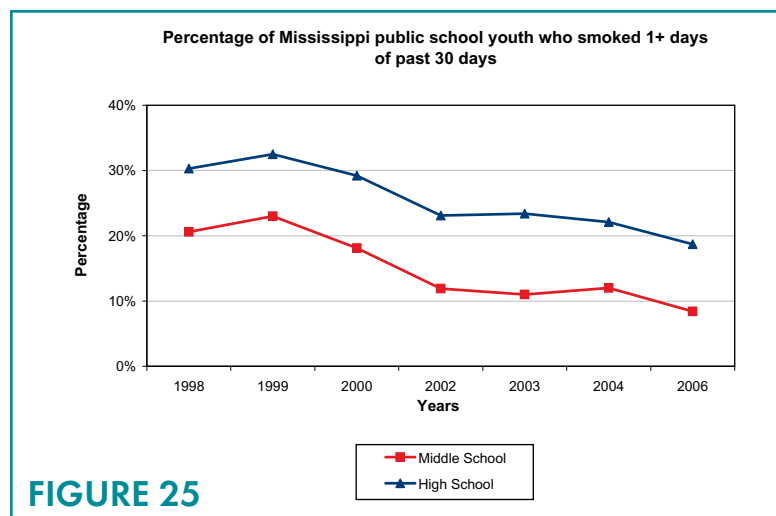
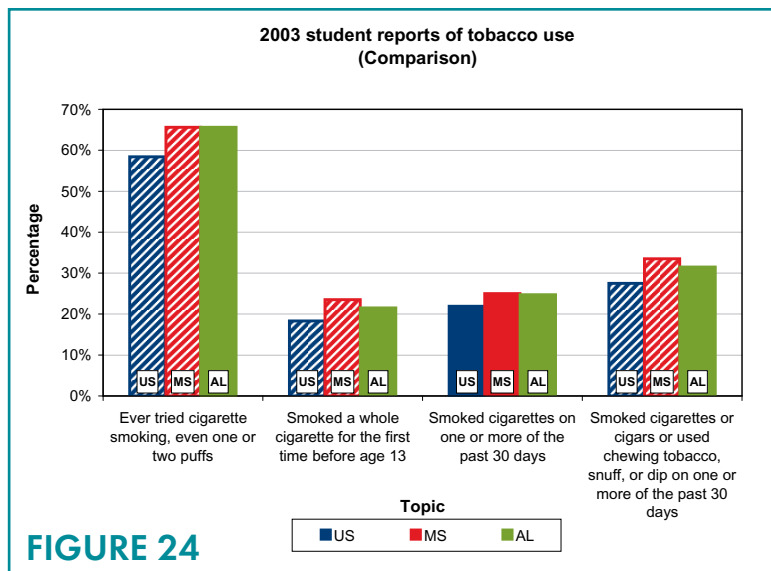
HEALTH

TOBACCO, ALCOHOL & MARIJUANA USE

key findings:

TOBACCO USE

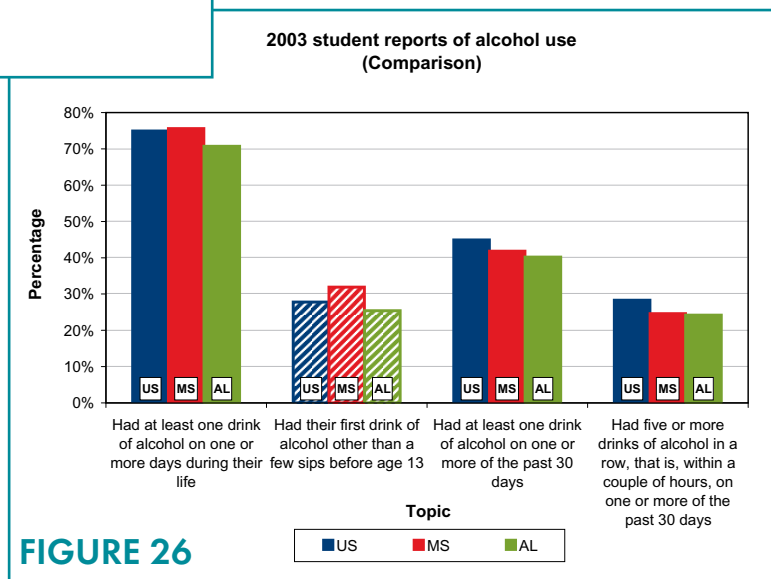
In 2003, percentages of Mississippi 9th- to 12th-grade students reporting that they had done the following were significantly higher than those of the nation as a whole: ever tried cigarette smoking, even one or two puffs (65.6% compared to 58.4%), smoked a whole cigarette for the first time before age 13 (23.5% vs. 18.3%), and/or smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days (33.5% vs. 27.5%). However, Mississippi was not significantly higher than the United States on the percentage of students who reported smoking cigarettes on one or more of the past 30 days.^{8,a,q} [FIGURE 24]



Recent Mississippi data reveal that current cigarette use among students is on the decline. From 1999 to 2006, the prevalence of current smokers decreased by 43% among Mississippi public high school students and decreased by 65% among public middle school students.^{23,b} [FIGURE 25]

ALCOHOL USE

In 2003, Mississippi was significantly higher (31.9%) than the United States (27.8%) and Alabama (25.4%) in the percentage of students who reported having their first drink of alcohol before age 13. However, Mississippi 9th- to 12th-grade students were not significantly different than those in the United States as a whole or Alabama on the percentage who reported having had at least one drink of alcohol during their lifetime or during the past 30 days, or five or more drinks in a row within a few hours in the past 30 days.^{8,a,q} [FIGURE 26]



31.9%

of Mississippi students in 2003
reported having their first drink
of alcohol before age 13

TOBACCO, ALCOHOL & MARIJUANA USE

key findings:

MARIJUANA USE

On a number of measures reflecting marijuana use, a significantly lower percentage of Mississippi 9th-12th graders reported these types of activities than did 9th-12th graders throughout the nation in 1993. However, between 1993 and 2003, Mississippi student reports on all marijuana use topics significantly increased. In 1993, a significantly lower percentage of Mississippi students reported recent marijuana use than did U.S. students, but by 2003, the gap had closed, and the percentages were not significantly different.^{8,a,q} [FIGURES 27, 28]

Notes:

Figures 24, 26, 27 and 28 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/^a

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^q

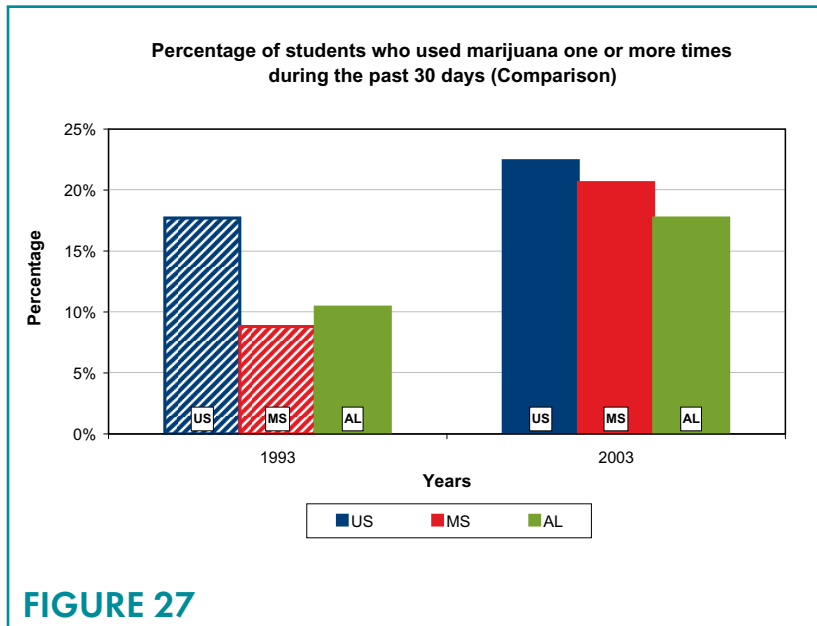


FIGURE 27

Mississippi 9th- to 12th-grade Student Reports of Marijuana Use (1993 vs. 2003)			
Question	1993 Results Percentage	2003 Results Percentage	Direction of Change
Percentage of students who used marijuana one or more times during their life	20.8%	38.7%	Significantly Increased
Percentage of students who tried marijuana for the first time before age 13	4.0%	9.5%	Significantly Increased
Percentage of students who used marijuana one or more times during the past 30 days	8.8%	20.6%	Significantly Increased
Percentage of students who used marijuana on school property one or more times during the past 30 days	1.8%	4.4%	Significantly Increased

FIGURE 28

policy considerations:

Parents, teachers, and other role models are needed to advance no-smoking norms in children's environments. Adults influence children and can be deterrents to alcohol, cigarette, and drug-abusing behavior, which poses physical and even mental health risks for children and adolescents.²⁹ Program interventions in schools, churches and communities throughout Mississippi need to begin early and reach children through media messages that are developmentally appropriate, age specific and culturally sensitive. Ongoing media campaigns for youth, made in concert with youth and delivered by youth and/or youth "heroes," can serve as important messages to connect the increased risk for both short- and long-term consequences of using tobacco, alcohol, marijuana and other drugs. In 2003, almost 17% of current student smokers (27% of male smokers, 6% of female smokers) in Mississippi reported buying their own cigarettes in a store or gas station. The prevalence of youth access to tobacco products calls for additional community surveillance.

HEALTH

ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS



Sexual activity puts teenagers at risk of having an unwanted pregnancy and/or a sexually transmitted infection.³⁰ Over 40% of adolescent girls become pregnant at least one time before the age of 20. Of these pregnancies, 14% end in miscarriages or stillbirths; 35% end in abortion; and 51% end in live births.³¹

In 2004
Mississippi
had the
**second
highest**
teen birth rate
of all the states
in the nation for
teens ages 15-19

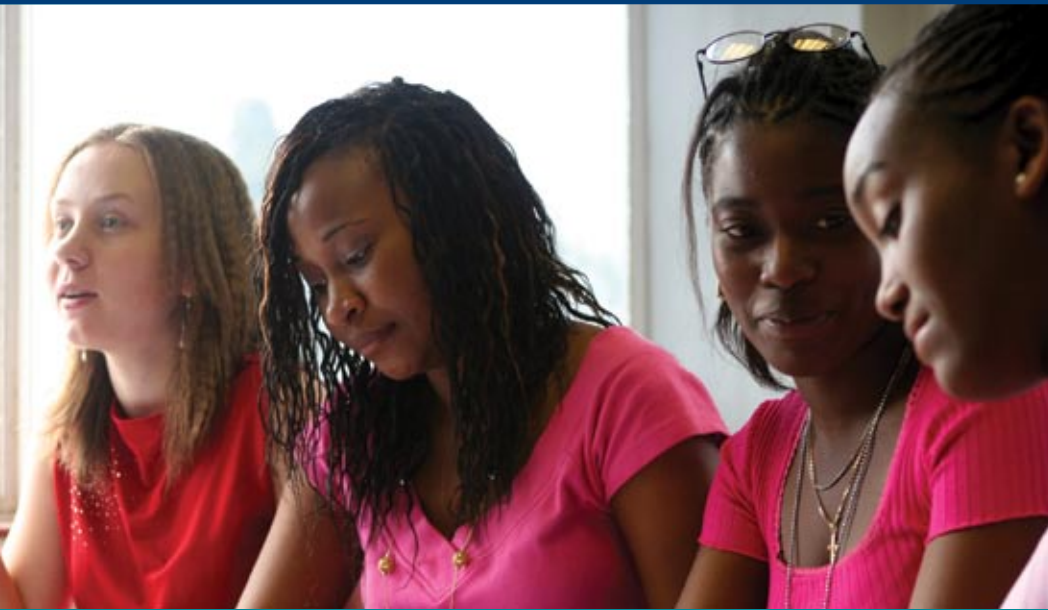
facts:

- A stable family environment, regular attendance at a church or other worship center, and higher family income are all associated with delayed sexual activity among adolescents. In addition, parental guidance and expectations, as well as close parent/child relationships, are associated with a reduction in risky sexual activity.³¹
- Almost half of the nearly 19 million new STDs in the United States each year are acquired by youth who are 15 to 24 years old.³²
- "Adolescent childbearing is usually inconsistent with mainstream societal demands for attaining adulthood through education, work experience, and financial stability. Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, as many as 83% of adolescents who give birth and 61% who have abortions are from poor or low-income families." -American Academy of Pediatrics³¹
- In 2005, Hispanic teens had the highest birth rates (81.5 per 1,000 females 15 to 19 years old) nationally, followed by Black teens (60.9), American Indian teens (52.7), White teens (26.0), and Asian teens (16.9).³³

6,543

babies were born in Mississippi
in 2004 to teenagers between
the ages of 15 and 19^{21,d,k}

ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS



Healthy People 2010 Goals:

The national goal is to reduce pregnancies among adolescent females from 67 (per 1,000 females aged 15 to 17) in 1996 to 43 by 2010. (Objective 9-7)⁹

Another national goal is to increase the proportion of students in grades 9 through 12 who have never had sexual intercourse from 50% (in 1999) to 56% by 2010. (Objective 25-11a)⁹

- In 2004, Mississippi had the second highest teen birth rate of all the states in the nation for teens 15-19.^{21,d,k}
- A survey released by the National Campaign to Prevent Teen Pregnancy revealed that 47% of teens said they were most influenced by parents in their decisions about sex. These numbers indicate that parents sometimes underestimate their influence. One thousand parents were surveyed, and only 34% thought they were the most influential factor. Of the 1,000 teens surveyed, only 18% said their friends were the most influential factor. – *The Clarion Ledger*, March 4, 2007³⁴

Nearly **19 million**
new STDs are acquired each year in the U.S.,
almost half by 15- to 24-year-olds

HEALTH

ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS

key findings:

SEXUAL ACTIVITY

A significantly higher percentage of Mississippi 9th to 12th-grade students reported that they had sexual intercourse with one or more people during the past three months in comparison to the U.S. percentage for each year they were surveyed from 1993 through 2003. In addition, a significantly higher percentage of students in Mississippi reported having sexual intercourse with four or more people during their life, compared to the U.S. data for all surveyed years between 1993 and 2003. Alabama only had data available for the years of 2003 and beyond for these topics, and Mississippi was not significantly different than Alabama in 2003. There were no significant differences between the 1993 and 2003 percentages of Mississippi students responding affirmatively on these two topics.^{8,9}

[FIGURES 29, 30]

Notes:

Figures 29 and 30 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbs/⁹

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.⁹

*Data were not available for Alabama in 1993.

Percentage of students who had sexual intercourse with one or more people during the past three months (Comparison)

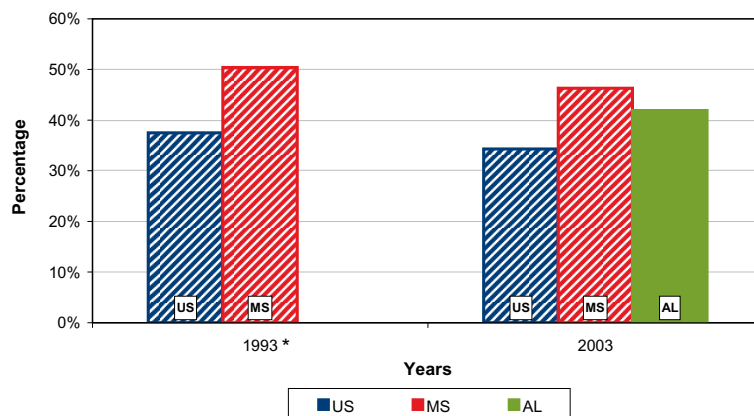


FIGURE 29

Percentage of students who had sexual intercourse with four or more people during their life (Comparison)

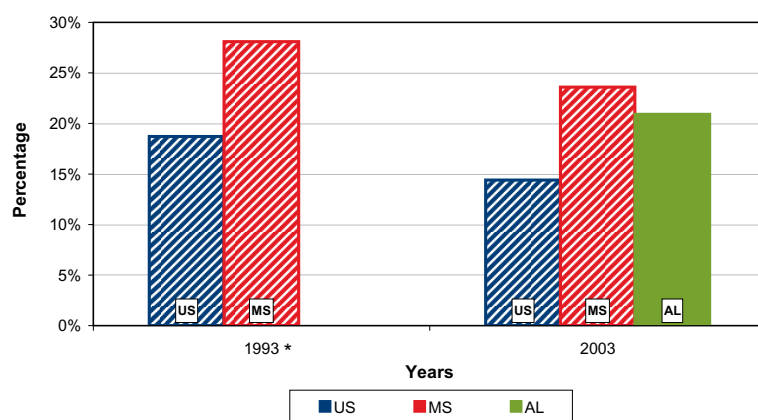


FIGURE 30

OVER
40%

of adolescent girls become
pregnant at least one time
before the age of 20³¹

ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS

key findings:

PREGNANCY

The Mississippi total teenage pregnancy rate for the 15-19 age group in 2005 (67.7 per 1,000) was lower than in 1999 (83.2). From 1999 through 2005, the teenage pregnancy rate for Whites ages 15 to 19 was lower than for Nonwhites ages 15 to 19. The five counties with the highest 2001-2005 average pregnancy rates for teens ages 15 to 19 were Humphreys (117.20), Tunica (111.40), Yazoo (100.88), Chickasaw (95.68), and Coahoma (95.48). The five counties with the lowest 2001-2005 average pregnancy rates for teens ages 15 to 19 were Lafayette (27.50), Oktibbeha (44.16), Choctaw (44.66), Itawamba (47.90), and Claiborne (48.96). Please see Figures 32 and 33 for county-level data representing the 2001-2005 average pregnancy rates for White and Nonwhite teens ages 15 to 19.^{35,c,j,r} [FIGURES 31, 32, 33]

Line Graph:

*Mississippi Total values include some for which the race of the mother was unknown.

Maps:

Teenage pregnancy rate: Live births plus reportable spontaneous fetal deaths plus induced terminations per 1,000 females in specified age/race group.

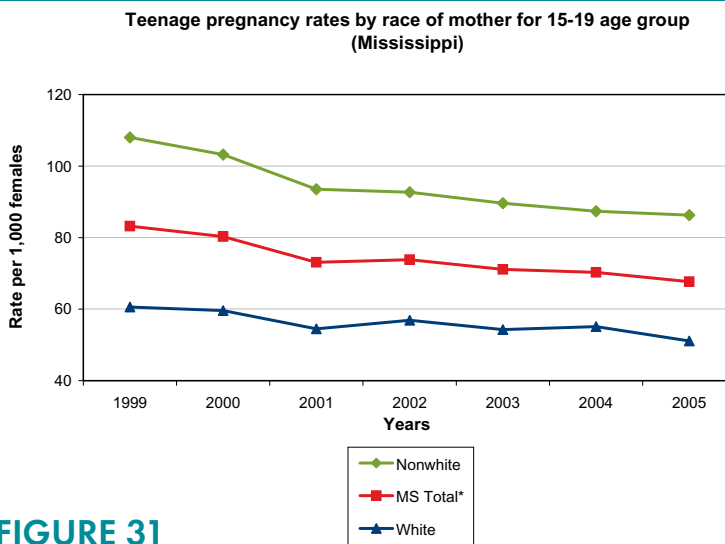
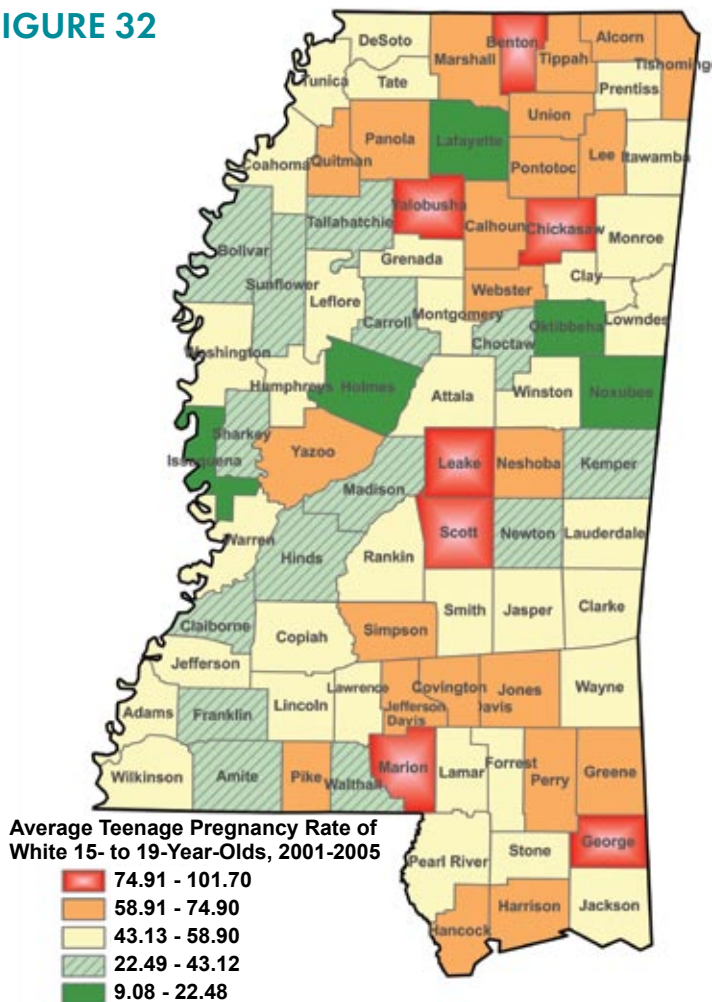


FIGURE 31

FIGURE 32



HEALTH

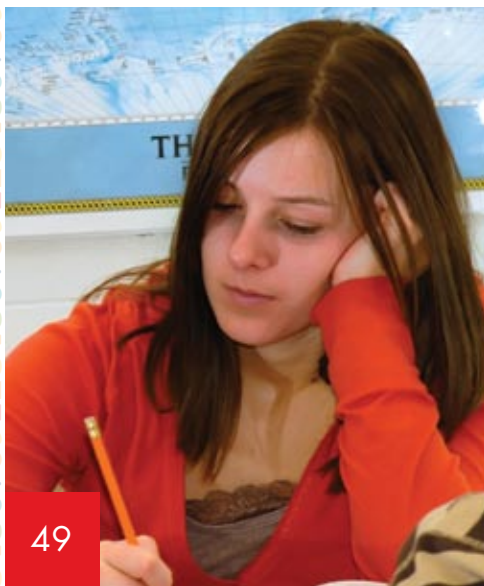
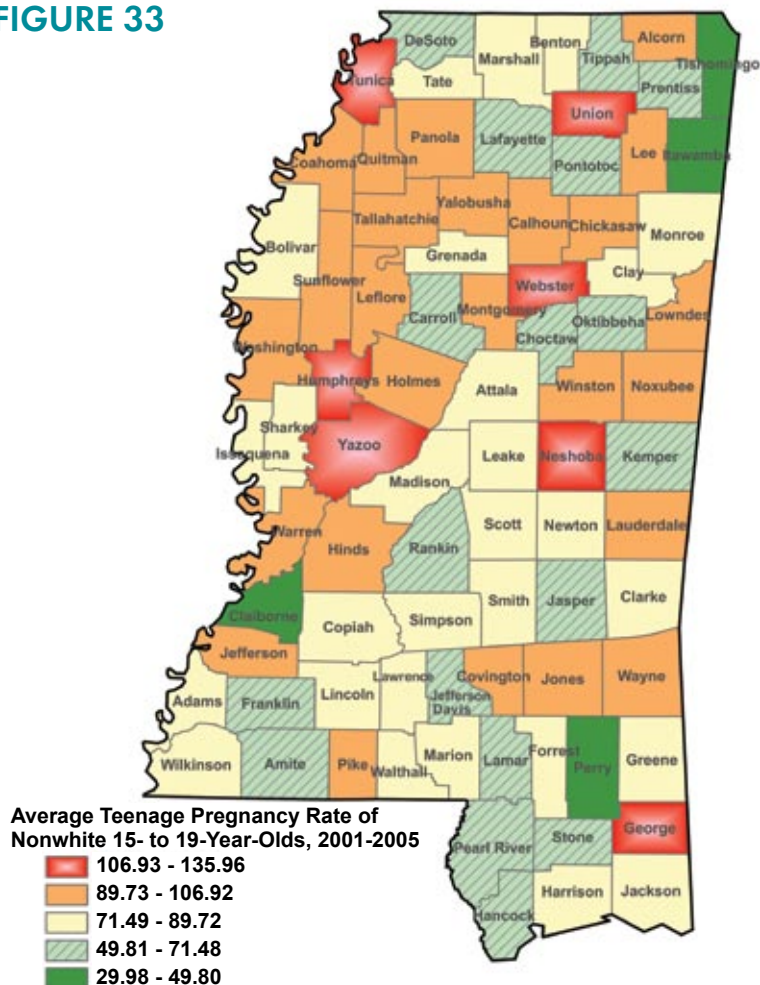
ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS

key findings: PREGNANCY

Map:

Teenage pregnancy rate: Live births plus reportable spontaneous fetal deaths plus induced terminations per 1,000 females in specified age/race group.

FIGURE 33



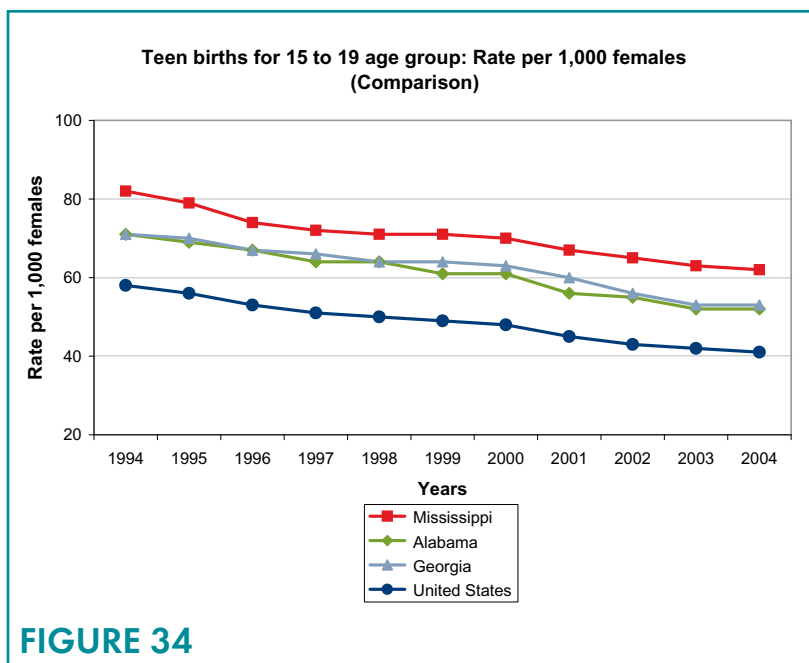
AS MANY AS
83% of U.S. adolescents who
 give birth are from poor
 or low-income families³¹

ADOLESCENT SEXUAL ACTIVITY, PREGNANCY & BIRTHS

key findings:

BIRTHS

From 2000 to 2004, there was a significant decrease in birth rates among Mississippi teens ages 15 to 19 (70 per 1,000 in 2000 vs. 62 per 1,000 in 2004). In 2004, Mississippi (62) was significantly higher than the nation as a whole (41), Georgia (53), and Alabama (52). In 2004, there were 6,543 births to teenagers between the ages of 15 to 19 in Mississippi.^{21,d,k} [FIGURE 34]



policy considerations:

The National Campaign to Prevent Teen Pregnancy report “No Time to Waste: Programs to Reduce Teen Pregnancy among Middle School-aged Youth” emphasizes that not one program in and of itself will prevent teen pregnancy, particularly with the complexity of factors involved. The report emphasizes the importance of beginning programs at least by the middle school years, given that nationally, 20% of youth have had sexual intercourse by the age of 15.³⁶ In addition, the Guttmacher Institute states that “comprehensive sex education programs that provide information about both abstinence and contraception can help delay the onset of sexual activity among teens, reduce their number of sexual partners and increase contraceptive use when they become sexually active.”³⁷

The importance of the involvement of teenagers’ families, schools, churches and communities cannot be overstated. A first step is acknowledging the level of sexual activity that is occurring and understanding the influence parents have on the onset of their child’s sexual activity. Educating parents about the average age for the onset of sexual activity is crucial. In a recent study in North Carolina, just 12% of parents of teenagers believed that their teen was sexually active, while 51% of North Carolina’s teenagers reported having had sex; 37% reported that they were currently sexually active.³⁸

Learning from successful models within Mississippi is another important policy consideration. Several programs and efforts, such as the Girls to Women Program in Jonestown, MS; the Teen Treasures program by the Cary Christian Center; the Making Alternative Decisions and Modeling Excellence, as well as the Boyz to Men Programs by Youth Opportunities Unlimited; and the Coordinated School Health Program implemented by McComb Public Schools deserve attention.

HEALTH

LOW BIRTH WEIGHT & INFANT MORTALITY

“Rates of infant mortality are sensitive indicators of a broad range of factors affecting children’s health. As such, infant mortality is the ‘tip of the iceberg’ of child health problems, and changes in infant mortality are a signal of factors affecting child health more broadly.”

-American Academy of Pediatrics
Task Force on Infant Mortality³⁹

“In the 1960s,...a unique program was envisioned and implemented...[that] utilized certified...nurse midwives and aides. The program concentrated on education, prenatal care, home visiting throughout the pregnancy as well as post natally up to 2 years. The success was phenomenal, and the infant mortality rate progressively dropped. Unfortunately, after about 14 years, the program could not be economically sustained and closed. It is too bad that these types of programs cannot be sustained since they have a proven track record of decreasing the infant mortality rate. Thus, the infant mortality rate remains unacceptable.”

-J. Edward Hill, MD, FAAFP⁴⁰

facts:

- The United States has the highest rate of infant death compared to 19 other industrialized nations—primarily due to the large number of babies born each year with low birth weights (under 2,500 grams, or 5 lbs., 8 ozs.). Low-birth-weight babies fall into one of two categories: those who are born preterm (prior to the 37th week of gestation) and those who are born full term, but at a weight that is low for their gestational age.^{41, 42}
- Furthermore, the first weeks of life, called the neonatal period (<28 days), remain a time of high risk for many babies. Most of the progress in preventing infant mortality has come about in what physicians call the “postneonatal period”—28 days to 1 year old.⁴¹
- “Babies who are very low in birth weight (less than 1,500 grams, or 3 pounds, 4 ounces) have a 25 percent chance of dying before age one.” -Child Trends⁴³
- Low birth weight occurs more often among Black infants who, in 2005, were more than twice as likely to have very low birth weights than other infants.⁴³
- Causes of infant mortality include congenital abnormalities, low birth weight, Sudden Infant Death Syndrome, pregnancy complications, and respiratory distress syndrome.⁴⁴

4,566

Mississippi children died in infancy
from 1992 to 2001 (nearly 1/2 of
all child deaths)

LOW BIRTH WEIGHT & INFANT MORTALITY



Healthy People 2010 Goals:

*The national goal is to
reduce all infant deaths
(within 1 year) from 7.2
(per 1,000 live births)
in 1998 to 4.5 by 2010.
(Objective 16-1c)⁹*

*Another national goal
is to reduce neonatal
deaths (within the first
28 days of life) from 4.8
(per 1,000 live births)
in 1998 to 2.9 by 2010.
(Objective 16-1d)⁹*

*Another national goal is
to reduce postneonatal
deaths (between 28 days
and 1 year) from 2.4
(per 1,000 live births)
in 1998 to 1.2 by 2010.
(Objective 16-1e)⁹*

- In 2004, Mississippi had the highest percentage of low-birth-weight babies of any state in the nation and ranked 49th in infant mortality.^{21,e,l}
- From 1992-2001, approximately one half of all deaths of Mississippi children occurred within the first 12 months of a child's life. From 1992 to 2001, 9,432 children (ages 0-19) died in Mississippi. Of those, 4,566 were infants.⁴⁵ A primary reason for infant mortality is low birth weight, which is highly correlated with preterm delivery (less than 37 weeks).⁴¹
- According to Interim State Health Officer Dr. Ed Thompson, Mississippi's infant mortality rate last year remained at its worst level in over a decade. Although the total infant death rate was slightly lower than the previous year, overall, there was not a significant decrease. "We are the worst in the nation, and we are not getting better," he remarked. As a result of these statistics, he has asked Governor Barbour to appoint a panel to tackle this issue. According to Thompson, the infant death rate "reflects how well a society provides a safety net for the most vulnerable." - *The Clarion Ledger*, October 2, 2007⁴⁶

HEALTH

LOW BIRTH WEIGHT & INFANT MORTALITY

key findings:

LOW BIRTH WEIGHT

There was a significant increase in the percentage of low-birth-weight babies (less than 5.5 pounds) born in Mississippi between 2000 (10.7%) and 2004 (11.6%, or 4,956 babies). In 2004, Mississippi's percentage of low-birth-weight babies (11.6%) was significantly higher than the U.S. (8.1%) and Georgia (9.3%), but not significantly higher than Alabama (10.4%).^{21,e,l,s} [FIGURE 35]

INFANT MORTALITY

There was no significant change in the infant mortality rate in Mississippi from 2000 to 2004. In 2004, Mississippi's rate (9.8 per 1,000) was significantly higher than the rates of the United States as a whole (6.8) and Georgia (8.5), but Mississippi's rate was not significantly higher than Alabama's (8.7).^{21,f,m,s} [FIGURE 36]

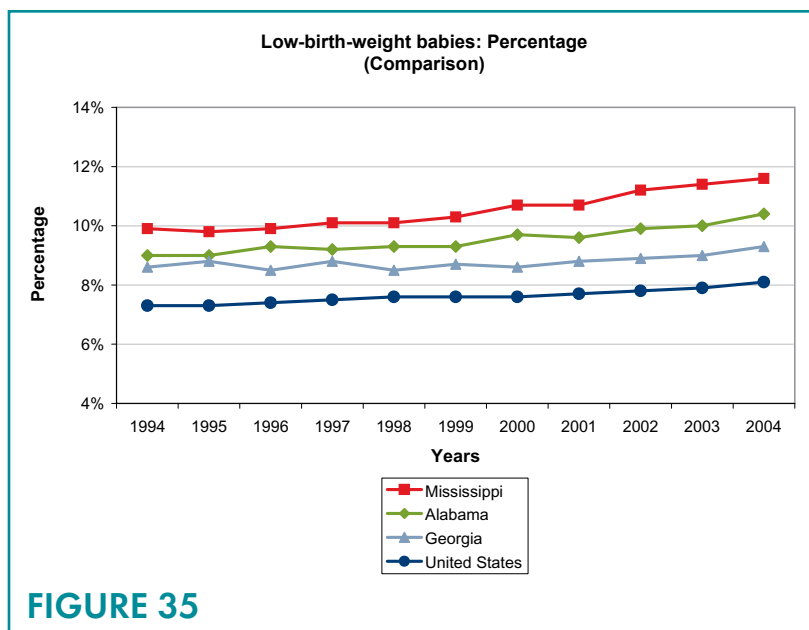


FIGURE 35

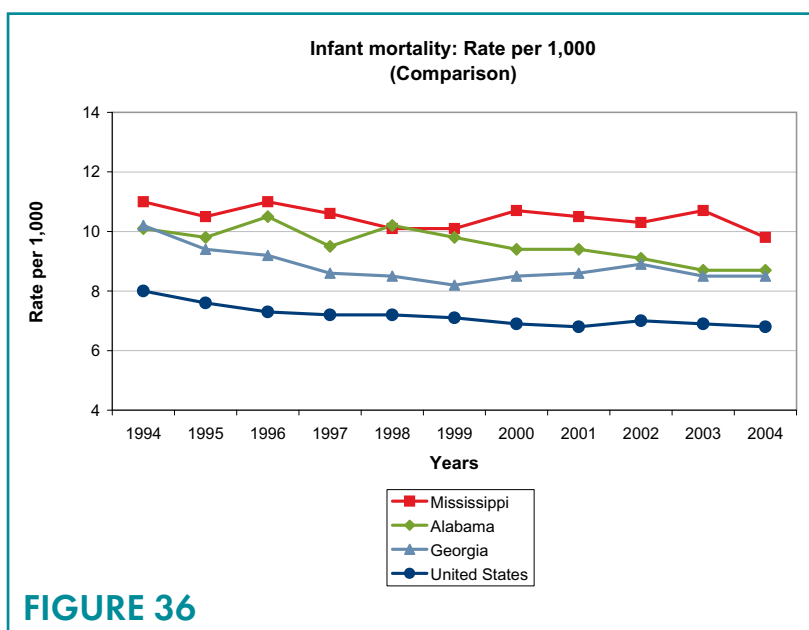


FIGURE 36

59%

of all Mississippi infant deaths in 2005 occurred during the neonatal period (less than 28 days)

LOW BIRTH WEIGHT & INFANT MORTALITY

key findings:

INFANT MORTALITY

From 2001 to 2005, there was a wide variation in infant mortality rates by race. The average infant mortality rate was 6.7 per 1,000 live births for Whites and 15.1 for Nonwhites. The neonatal five-year average mortality rate increased from 5.2 in 1997-2001 to 6.4 in 2001-2005, while the postneonatal five-year average mortality rate declined from 5.2 in 1997-2001 to 4.2 in 2001-2005. In 2005, 59% of all infant deaths (283 out of 481) occurred during the neonatal period, and 41% (198 out of 481) occurred during the postneonatal period. Please see Figures 37-42 for county-level data representing the 2001-2005 average infant, neonatal, and postneonatal mortality rates for Whites and Nonwhites.^{47,9,n,t} [FIGURES 37, 38, 39, 40, 41, 42]

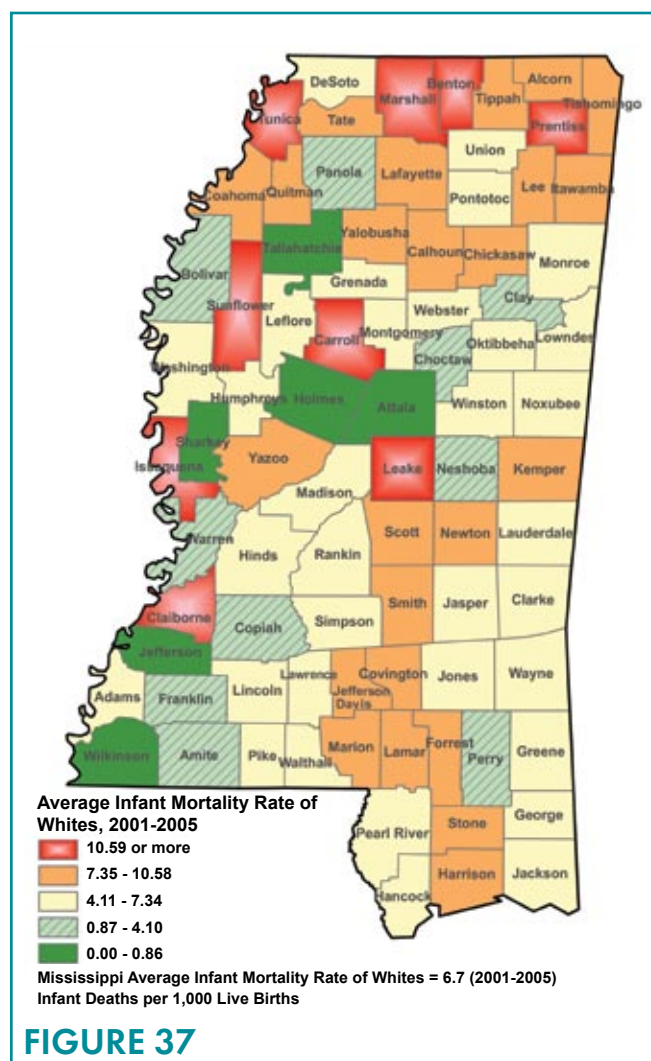


FIGURE 37

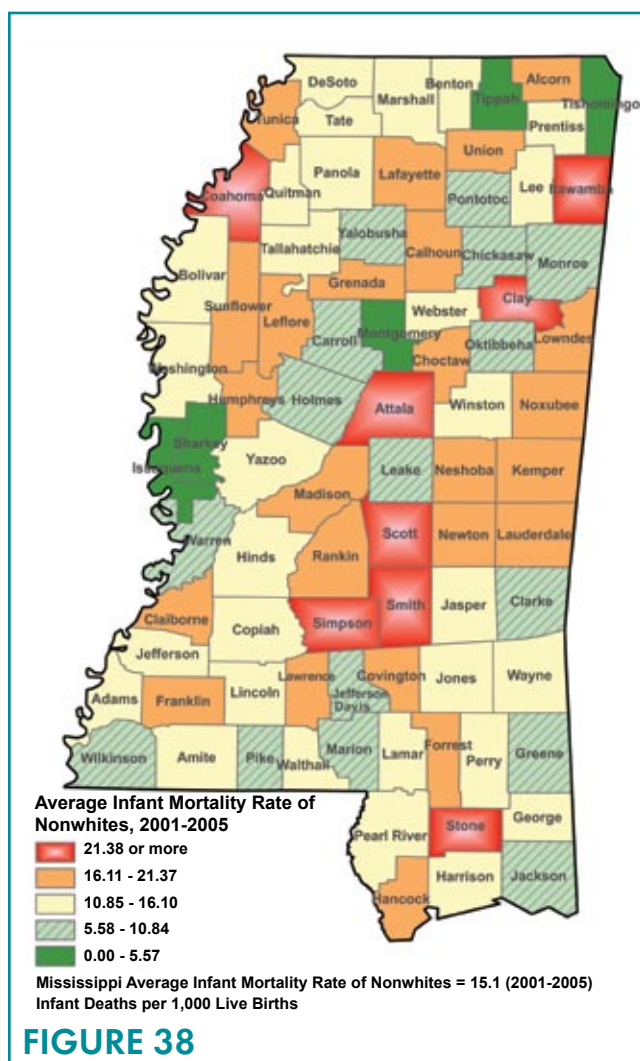


FIGURE 38

Maps:

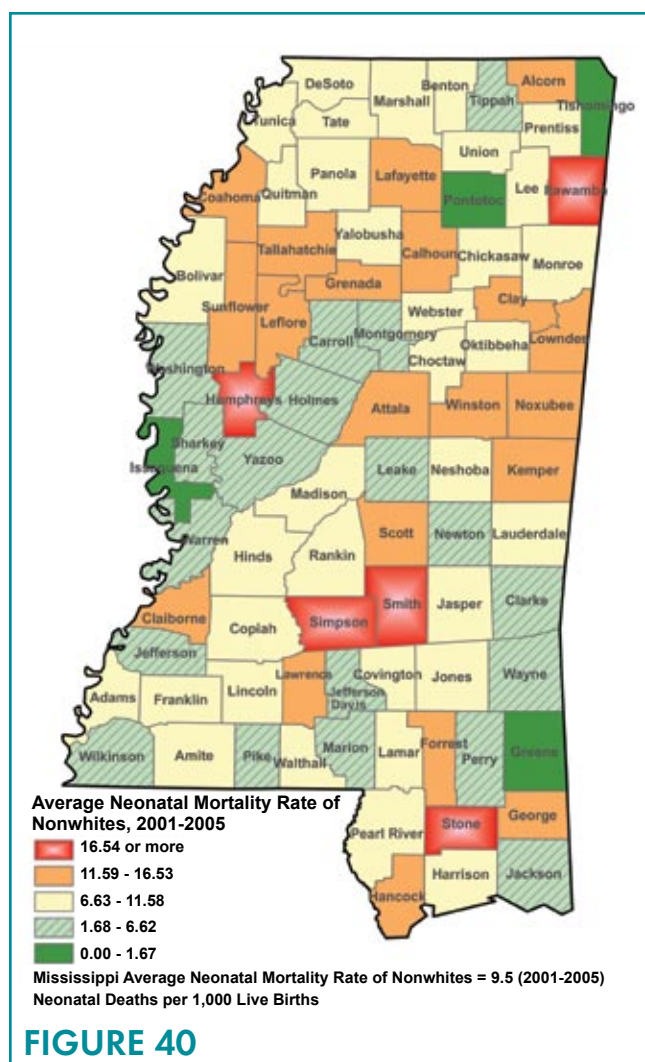
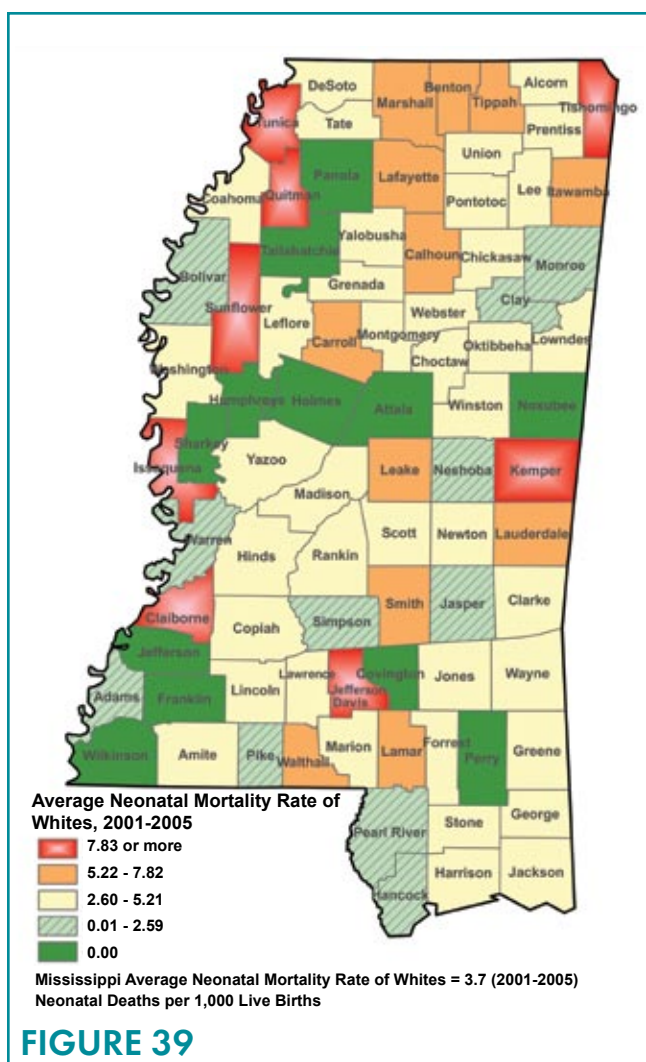
Infant deaths are those of children under one year of age; neonatal deaths are those of infants under 28 days of age; postneonatal deaths are those of infants ages 28 days to 1 year. Deaths per 1,000 live births.

HEALTH

LOW BIRTH WEIGHT & INFANT MORTALITY

key findings:

INFANT MORTALITY



policy considerations:

As we go to press with the KIDS COUNT Data Book, we are pleased to note that Governor Barbour is calling for names to form an Infant Mortality Task Force. The importance of an executive-level Mississippi task force, specifically focused on infant mortality, cannot be overstated.

Part of the response to infant mortality in Mississippi needs to include a retrospective review of data and health systems that were previously in place when low birth weight occurred less frequently. For example, the venues where prenatal services are delivered have changed dramatically. This year (2007), less than 20% of women in Mississippi are receiving prenatal care through the local health departments, compared to approximately 50% just under 10 years ago.⁴⁸

THIS YEAR (2007), LESS THAN

20%

of women in Mississippi are receiving prenatal care through local health departments

LOW BIRTH WEIGHT & INFANT MORTALITY

key findings: INFANT MORTALITY

Maps:

Infant deaths are those of children under one year of age; neonatal deaths are those of infants under 28 days of age; postneonatal deaths are those of infants ages 28 days to 1 year. Deaths per 1,000 live births.

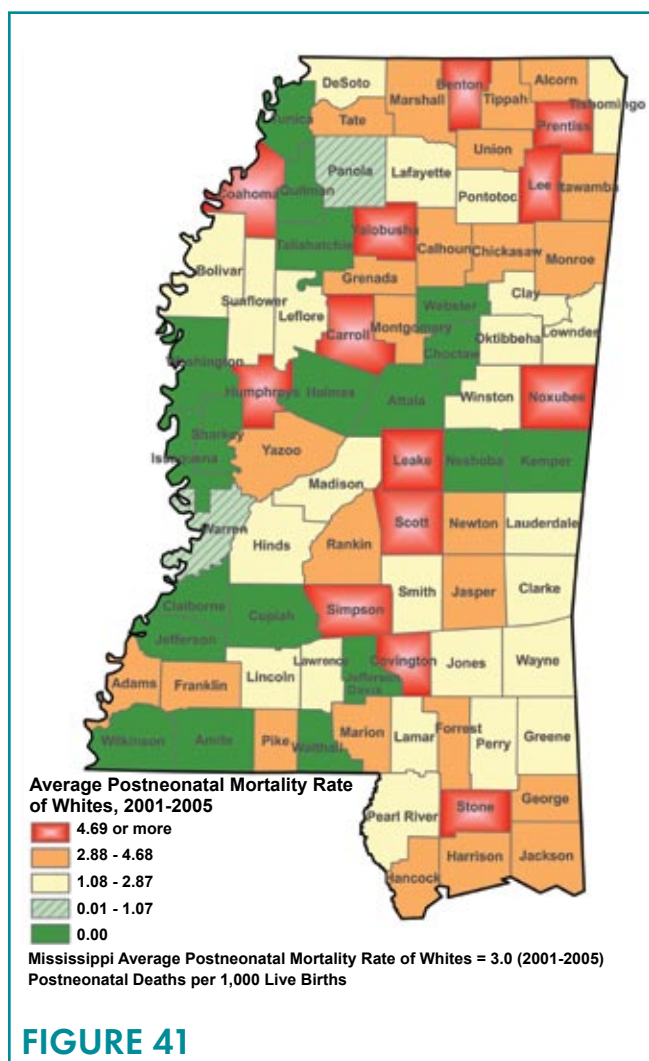


FIGURE 41

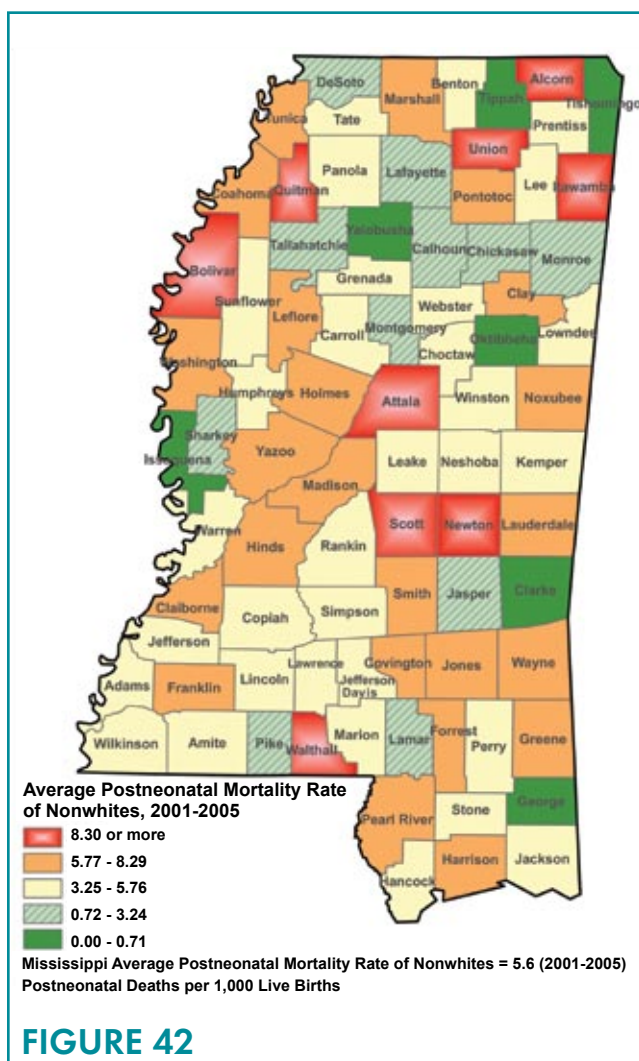


FIGURE 42

Other suggestions include the following:

- Hospital reviews of infant deaths
- Reviews of which counties and county populations have persistently high neonatal and postneonatal infant mortality rates
- Comparisons of infant mortality rates with the trimester in which women entered prenatal care
- Establishment of county-level infant mortality review teams coordinated via the county Health Departments
- Assessment of the strengths and needs of mothers and families with low-birth-weight babies
- Community supports for mothers of low-birth-weight babies to assist for at least one year, but ideally two years postpartum

HEALTH

CHILD & TEEN DEATHS



During the 20th century, breakthroughs in medicine and sanitation sharply reduced child mortality. Not all segments of the population benefited equally, however. To a large extent, the racial and ethnic disparities in child mortality that prevailed early in the last century have persisted, with African American children bearing more than twice the risk of White children. Furthermore, the rate of teen death in the U.S. remains substantially higher than in many of our peer nations, based largely on higher rates for the three most prevalent causes of death among adolescents and young adults: motor vehicle crashes, homicide, and suicide.^{49,50}

-Annie E. Casey Foundation^{49,50}

"The Child Death Review Panel was established in August of 2006 to look at infant and child deaths in Mississippi and to make recommendations to the legislature on how to most effectively direct state resources in order to decrease infant and child deaths in Mississippi...

[However,] until we have a fully funded and staffed Medical Examiner's office in this state, as well as adequately trained pathologists available to perform pediatric autopsies, the state will still lack the reliable data on the causes of child deaths that is needed to prevent those deaths in the future, and Mississippi's child death rate will remain far too high."

-Tami H. Brooks, MD
Pediatrician and Co-Chair
MS Child Death Review Panel⁵¹

facts:

- In 2004, Mississippi ranked 45th in the nation for its rate of child deaths and 48th for its rate of teen deaths.²¹
- In Mississippi, from 1992 to 2001, "other" injuries (including those caused by accidents, fire and burns, and drowning, but not including those caused by motor vehicle crashes) accounted for 31% of all deaths among children ages 1 to 4, followed by motor vehicle crashes (17%). For children ages 5 to 14, other injuries accounted for 28% of all deaths, and motor vehicle crashes accounted for 26%. By the time Mississippi children reach driving age (15 to 19 years old), 43% of deaths are caused by motor vehicle crashes, with homicide (16%), other injuries (12%), and suicide (9%) also claiming lives.⁴⁵
- "Forty percent of all teen deaths in the United States are the result of motor vehicle crashes. In 2003, more than 5,000 youth ages 15 to 19 were killed and approximately 308,000 youth ages 15 to 20 were injured in motor vehicle crashes... A number of factors related to lack of driving experience and maturity contribute to younger drivers having higher crash rates, including following too closely, driving too fast, and violating traffic signs and signals. Other risk factors include the presence of other teenage passengers and use of alcohol." -Child Trends⁵²
- Of teen homicides nationally, two-thirds are committed by someone aged 18 or over. Many teen murders are the result of gang violence, which was responsible for approximately 75% of teen homicides in 2002.⁵³

CHILD & TEEN DEATHS

Healthy People
2010 Goals:

The national goals are to reduce deaths for children ages 1 to 4 from 34.1 (per 100,000) in 1998 to 20.0 by 2010 and for children ages 5 to 9 from 17.2 in 1998 to 13.0 by 2010. (Objectives 16-2a, 16-2b)⁹

Other national goals are to reduce the death rate for adolescents ages 10 to 14 from 21.5 (per 100,000) in 1998 to 16.5 by 2010 and for adolescents ages 15 to 19 from 69.5 in 1998 to 38.0 by 2010. (Objectives 16-3a, 16-3b)⁹

Another national health goal is for an increase in the number of states that review 100% of deaths to children ages 17 and under due to external causes. (Objective 15-6)⁹
As of 2000, only 10 states had child fatality review teams. Mississippi established its Child Death Review Panel in 2006.



- Twenty children in Mississippi committed suicide in 2004. In 2005, the total was 13. – *The Clarion Ledger*, May 11, 2007⁵⁴
- More than 90% of teens who commit suicide meet the criteria for a psychiatric disorder, underscoring the need for timely assessment and referral.⁵⁵ Also, a number of social and environmental risk factors may be present, including firearms in the home, strained parent-child relationships, school difficulties, social isolation, or a stressful life event.⁵⁶
- “Males ages 15 to 19 are about four times more likely than females to die from suicide, six times more likely to die from homicide, and about ten times as likely to die by firearm.” – Child Trends⁵³
- Of Mississippi 9th- to 12th-grade students in 2003, a significantly higher percentage of females than males reported each of the following experiences in the past 12 months: feeling so sad or hopeless that they stopped doing usual activities, seriously considering suicide, and attempting suicide. However, there was not a significant difference between the percentages of males and females who reported they required treatment by a doctor or nurse for a suicide attempt.^{8,a,q}

HEALTH

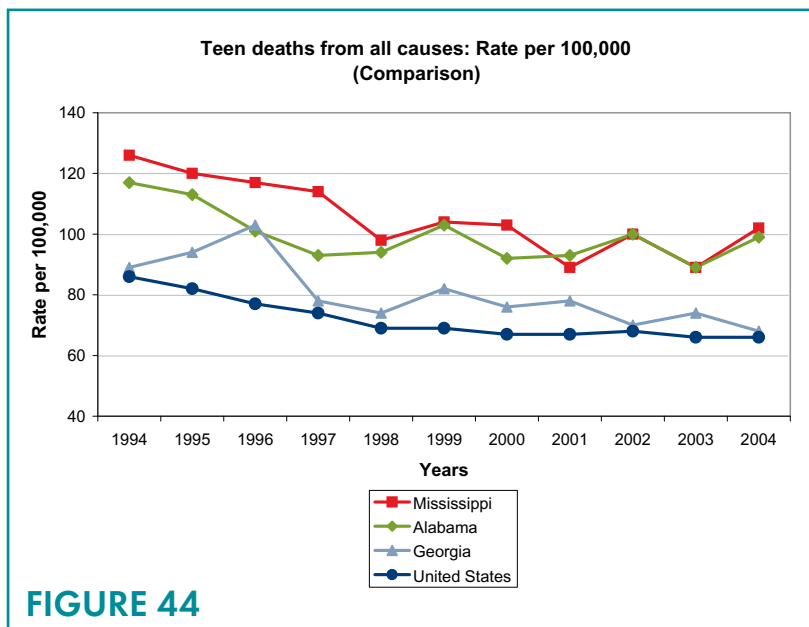
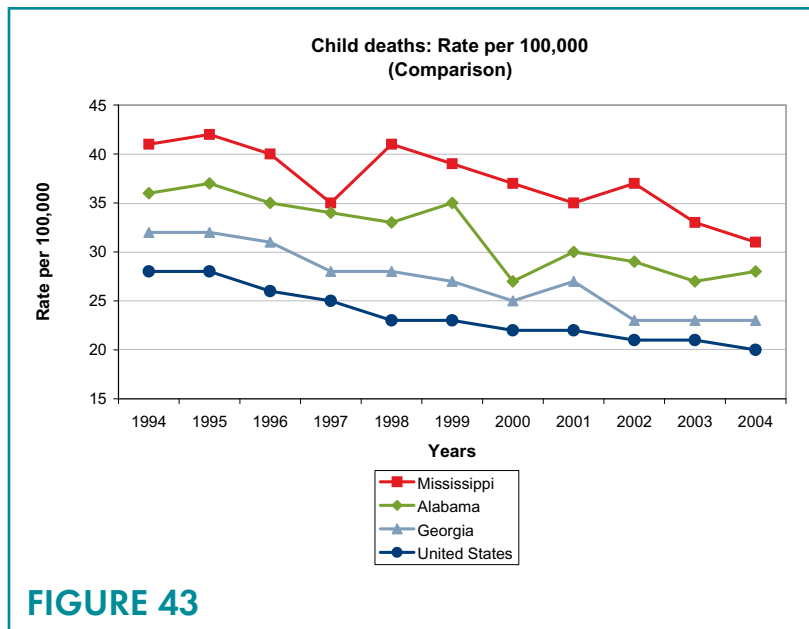
CHILD & TEEN DEATHS

key findings:

CHILD AND TEEN DEATHS

There was not a significant change in the child death rate or the teen death rate in Mississippi from 2000 to 2004. In 2004, there were 181 total deaths of Mississippi children ages 1 to 14 and 220 total deaths of Mississippi teens between the ages of 15 and 19. That same year, Mississippi had significantly higher child and teen death rates than Georgia and the United States as a whole, but not Alabama.^{21,h,i,o,p,s}

[FIGURES 43, 44]



13.5%

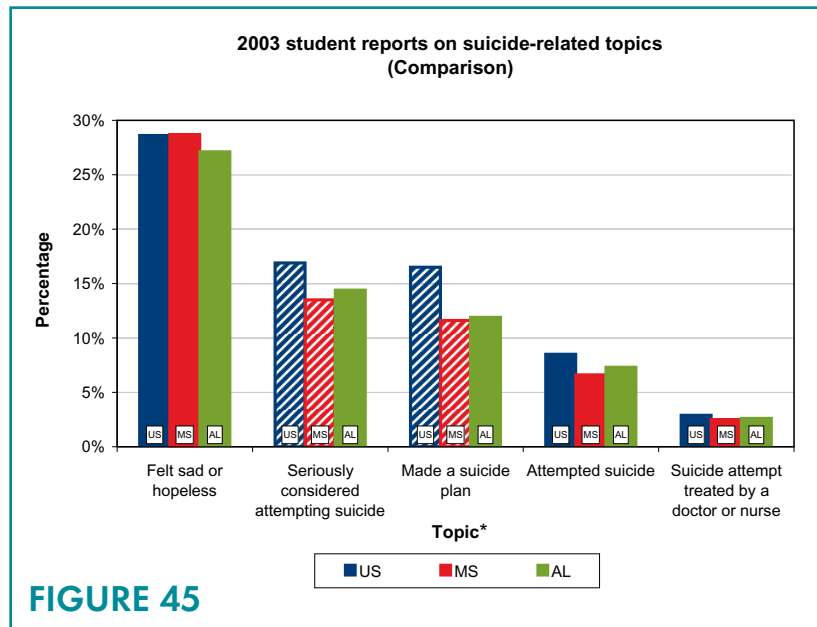
of Mississippi 9th-12th graders in 2003 reported that they had seriously considered attempting suicide during the past 12 months

CHILD & TEEN DEATHS

key findings:

YOUTH SUICIDE

In 2003, 28.7% of Mississippi 9th-12th graders reported that they “felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities” during the past 12 months. This percentage was not significantly different from the U.S. average of 28.6% or from Alabama (27.1%). The percentages of Mississippi students who reported that they seriously considered attempting suicide during the past 12 months (13.5%) or that they made out a plan about how they would attempt suicide (11.6%) were significantly lower than the U.S. averages of 16.9% and 16.5%, but were not significantly different than Alabama percentages (14.4% and 11.9%). The percentages of Mississippi students who actually attempted suicide during the past 12 months (6.6%) or “whose suicide attempt resulted in injury, poisoning, or overdose that had to be treated by a doctor or nurse” (2.5%) were not significantly different than the U.S. averages (8.5% and 2.9%, respectively) or the Alabama percentages (7.3% and 2.6%).^{8,a,q} [FIGURE 45]



Notes:

Figure 45 was created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbss/^a

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^q

*The topic labels in Figure 45 are abbreviated versions of the YRBSS questions. For further information, visit the CDC's YRBSS Web site at: <http://www.cdc.gov/HealthyYouth/yrbss/>^a

HEALTH

CHILD & TEEN DEATHS



“One of the keys to a successful mental health system in Mississippi lies in prevention with young adults. We’ve got to focus on prevention activities because if we don’t get to the kids, their families, schools, and communities by facilitating positive peer group interaction and sending a strong message about youth suicide, dispelling the stigma associated with mental illness, underage drinking and substance abuse, then we really are not doing a whole lot.”

– Edwin C. LeGrand III

Executive Director, Mississippi Department of Mental Health⁵⁷

policy considerations:

Promoting effective policies and programs to prevent the deaths of children requires a basic knowledge of the causes of death and how they change relative to the child’s age. Ten-year averages for Mississippi child deaths reveal that motor vehicle crashes were the leading cause of death for all children ages 1 to 19 from 1992 to 2001, followed by fire/burns for 1- to 9-year-olds, and homicide for 10- to 19-year-olds. Suicide is the third leading cause of death for teens ages 15 to 19.⁴⁵ (Please see the infant mortality section beginning on page 51 for a discussion of deaths of children ages 0 to 12 months.)

Given that the number one reason for death among Mississippi children from 1992 to 2001 was motor vehicle crashes, the significance of the primary seat belt law passed by the 2006 Legislature is evident, as is its enforcement (see the Safety/Safety Belt Usage section beginning on page 19 for additional information). Fire safety education and safe living environments for young children, as well as access to specialized treatment for burn victims in Mississippi, are also critically important. Furthermore, given that more youths (ages 10-19) are killed due to violence than physical/medical conditions is clearly cause for concern. Families and communities’ tolerance of youth access to weapons and drugs warrants consideration. Over-the-counter drugs and prescription medications are often used in suicide attempts. Finally, recognizing risk factors among youth is an important step in identifying those susceptible to suicide and other violent behavior.



MISSISSIPPI INDICATORS OF CHILD, FAMILY AND COMMUNITY

EDUCATIONAL SUCCESS



EDUCATION

EDUCATION

SCHOOL PERFORMANCE



High-quality public schools are increasingly important. With an expanding global economy and competition for jobs now extending way beyond American borders, students, particularly those from low-income families, depend now more than ever on public schools to provide them with the skills they need to compete. Unfortunately, many schools struggle to meet those demands, and expectations for U.S. students fall below those of other industrialized nations, as do test scores. With such high returns for students and society, public schools are an invaluable investment for America's future.¹⁻³

"For the first time all components of a school—students, teachers, principals, superintendents, school board members—are held accountable for student learning."

-Mississippi Public School Accountability Standards, 2007⁴

facts:

- In 2006, Mississippi had the second highest percentage of low-income children attending public schools. Seventy-five percent of Mississippi's public school students were from families with low incomes. In 1989, 59% of Mississippi's students were considered low income.⁵
- "Increases in education of the American workforce accounted for nearly one-quarter of the total growth in labor productivity in the 20th century. In the 21st century, knowledge will be even more important to economic prosperity." -The Brookings Institution⁶
- Workers in the United States now have competitors all over the world, and the most educated job seekers will be the most competitive.¹
- Several aspects of school quality affect student learning, including the skill level of teachers, the quality of classroom instruction, and the overall atmosphere of the school.⁷
- "About 70% of U.S. 8th graders are below the proficient level in reading, and most will never catch up." -Strong American Schools³
- "Ninth grade English teachers say they spend one-third of their time trying to re-teach skills that students should already have learned in middle school." -Strong American Schools³

The U.S. 8th-grade math curriculum is
at least 2 years behind that of other countries

SCHOOL PERFORMANCE



- The U.S. 8th-grade math curriculum is at least two years behind that of other countries, and 84% of American manufacturing companies cite specific deficits in the math and science skills of American students.³
- The Education Reform Act of 1982 required the Mississippi State Board of Education, acting through the Commission on School Accreditation, to establish and implement a permanent performance-based accreditation system for all public schools. School performance levels are assigned based on the following criteria: (a) meeting an annual growth expectation established for each individual school and (b) the percent of students who are achieving at certain levels. -Mississippi Department of Education, Office of Accreditation⁴
- Mississippi Superintendent of Education Hank Bounds stated in a September 2007 *Northeast Mississippi Daily Journal* interview that Mississippi is facing a teacher shortage that he characterizes as “a crisis.” Despite teacher pay raises, Mississippi is still below the Southeastern average since other states have also increased teacher pay. Consequently, many of the state’s students, particularly those from low-income families, find themselves in classrooms with teachers who have not obtained proper certification. Over 6% of Mississippi’s teachers have not acquired necessary certification.⁸
- Mississippi has 152 school districts, serving nearly 500,000 students and employing over 32,000 teachers.⁹

EDUCATION

SCHOOL PERFORMANCE

key findings:

SCHOOL ACCREDITATION

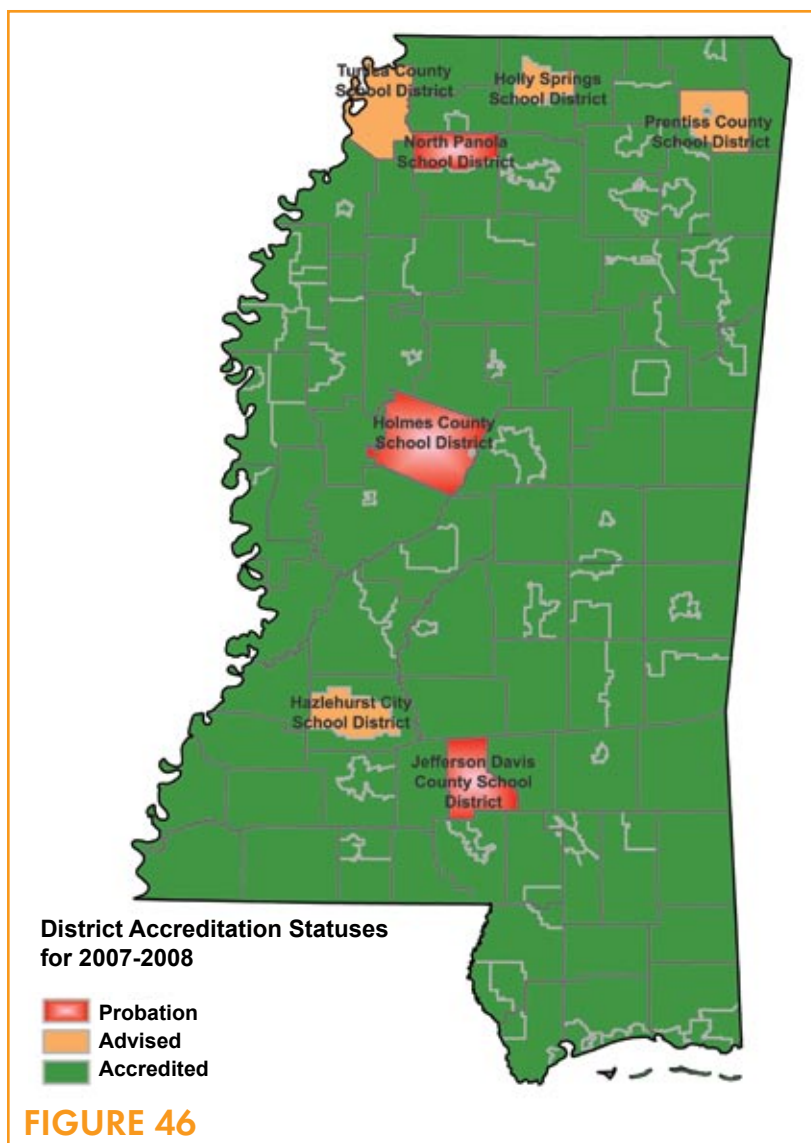
The 2007-2008 accreditation status for most (95%) Mississippi school districts is "accredited." Several school districts (3%) are "advised": Hazlehurst City School District, Holly Springs School District, Prentiss County School District, and Tunica County School District. A few school districts (2%) are on probation: Holmes County School District, Jefferson Davis County School District, and North Panola School District.^{10,aj} [FIGURES 46, 47]

Notes:

Data used to create Figures 46 and 47 were taken from the "Mississippi Statewide Accountability System: 2007 Results." The final results were approved by the State Board of Education on September 13, 2007, and are available online at <http://www.mde.k12.ms.us/Account/SAM07/ACC07LST.PDF>.

See Appendix B for further information on accreditation status designations.¹

*Percentages are based on 152 school districts.



District Accreditation Statuses for 2007-2008		
Status	# Districts	% Districts*
Accredited	145	95%
Advised	4	3%
Probation	3	2%
Withdrawn	0	0%

FIGURE 47

SCHOOL PERFORMANCE

key findings:

SCHOOL PERFORMANCE CLASSIFICATIONS

The percentage of schools receiving a superior, or Level 5, ranking in Mississippi increased from 19% in the 2003-2004 school year to 25% in 2007, while schools receiving a ranking of under-performing or low-performing decreased.^{10, 11,a,b,k}

[FIGURE 48]

School Performance Classifications	2003-2004		2007	
	# Schools	% Schools*	# Schools	% Schools
Level 5 Superior-Performing	153	19%	207	25%
Level 4 Exemplary	223	27%	215	26%
Level 3 Successful	309	38%	313	37%
Level 2 Under-Performing	106	13%	96	11%
Level 1 Low-Performing	31 [∞]	4%	11 [‡]	1%

FIGURE 48

Notes:

According to the 2007 Mississippi Public School Accountability Standards,⁴ performance classifications are based on "(a) the percentage of students at the school who are performing at criterion levels (basic and proficient) and (b) the degree to which student performance has improved over time (based on an expected growth value for the school)."

See Appendix B for further information on performance classifications.¹

Individual school performance classifications were assigned for the first time in September 2003.

*Percentages may not equal 100 due to rounding.

[∞]10 of these 31 were Priority Schools.

[‡]These 11 schools are Priority Schools, indicating that they were identified by the Mississippi Department of Education as being "deficient in educating students and are in need of improvement."⁴

policy considerations:

Several measures have affected public education in Mississippi in recent years. The Mississippi Student Improvement Act of 1999 (passed by the Legislature in 1999 with additional legislation in 2000) expanded the 1982 sweeping Education Reform Act by not only holding individual school districts accountable for their accreditation status, but also incorporating performance standards that measure each school's progress based on student achievement. The 2007 legislative session provided first-time full funding of the Mississippi Adequate Education Program, designed to ensure that every school district has sufficient funds to meet accreditation requirements.⁴ These measures are a beginning toward improved school performance. Consequently, there is work to be done among researchers, school districts, and communities to track progress and determine long-term benefits for economic development and to also provide solid data on the actual return on investments at a local level.

There are other steps that can be taken. Research indicates that increased returns on investments can be made with the adoption of several policy options in the Quality Education Act of 2008, ranging from the establishment of quality pre-K programs to increasing support for children at risk.¹² The findings of the 2007 Legislature-appointed Commission on At Risk Funding (expected December 2007) should be widely disseminated and communicated to Mississippi's citizenry to increase awareness about the proportion of Mississippi's children considered at risk. Furthermore, enhanced student and family-centered supports could be provided for children attending non-accredited schools to assist with individual student learning during probationary periods. Finally, community-based awards for exemplary students and school personnel (e.g., bus drivers, cafeteria workers, teacher assistants, support staff, teachers, principals and superintendents) can be provided through economic development partnerships.

EDUCATION

EDUCATIONAL ATTAINMENT



“Education has always played a role in determining Americans’ economic and occupational success, but its influence has never been greater than it is today. Over the past two decades, people without high school diplomas have suffered an absolute decline in real income and have dropped further behind individuals with more education. The result is a pattern of increased economic marginalization for those Americans with the least education.”

-The Annie E. Casey Foundation¹³

facts:

- In 2005, Mississippi ranked 36th in the nation for its percentage (9%) of teens (ages 16 to 19) who were high school dropouts.^{15,e,g} This status rate, or “snapshot,” applies to a single year and measures the proportion of students in a particular age category who are not enrolled in school and who have not yet completed high school. Consequently, this measure typically yields a low rate.
- Preliminary “full cohort” analyses, often considered a more useful measure, were conducted by the Mississippi Department of Education and estimated the current dropout rate to be 26.6%. Full cohort analyses estimate the number of students who did not complete high school on time by following a group of students from their freshman year to their senior year, accounting for the original students in the group plus every student who was added to the group over time. “True cohort” analyses examine data for the original freshmen students only, and the preliminary true cohort dropout figure is estimated by the Department of Education at 26.0%.^{16,17,c,d,l,m} Official 2006 dropout estimates will be released by the Department of Education in December 2007.

[Note: The concepts of dropout rates and graduation rates can be measured in a number of ways. This section represents our efforts at presenting the most recent and valid measures of educational attainment in Mississippi. Please consult Appendix B for the details of each individual measure.]

- “[Nationwide], more than 1.2 million students drop out of school every year, 60% of whom are from low income families.” “That’s more than 6,000 students every school day and one every 26 seconds.” -Strong American Schools^{2,3}
- Nationally, minority students have much lower graduation rates. And, approximately just half of all Latino and African American students graduate high school on time.³
- Families with head-of-household dropouts are more than twice as likely to live in poverty, and almost 44% of those under the age of 24 who drop out of high school are unemployed. For those over age 25 who drop out of high school, the unemployment rate is more than three times that of those who completed college.³

IN 2005

11%

of Mississippi teens ages 16 to 19 were not enrolled in school or employed

EDUCATIONAL ATTAINMENT



Healthy People 2010 Goals:

The national goal is to increase the proportion of persons aged 18 to 24 who have completed high school from 85 percent (1998) to 90 percent by 2010. (Objective 7-1)³⁴

- A 2006 national report funded by the Bill and Melinda Gates Foundation revealed that Mississippi is graduating a higher percentage of African American males than the national average. Mississippi public schools tend to lag behind in graduating males, especially White males, compared to the nation as a whole. The graduation rate for Mississippi males was 11.6 percentage points lower than the national rate, and the largest difference was for White males, which was 13.5 percentage points lower.¹⁸
- A study by the Philadelphia Education Fund and Johns Hopkins University revealed that indicators of high school drop out are present by the sixth grade, and almost 50% of future dropouts can be identified at that time. The indicators include failing grades in math or English and poor behavior and attendance.¹⁹
- Nationally, 9% of females were high school dropouts in 2004, compared to 12% of males.²⁰
- Based on preliminary numbers released in November 2006, more than one-fourth of Mississippi's public school students are not graduating. These numbers are higher than in past years. According to the State Department of Education, a new tracking system is the reason for more accurate numbers. A new state Dropout Prevention Plan has been created, which calls for the dropout rate to be cut in half by 2013. Two summits will be held by the Mississippi Department of Education in January 2008. One will be held for students, one for adults. An awareness campaign is also planned that will utilize television, newspaper, and radio advertisements. Furthermore, committees from each school district are charged with finding solutions to high dropout rates. – *The Clarion Ledger*, November 17, 2006 and April 9 & October 26, 2007^{21, 22, 23}
- In 2005, Mississippi tied with 5 other states (Georgia, Kentucky, New Mexico, Tennessee, and West Virginia) for the highest percentage (11%) of teens ages 16 to 19 who were not enrolled in school or employed.^{15,e,h}

EDUCATION

EDUCATIONAL ATTAINMENT

key findings:

GRADUATION RATES

Estimated dropout and 4-year graduation rates were determined by following Mississippi students from their freshman year until expected graduation. The 2001 9th-grade “true cohort” consisted of 38,818 students. For this cohort, the 4-year estimated graduation rate was 60.6%; this number increases to 63.2% when the students who took more than four years to graduate were considered. An estimated 26% of this true cohort dropped out of school. Updated cohort dropout rates for 2006 will be available December 2007 from the Mississippi Department of Education.^{17,d,m,n,o,p} [FIGURE 49]

Mississippi 4-year graduation rate estimates:
True cohort of students in Grade 9 in September 2001
(The Graduating Class of 2005)

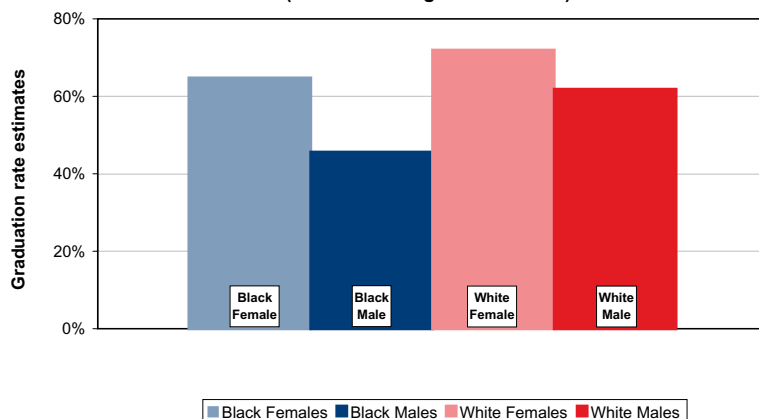


FIGURE 49

“When you lose 13,000 students a year in dropouts, think about what kind of workforce you’re losing. It will take all of us focusing on these efforts to change the face of things.”

-Mississippi Education Superintendent Hank Bounds in an October 26, 2007, Interview, *The Clarion Ledger*²³

policy considerations:

A number of strategies may be employed by schools to address the issue of drop out and encourage graduation.^{24,25}

- attracting and maintaining highly qualified teachers and administrators
- encouraging attainment of benchmarks that measure progress toward graduation, beginning with quality early learning environments that promote school readiness
- examining the myriad determinants of students’ outcomes (both successful and less than optimal)
- providing administrators and school boards with “model schools/programs” that highlight school successes from Mississippi and the nation
- working with researchers to link economic development activities to school successes
- establishing uniform definitions of drop out and graduation for use in reporting
- reporting graduation and dropout rates by gender, ethnicity and school district
- providing after-school programs, summer programs, mentoring, and health clinics for students

AN ESTIMATED

1.2 million

students in the class of 2007 failed to graduate with their peers²⁶

EDUCATIONAL ATTAINMENT

key findings:

HIGH SCHOOL DROPOUTS

Mississippi had a significantly lower percentage of teens aged 16 to 19 who were high school dropouts in 2005 (9%) than in 2000 (15.4%). However, Mississippi had a significantly higher percentage of dropouts in 2005 than the nation as a whole (7.3%). Mississippi was not significantly different from Alabama or Georgia in 2005, however.^{15,e,g,i,q} [FIGURE 50]

In 2005, Mississippi was ranked 45th in the nation for its percentage of children (20%, or 152,000 children) living in a household where the head of household was a high school dropout. The national average for 2005 was 16%.^{15,e,g,i,q} [FIGURE 51]

“The McComb School District has established an on-site day care for the children of the girls who attend their school. This enables these young mothers to attend school, to be taught how to parent their children by school staff on-site, to be given information about delaying the second pregnancy, and to be encouraged to graduate for the sake of their child and family. The children of these young mothers are given a safe environment for eight hours of the day, given appropriate nutrition, and are given a chance to be ‘caught up’ for pre-school or first grade. It’s a win-win-win situation.”

-Mary Armstrong, MD
Mississippi Department of Health²⁷

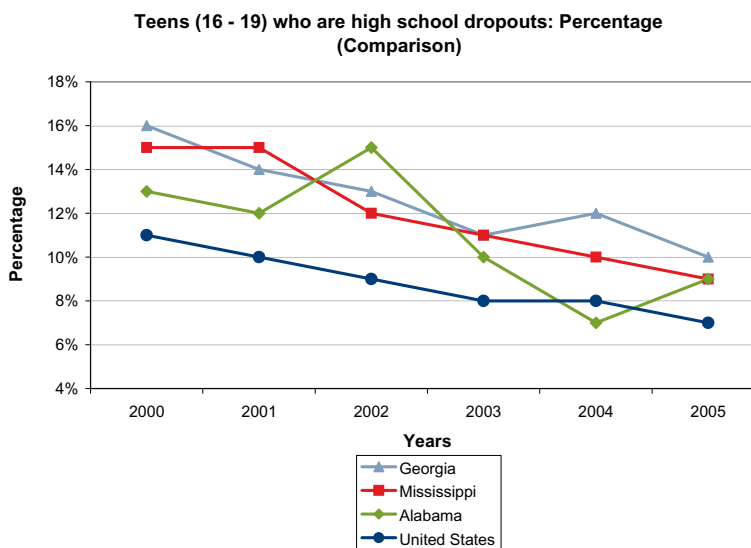


FIGURE 50

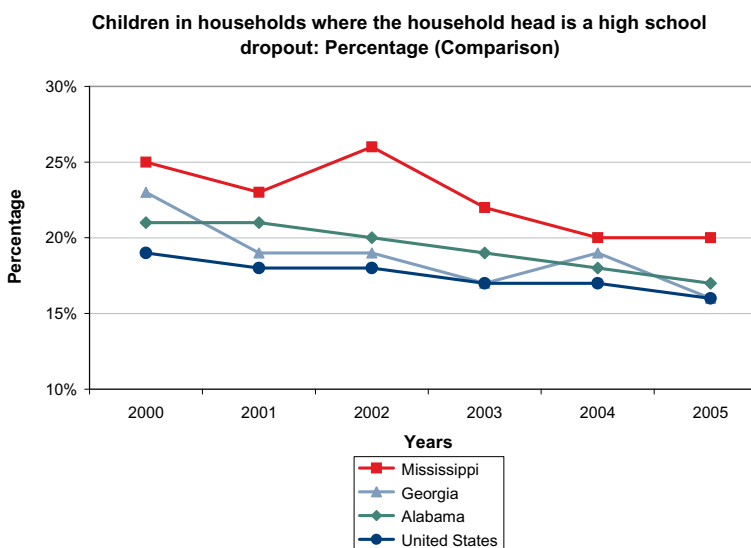


FIGURE 51

“Higher educational attainment levels are critical to our long-term well-being. Our relatively low educational attainment levels are being fueled by unreasonably high dropout rates at the high school and college levels in Mississippi.”

-Lewis Whitfield
Senior Vice President
CREATE Foundation¹⁴

EDUCATION

SCHOOL VIOLENCE



“Youth attending schools where fighting is common may be unable to maintain the focus necessary for academic success. Adolescents who are victims of violence are also more likely to be a victim or perpetrator of violence during adulthood. The likelihood of drug use, property offenses, and stress during adulthood also increase with youth violence.”

-Child Trends²⁸

“Protecting our children during school hours is an around-the-clock job, and requires a strong working relationship between law enforcement and the education community.”

-Anne Milgram

New Jersey Attorney General

in Newsday.com

October 28, 2007²⁹

facts:

- Nationally in 2005, a lower percentage of 12th-grade students (29%) reported fighting than 9th-grade students (44%).²⁸ However, students in grades 9 through 12 showed very little difference in the percentage who reported that they carried a weapon.³⁰
- Family connectedness, close relations with peers, religiosity, and good grades are considered to be protective against youth fighting.²⁸
- “Risk factors that predict violence by youth include substance abuse by the youth, conflict and abuse in the home, harsh or inattentive parenting, antisocial and delinquent peers, and neighborhoods where crime and drug use are prevalent. Youth who are involved in physical fighting are also often engaged in other high-risk activities such as illegal drug use, binge drinking, carrying weapons, and having unsafe sex.” -Child Trends²⁸
- In 2005, 6% of the nation’s 9th- to 12th-grade youth reported that they did not attend school on one or more days in the past 30 days because they felt unsafe at school or on their way to/from school.³¹
- In a number of recent incidents of school violence nationwide, school bullying has been identified as a contributing factor. Bullying is said to occur when one person repeatedly exhibits aggressive behavior or intentional harm toward another, and a power imbalance exists in the relationship. School bullying is now considered a major public health issue.³²

In 2003

10.2%

of Mississippi 9th- to 12th-grade students reported being involved in a fight at school in the past year^{33,f}

SCHOOL VIOLENCE

Healthy People 2010 Goals:

A national health goal for 2010 is to reduce weapon carrying by adolescents on school property to 4.9%, which would be down from 6.9% in 1999. (Objective 15-39)³⁴



- A statement released May 25, 2007, indicated that Mississippi Attorney General Jim Hood has joined a coalition of Attorneys General from around the nation. Given recent and ongoing school violence around the country, this national Task Force on School Safety will consider legal issues associated with school violence and safety. Attorney General Hood remarked, "As the chief legal officers of our respective jurisdictions, Attorneys General have a unique role in implementing steps to ensure that all places of learning are safe, secure and free from the disruptive influences of fear and violence."³⁵
- In 2003, the national percentage of students who had been threatened or injured with a weapon on school property during the past 12 months was significantly higher than the Mississippi percentage. No significant difference was found between Mississippi and Alabama for 2003.^{33,f,r}

EDUCATION

SCHOOL VIOLENCE

key findings:

CARRYING A WEAPON ON SCHOOL PROPERTY

The percentage of Mississippi 9th- to 12th-grade students who reported they carried a weapon on school property on one or more of the past 30 days decreased significantly from 1993 (13.5%) to 2003 (5.2%). A significantly higher percentage of Mississippi 9th- to 12th-grade males reported that they carried a weapon on school property for each surveyed year from 1993 to 2003.^{33,f,r}

[FIGURE 52]

Percentage of students who carried a weapon on school property on one or more of the past 30 days (Mississippi)

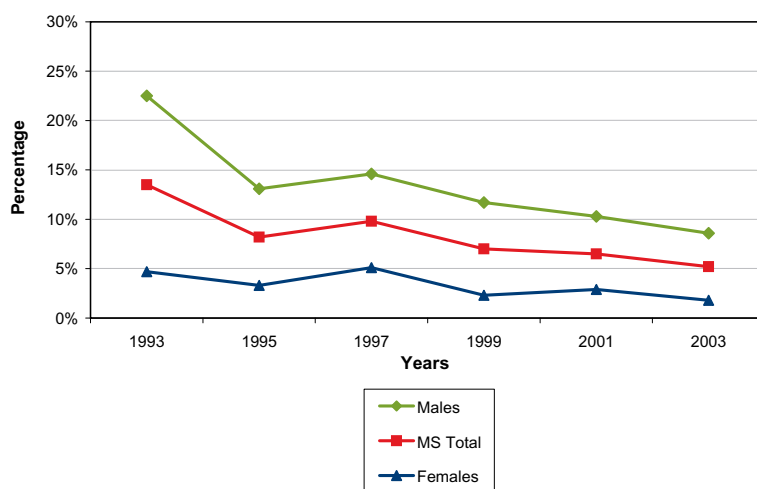


FIGURE 52

FIGHTING ON SCHOOL PROPERTY

For each surveyed year between 1993 and 2003, a significantly higher percentage of Mississippi 9th- to 12th-grade males reported fighting on school property in the past 12 months than did females. There was a significant decrease in the percentage of students who reported being involved in fights on school property from 1993 (17%) to 2003 (10.2%).^{33,f,r}

[FIGURE 53] Additionally, in 1993, a significantly higher percentage of Mississippi students reported being involved in fights on school property compared to the percentage of Alabama students. However, in 2003, there were no significant differences between Mississippi and Alabama or the United States as a whole.

Percentage of students who were in a physical fight on school property one or more times during the past 12 months (Mississippi)

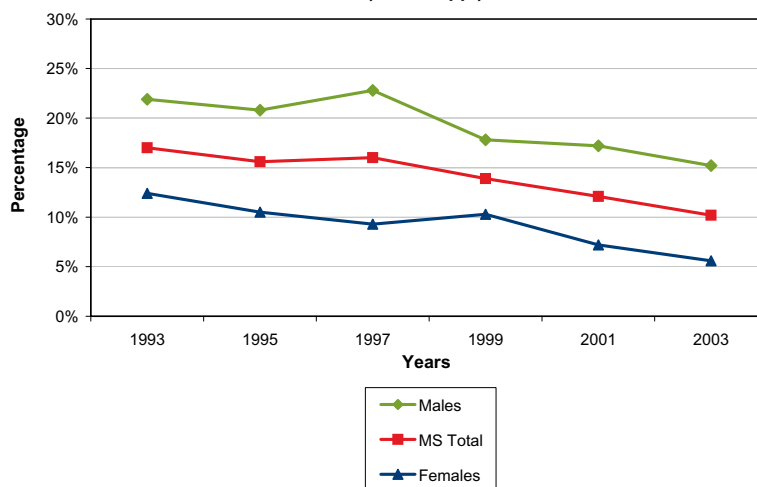


FIGURE 53

In 2003

26.4%

of Mississippi 9th- to 12th-grade students reported having property stolen or damaged at school in the past year

SCHOOL VIOLENCE

key findings:

PROPERTY STOLEN OR DAMAGED ON SCHOOL PROPERTY

In 1993, a significantly higher percentage of Mississippi 9th- to 12th-grade students (38.3%) reported having property stolen or damaged at school during the past 12 months compared to the U.S. (32.7%). However, between 1993 and 2003, Mississippi demonstrated significant declines in the percentage of students reporting stolen or damaged property, and in 2003, the Mississippi percentage (26.4%) was significantly lower than the U.S. percentage (29.8%).^{33,f,r}

[FIGURE 54]

Notes:

Figures 52-54 were created using data from the Youth Risk Behavioral Surveillance System (YRBSS). For some survey questions, 2005 data were available for the U.S. and/or other states. However, Mississippi's 2005 YRBSS did not achieve a 60% response rate; therefore, the results were not statistically reflective of all students in grades 9-12. Unweighted data are typically not released. Therefore, we are making comparisons to other states and the nation using selected data from the years 1993-2003. For further information, visit the CDC's YRBSS Web site at: www.cdc.gov/HealthyYouth/yrbs/

Bar Graphs:

Bars with diagonal lines indicate that Mississippi was significantly different than the U.S. and/or other states. For example, if the Mississippi bar is filled with diagonal lines, and so is the U.S. bar, Mississippi is significantly different from the U.S. Solid bars indicate the differences were not significant between Mississippi and the U.S. and/or other states.^f

*Data were not available for Alabama in 1993.

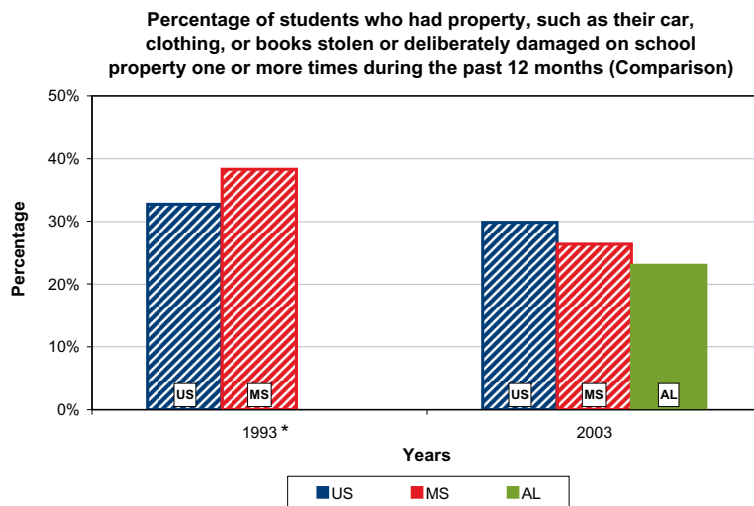


FIGURE 54

"Most young people do not seek support services and, quite often, family members and school personnel are unaware of the youth's exposure [to violence]. Consequently, a more uniform identification and referral procedure is needed... Schools appear to be the most promising avenue for successful identification of and therapeutic intervention for exposed and victimized youth."

-Garbarino, Bradshaw & Vorrasi in *The Future of Children*³⁶

policy considerations:

In order for schools to be safe, a combination of efforts is required. School environments must be evaluated and controlled, and students, school staff, parents, and communities must be educated. Recommendations for the prevention of bullying and school violence include the following:^{36, 37}

- comprehensive anti-bullying and anti-violence programs for children and teens in kindergarten through high school
- education for parents on reducing children's access to violent media, recognizing risk behaviors, and being involved in their children's lives
- training for all school personnel, including teachers, bus drivers, maintenance workers, cafeteria workers, etc.
- management of school grounds to minimize the opportunity for violence
- comprehensive prevention and intervention programs for communities

The Attorneys General Task Force on School Safety report is available on Mississippi Attorney General Jim Hood's Web site at http://www.ago.state.ms.us/index.php/sections/families/school_safety.

ACKNOWLEDGEMENTS

Building a strong **MS KIDS COUNT** program requires the work and support of many individuals. The various skills and expertise are evident in the production of the first **MS KIDS COUNT** Data Book from its new home at Mississippi State University (MSU). This Data Book reflects the work of a truly dedicated team who recognize the potential significance of KIDS COUNT in Mississippi.

The team members include the following: Dorris Baggett, Dr. Ronald Cossman, Ginger Cross, Meghan Dunaway, Heather Hanna, Laura Kerr, Ayesha Khurshid, Sarah Leonard, Erdenechimeg Eldev-Ochir, and Deadric Williams.

We are also appreciative of **MS KIDS COUNT** Advisory Board members, several of whom helped us identify successful Mississippi programs and obtain quotes from Mississippians involved in the day-to-day work of improving outcomes for children. Clarification of data issues, particularly from the MS State Department of Education and MS State Department of Health's research and data departments were extremely helpful.

The work of Haley Montgomery at Dux D'Lux in layout has been outstanding. Although named earlier, the long hours and tedious work of coordinating layouts and final editing in order to 'go to press' on time performed by Dorris Baggett, Heather Hanna and Ginger Cross have been phenomenal, making the Data Book deadlines a reality. Some of the original photos in the Data Book were taken by Richard Levine, who graciously donated his time in this effort. We anticipate the inclusion of additional photos on the **MS KIDS COUNT** Web site (<http://www.ssrc.msstate.edu/mskidscount>) at a later date and appreciate the permission of the parents and the participation of the children who agreed to be photographed.

We have been encouraged by Cory Anderson, Laura Beavers, Don Crary and William O'Hare with the Annie E. Casey Foundation, as well as other KIDS COUNT grantees across the country.

We would also like to extend special recognition to Blue Cross & Blue Shield of Mississippi for their support of the inaugural "State of Mississippi's Children Summit," where the 2007 **MS KIDS COUNT** Data Book will be released. Shortly after the summit, the Data Book will be available online.

The ongoing support of Dr. Vance Watson, MSU's Vice President of the Division of Agriculture, Forestry and Veterinary Medicine, along with Dr. Arthur G. Cosby, Director of MSU's Social Science Research Center (SSRC), cannot be overstated in making this a reality.

As noted in the introduction, this Data Book is just a beginning and seeks to provide an overview of the various domains affecting the lives of children, their families and communities within Mississippi. While there are numerous projects that we have been and continue to be fortunate to work on at the Family and Children Research Unit at the SSRC, we, the KIDS COUNT staff, are honored to be a part of a publication and recognized program that provides solid, up-to-date data about and on behalf of Mississippi's children.

Linda H. Southward, **MS KIDS COUNT** Coordinator



APPENDICES

APPENDIX A: References

THE STORY

1. U.S. Census Bureau, Population Division. Estimates of the Population by Selected Age Groups for the United States and States and for Puerto Rico: July 1, 2006 [SC-EST2006-01]. May 17, 2007. Available at: <http://www.census.gov/popest/states/asrh/tables/SC-EST2006-01.xls>. Accessed October 29, 2007.
2. Population Reference Bureau. Analysis of data from the U.S. Census Bureau. 2006 American Community Survey. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed October 1, 2007.
3. U.S. Census Bureau. Mississippi Population and Housing Narrative Profile: 2006. Available at: http://factfinder.census.gov/servlet/NPTable?_bm=y&-geo_id=04000US28&-qr_name=ACS_2006_EST_G00_NP01&-gc_url=null&-ds_name=&-_lang=en&-redoLog=false. Accessed December 7, 2007.
4. The Annie E. Casey Foundation. KIDS COUNT State-level data online. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.
5. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "Full Cohort" Analysis - Updated. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.
6. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "True Cohort" Analysis. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.

SAFETY

1. National Highway Traffic Safety Administration. Primary Enforcement Saves Lives. Available at: <http://www.nhtsa.dot.gov/people/injury/enforce/PrimaryEnforcement/pages/Section6.htm#slhggvshgvdjssjdj>. Accessed October 2, 2007.
2. Kim Proctor. Mississippi Office of Highway Safety. Personal communication (E-mail). October 8, 2007.
3. U.S. Department of Health and Human Services. Healthy People 2010 Midcourse Review. Available at: <http://www.healthypeople.gov/>. Accessed November 1, 2007.
4. Child Trends Data Bank. Seat Belt Use and Child Safety Seats. Available at: <http://www.childtrendsdatabank.org/indicators/45seatbeltuse.cfm>. Accessed October 1, 2007.
5. National Highway Traffic Safety Administration. Traffic Safety Facts 2005: Children. Washington (DC). December, 2006.
6. National Highway Traffic Safety Administration (2006). Primary enforcement saves lives: The case for upgrading secondary safety belt laws. [DOT HS 810 649. Available at: <http://www.nhtsa.dot.gov/people/injury/enforce/PrimaryEnforcement/images/PrimaryEnforcement.pdf>. Accessed December 7, 2007.
7. National Highway Traffic Safety Administration. 2006 Annual Assessment of Motor Vehicle Crashes. Available at: <http://www.nhtsa.dot.gov/portal/site/nhtsa/menuitem.416f74e8613992381601031046108a0c/>. Accessed December 7, 2007.
8. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results. Available at: www.cdc.gov/yrbss. Accessed November 1, 2007.
9. Presidential Initiative for Increasing Seat Belt Use Nationwide: Recommendations from the Secretary of Transportation. National Highway and Transportation Safety Administration. Available online at: http://www.nhtsa.dot.gov/people/injury/airbags/Archive-04/PresBelt/america_seatbelt.html. Accessed December 7, 2007.
10. National Highway Traffic Safety Administration. Traffic Safety Facts: Crash Stats. Seat belt use in 2006. A Brief Statistical Summary. [DOT HS 810 690]. January 2007. Available at: <http://www.nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/RNotes/2007/810690.pdf>. Accessed December 7, 2007.

APPENDIX A: References

11. National Highway Traffic Safety Administration. Traffic Safety Facts. Traffic Tech – Technology Transfer Series [Number 317]. Primary enforcement saves lives: The case for upgrading secondary safety belt laws. September 2006. Available at: <http://www.nhtsa.dot.gov/staticfiles/DOT/NHTSA/Communication%20&%20Consumer%20Information/Traffic%20Tech%20Publications/Associated%20Files/tt317.pdf>. Accessed December 7, 2007.
12. Chen L, Baker S, Li, G. Graduated driver licensing programs and fatal crashes of 16-year-old drivers: A national evaluation. *Pediatrics*. 2006; 118; 56-62. Available at: <http://www.pediatrics.org/cgi/content/full/118/1/56>. Accessed December 7, 2007.
13. Schieber RA, Sacks JJ. Measuring community bicycle helmet use among children. *Public Health Rep*. March-April 2001; 116:113-121. Available at: <http://cdc.gov/ncipc/pub-res/helmet.pdf>. Accessed October 2, 2007.
14. American Academy of Pediatrics. Committee on Injury and Poison Prevention. Bicycle helmets. *Pediatrics*. 2001; 108: 1030-1032. Available at: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/4/1030>. Accessed December 7, 2007.
15. Hayden C. Safety matters. *Clarion-Ledger*. December 4, 2003: Local Section: 1B.
16. Cookie Leffler. Mississippi Department of Transportation. Personal communication (E-mail). September 25, 2007.
17. Ortega H, Shields B, Smith G. Bicycle-related injuries to children and parental attitudes regarding bicycle safety. *Clin Pediatr*. 2004; 43(3): 251-259.
18. American Medical Association. AMA policies on alcohol: Operating vehicles under the influence of alcohol or other drugs – underage drinking and driving. May 8, 2002. Available at: http://www.ama-assn.org/ama1/pub/upload/mm/388/underage_drnkndrive.pdf. Accessed October 3, 2007.
19. The Century Council. Fact Sheet - 65% Campaign. Available online at: http://www.centurycouncil.org/underage/65_factsheet.html. Accessed December 7, 2007.
20. Child Trends DataBank. Drunk driving. Available at: <http://www.childtrendsdatabank.org/indicators/41DrunkDriving.cfm>. Accessed October 3, 2007.
21. Shults RA. Child passenger deaths involving drinking drivers—United States, 1997–2002. *MMWR Weekly*. 2004; 53(4):77–79. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5304a2.htm>. Accessed December 7, 2007.
22. National Center on Addiction and Substance Abuse at Columbia University. Califano calls for fundamental shift in attitudes and policies about substance abuse and addiction. May 7, 2007. Available at: <http://www.casacolumbia.org/absolutenm/templates/pressreleases.aspx?articleid=487&zoneid=65>. Accessed December 7, 2007.
23. Centers for Disease Control and Prevention, Public Health Law Program. The public's health and the law in the 21st century. 5th Annual Partnership Conference. Innovative tools to fight gang violence. Available at: http://www2a.cdc.gov/phlp/conferencecd2006/docs/out_21.pdf. Accessed October 3, 2007.
24. Legal Community against Violence (LCAV). Regulating guns in America: an evaluation and comparative analysis of federal, state and selected local gun laws. August 2006. Available at: http://www.lcav.org/content/child_access_prevention.pdf. Accessed October 3, 2007.
25. Child Trends DataBank. Students carrying weapons. Available at: <http://www.childtrendsdatabank.org/indicators/19StudentsCarryingWeapons.cfm>. Accessed October 3, 2007.
26. Child Trends DataBank. Physical fighting by youth. Available at: <http://www.childtrendsdatabank.org/indicators/22PhysicalFighting.cfm>. Accessed October 3, 2007.
27. Duran R, Barkin S, Craig J, Weiley V, Ip E, Wasserman R. Firearm ownership and storage patterns among families with children who receive well-child care in pediatric offices. *Pediatrics*. 2007; 119(6): 1271-1279.

APPENDICES

APPENDIX A: References

WELL-BEING

1. Shore R. Increasing the percentage of children living in two-parent families. KIDS COUNT Indicator Brief. July 2003. The Annie E. Casey Foundation. Available at: <http://www.aecf.org/upload/PublicationFiles/increasing%20the%20percentage.pdf>. Accessed October 1, 2007.
2. Butts DM, Peterson, J. Grandparents Raising Grandchildren. In: Cosby AG, Greenberg RE, Southward LH, Weitzman M, eds. About Children: An Authoritative resource on the state of childhood today. Chicago, IL: American Academy of Pediatrics.
3. Sawhill I, Haskins R. Ending poverty in America: using carrots and sticks. Am Prospect. May 2007. Available at: <http://brookings.edu/views/articles/sawhill/200705haskins.htm>. Accessed October 1, 2007.
4. Child Trends DataBank. Secure parental employment. Available at: <http://childtrendsdatabank.org/indicators/68ParentalEmployment.cfm>. Accessed October 1, 2007.
5. Fields JM, Smith KE. Poverty, family structure, and child well-being: Indicators from the SIPP. U.S. Bureau of the Census, Population Division. Working Paper No. 23. April 1998. Available at: <http://www.census.gov/population/www/documentation/twps0023.html>. Accessed October 1, 2007.
6. The Annie E. Casey Foundation. KIDS COUNT State-level data online. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.
7. U.S. Department of Labor, Bureau of Labor Statistics (October 2007). Unemployment rates for states: Monthly rankings seasonally adjusted. Available at: <http://www.bls.gov/web/laumstrk.htm>. Accessed November 6, 2007.
8. Mississippi Department of Employment Security. Mississippi employment rates by county. October 2007. http://www.mdes.ms.gov/wps/PA_1_0_CH/docs/LMI/MAPS/URATESMAPBW.pdf. Accessed December 5, 2007.
9. Speechley KN, Avison WR, Thorpe CF. Parental unemployment and children's health. *Pediatr Res*. April 1996;39 (suppl 2):114.
10. Meyer K. An initial description of the relationship between parental unemployment and adolescent employment. Paper presented at the Annual Meeting of the American Educational Research Association. *Eric Digest* - ED292991. April 1988. Available at: http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/1c/8d/2f.pdf. Accessed October 1, 2007.
11. Shore R. Increasing the percentage of children whose parents have stable employment. KIDS COUNT Indicator Brief. July 2005. Available at: <http://www.aecf.org/upload/PublicationFiles/DA3622H1246.pdf>. Accessed October 31, 2007.
12. Christina R, Goodman J. Going to scale with high-quality early education. Choices and consequences in universal pre-kindergarten efforts. Available at: http://www.rand.org/pubs/research_briefs/RB9101/index1.html. Accessed December 7, 2007.
13. National Center for Children in Poverty. Columbia University Mailman School of Public Health. Child poverty. Available at: <http://www.nccp.org/topics/childpoverty.html>. Accessed October 1, 2007.
14. O'Hare W. Child poverty high in rural America. Fact Sheet 6. 2007. Available online at: http://carseyinstitute.unh.edu/FS_ruralchildpoverty_07.htm. Accessed December 7, 2007.
15. Child Trends DataBank. Children in poverty. Available at: <http://www.childtrendsdatabank.org/indicators/4Poverty.cfm>. Accessed October 1, 2007.
16. Child Trends DataBank. Long-term poverty. Available at: <http://www.childtrendsdatabank.org/indicators/61LongTermPoverty.cfm>. Accessed October 1, 2007.
17. Sid Salter. *Clarion Ledger*. May 9, 2007: Main section: 9A.
18. Parisi, Domenico, Grice SM, Taquino M, Gill G. Community concentration and its consequences on nonmetropolitan county persistence of poverty in Mississippi. *Socio Spec*. 2005; 25:469-483.

APPENDIX A: References

19. U. S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE). Estimates for Mississippi Counties "Under age 18 in poverty, 2004". Available at: <http://www.census.gov/hhes/www/saie/>. Accessed November 1, 2007.
20. Cauthen NK. Improving work supports: Closing the financial gap for low-wage workers and their families. The Economic Policy Institute. Briefing Paper #198. October 2007. Available at: <http://www.sharedprosperity.org/bp198.html>. Accessed October 31, 2007.
21. Salter S. Morning with Joel B. Waters. Clarion-Ledger. December 4, 2005: Perspective section: 2G.

HEALTH

1. American Academy of Pediatrics. Council on Sports Medicine and Fitness and Council on School Health. Active healthy living: Prevention of childhood obesity through increased physical activity. Available at: http://aappolicy.aappublications.org/policy_statement/index.dtl#A. Accessed October 24, 2007.
2. Laura Jana, MD, FAAP. Personal communication (E-mail). October 17, 2007.
3. Child Trends DataBank. Participation in school athletics. Available at: <http://www.childtrendsdatbank.org/indicators/37SchoolAthletics.cfm>. Accessed October 24, 2007.
4. National Center for Chronic Disease Prevention and Health Promotion. Nutrition and the health of young people. Healthy Youth Web Site. Available at: <http://www.cdc.gov/HealthyYouth/nutrition/facts.htm>. Accessed October 24, 2007.
5. Child Trends DataBank. Overweight children and youth. Available at: <http://www.childtrendsdatbank.org/indicators/15OverweightChildrenYouth.cfm>. Accessed October 24, 2007.
6. Hellmich N. Parents in denial on kids' weight; It's up to adults to change. Chicago Sun Times. September 16, 2007. Available at: http://findarticles.com/p/articles/mi_qn4155/is_20070916/ai_n20504049. Accessed October, 2007.
7. Rebecca Helmes and Natalie Chandler. Clarion Ledger. April 16, 2007: Metro section: 1A.
8. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth online: Comprehensive results. Available at: www.cdc.gov/yrbss. Accessed November 1, 2007.
9. U.S. Department of Health and Human Services. Healthy People 2010 Midcourse Review. Available at: <http://www.healthypeople.gov>. Accessed November 1, 2007.
10. Kolbo JR, Harbaugh B, Anderson-Lewis C, Zhang L, Lee J, Sasser T. What do Mississippians think about childhood obesity? Findings from the 2006 Mississippi Public Perception of Childhood Obesity Survey. The Center for Mississippi Health Policy. December 2006. Available at: <http://www.mshealthpolicy.com/documents/USMObesitySurveyReport1-8-07.pdf>. Accessed November 6, 2007.
11. National Initiative for Children's Healthcare Quality. Childhood Obesity Action Network. CHDP Provider Information Notice No. 07-13. October 2007. Available at: <http://www.dhs.ca.gov/pfch/cms/onlinearchive/pdf/chdp/providerinformationnotices/2007/chdpin0713.pdf>. Accessed December 10, 2007.
12. American Academy of Pediatrics. Overweight and Obesity Web Site. Current News and Events. F as in Fat: How obesity policies are failing in America, Issue Report. August 2007. Available at: <http://healthyamericans.org/reports/obesity2007/Obesity2007Report.pdf>. Accessed October 24, 2007.
13. National Center for Chronic Disease Prevention and Health Promotion. Tobacco use and the health of young people. Available at: <http://www.cdc.gov/HealthyYouth/tobacco/facts.htm>. Accessed October 26, 2007.
14. Child Trends DataBank. Binge drinking. Available at: <http://www.childtrendsdatbank.org/indicators/2BingeDrinking.cfm>. Accessed October 26, 2007.

APPENDICES

APPENDIX A: References

15. National Institute on Drug Abuse. Marijuana: Facts parents need to know. Available at: <http://www.drugabuse.gov/MarijBroch/parentpg5-6N.html#>. Accessed October 26, 2007.
16. The National Center on Addiction and Substance Abuse at Columbia University. National Survey of American Attitudes on Substance Abuse VIII: Teens and Parents. August 2003. Available at: http://www.casacolumbia.org/pdshopprov/files/2003_Teen_Survey_8_19_03.pdf. Accessed October 26, 2007.
17. National Institute on Drug Abuse. Marijuana: Facts for teens. Available at: <http://www.nida.nih.gov/MarijBroch/teenpg13-14.html#addicted>. Accessed October 26, 2007.
18. The Henry J. Kaiser Family Foundation. U.S. teen sexual activity. January 2005. Available at: <http://www.kff.org/youthhivstds/upload/U-S-Teen-Sexual-Activity-Fact-Sheet.pdf>. Accessed October 26, 2007.
19. Robert McMillen. Mississippi State University. Personal communication (E-mail). October 24, 2007.
20. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Alcohol and drug use. Available at: <http://www.cdc.gov/HealthyYouth/alcoholdrug/index.htm>. Accessed October 26, 2007.
21. The Annie E. Casey Foundation. KIDS COUNT State-level data online. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.
22. Gallogly M. Campaign for Tobacco Free Kids. Smoking and kids. September 2007. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0001.pdf>. Accessed December 8, 2007.
23. McMillen R, Nagel J, Valentine N. Cigarette smoking: 1998-2006. The Mississippi Youth Tobacco Survey. Social Science Research Center. Mississippi State University.
24. Campaign for Tobacco Free Kids. Research Center. You need to know the truth. <http://tobaccofreekids.org/research/>. Accessed December 8, 2007.
25. McMillen R, Valentine N, Simms A. Smoke-free Legislation and the Social Climate of Secondhand Smoke in Mississippi. October 2007. Social Science Research Center. Mississippi State University.
26. National Institute on Drug Abuse. NIDA InfoFacts: Marijuana. Available at: <http://www.nida.nih.gov/Infofacts/marijuana.html>. Accessed December 8, 2007.
27. National Highway Traffic Safety Administration. Drug impaired driving. Available at: <http://www.nhtsa.dot.gov/people/outreach/SafeSobr/15qp/web/iddrug.html>. Accessed December 8, 2007.
28. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Teen popularity tied to alcohol, tobacco, and illegal drug use. Family guide. Available at: <http://family.samhsa.gov/teach/popularity.aspx>. Accessed October 26, 2007.
29. National Center on Addiction and Substance Abuse. Tobacco: The smoking gun. [press release]. October 23, 2007. Available at: <http://www.casacolumbia.org/absolutenm/templates/PressReleases.aspx?articleid=508&zoneid=65>. Accessed December 8, 2007.
30. Terry-Humen E, Manlove J, Cottingham S. Trends and recent estimates: sexual activity among U.S. teens. Child Trends Research Brief. June 2006. Publication #2006-08. Available at: http://www.childtrends.org/Files/Child_Trends-2006_06_01_RB_SexualActivity.pdf. Accessed October 19, 2007.
31. Klein JD and the Committee on Adolescence. Adolescent Pregnancy: Current Trends and Issues. American Academy of Pediatrics Clinical Report. July 2005. Available at: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/1/281>. Accessed October 31, 2007.
32. National Center for Chronic Disease Prevention and Health Promotion. Sexual Risk Behaviors. Healthy Youth Web Site. Available

APPENDIX A: References

- at: <http://www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm>. Accessed October 19, 2007.
33. Child Trends DataBank. Teen births. Available at: <http://www.childtrendsdatbank.org/indicators/13TeenBirth.cfm>. Accessed October 19, 2007
 34. Brown L. Sex, teens: Parental influence matters. Clarion-Ledger. March 4, 2007: 1F.
 35. Mississippi State Department of Health. Public Health Statistics. Available at: <http://www.msdh.state.ms.us/phs/statisti.htm>. Accessed September 12, 2007
 36. Manlove J, Franzetta K, McKinnery K, Romano-Papillo A, Terry-Humen E. No time to waste: Programs to reduce teen pregnancy among middle school-aged youth. Washington, DC. National Campaign to Prevent Teen Pregnancy. 2004.
 37. The Guttmacher Institute. Facts on sex education in the United States. December 12, 2006. Available at: http://www.guttmacher.org/pubs/fb_sexEd2006.html. Accessed October 19, 2007.
 38. Sex, drugs and rock n' roll: what teens do, what parents assume and what parents can do. Action for Children North Carolina. December 2006. Available at: http://www.ncchild.org/images/stories/PDFs/teenriskreport_12-06.pdf. Accessed October 19, 2007.
 39. Task Force on Infant Mortality. Statement on infant mortality. American Academy of Pediatrics Web Site. Available at: <http://pediatrics.aappublications.org/cgi/reprint/78/6/1155>. Accessed October 22, 2007
 40. J. Edward Hill, MD, FAAFP. Personal communication (E-mail). October 22, 2007.
 41. Shore R. KIDS COUNT Indicator Brief. Reducing infant mortality. The Annie E. Casey Foundation. July 2005. Available at: <http://www.aecf.org/upload/PublicationFiles/DA3622H1239.pdf>. Accessed October 22, 2007.
 42. Shore R. KIDS COUNT Indicator Brief. Preventing low birth weight. The Annie E. Casey Foundation. July 2003. Available at: <http://www.aecf.org/upload/PublicationFiles/brief%20low%20birth%20weight.pdf>. Accessed October 22, 2007.
 43. Child Trends DataBank. Low and very low birth weight infants. Available at: <http://www.childtrendsdatbank.org/indicators/57LowBirthweight.cfm>. Accessed October 22, 2007.
 44. Office of Minority Health and Health Disparities. Eliminate disparities in infant mortality. Available at: <http://www.cdc.gov/omhd/AMH/factsheets/infant.htm>. Accessed October 22, 2007
 45. Cossman R. Leading causes of death among children in Mississippi. Mississippi Health Policy Research Center. Social Science Research Center. Mississippi State University. February 2005. Available at: <http://www.healthpolicy.msstate.edu/publications/lcdcms.pdf>. Accessed October 22, 2007.
 46. Mitchell J. Infant deaths highest in Mississippi. Clarion-Ledger. Main Section. October 2, 2007: 1A.
 47. Mississippi State Department of Health. Public Health Statistics. 2005 Vital Statistics. Available at: <http://www.msdh.state.ms.us/phs/statisti.htm>. Accessed August 24, 2007.
 48. Ed Thompson, MD, MPH. Mississippi Department of Health. Personal communication. August 3, 2007.
 49. Shore R. KIDS COUNT Indicator Brief. Reducing the child death Rate. The Annie E. Casey Foundation. July 2003. Available at: <http://www.aecf.org/upload/PublicationFiles/brief%20child%20death%20rate.pdf>. Accessed December 8, 2007.
 50. Shore R. KIDS COUNT Indicator Brief. Reducing the teen death rate. The Annie E. Casey Foundation. July 2003. Available at: <http://www.aecf.org/upload/PublicationFiles/brief%20teen%20death%20rate.pdf>. Accessed October 22, 2007.
 51. Tami Brooks, MD. Mississippi Child Death Review Panel. Personal communication (E-mail). October 22, 2007.

APPENDICES

APPENDIX A: References

52. Child Trends DataBank. Motor vehicle deaths. Available at: <http://www.childtrendsdatabank.org/indicators/77VehicleDeaths.cfm>. Accessed October 23, 2007.
53. Child Trends DataBank. Teen homicide, suicide, and firearm death. Available at: <http://www.childtrendsdatabank.org/indicators/70ViolentDeath.cfm>. Accessed November 8, 2007.
54. Pettus G. Kids need a friend. Clarion-Ledger. Southern Style. May 11, 2007: 1E.
55. American Academy of Pediatrics. News briefs. Available at: <http://www.aap.org/advocacy/releases/sept07studies.htm#WARNING>. Accessed October 23, 2007.
56. Shain BN and the Committee on Adolescence. Suicide and suicide attempts in adolescents. Available at: <http://pediatrics.aappublications.org/cgi/content/full/120/3/669>. Accessed December 8, 2007.
57. Edwin C. LeGrand III. Mississippi Department of Mental Health. Personal communication (E-mail). October 22, 2007.

EDUCATIONAL SUCCESS

1. Strong American Schools. Education is key to economic competitiveness. <http://www.edin08.com/GetTheFacts.aspx>. Accessed October 29, 2007.
2. Strong American Schools. Education is key to ending poverty. <http://www.edin08.com/GetTheFacts.aspx>. Accessed October 29, 2007.
3. Strong American Schools. Weak education leaves Americans unprepared. <http://www.edin08.com/GetTheFacts.aspx>. Accessed October 29, 2007.
4. Mississippi Department of Education. Office of Innovation and School Improvement and Office of Accreditation. Mississippi public accountability standards 2007. Available at: http://www.mde.k12.ms.us/accred/2007_Edition.MS%20Public%20School%20AccountabilityStandards.pdf. Accessed October 29, 2007.
5. Southern Education Foundation. A New Majority: Low income students in the south's public schools. SEF Research Report. Atlanta, GA. Available at: www.southerneducation.org/showpublications.asp. Accessed October 31, 2007.
6. The Brookings Institute. Long-term security and our nation's public schools. Panel. Georgetown Public Policy Institute's Annual Conference. March 23, 2007. Available at: <http://www.brookings.edu/es/hamilton/20070323bordoff.htm>. Accessed October 29, 2007.
7. Mayer DP, Mullens JE, Moore MT. Monitoring school quality: An indicator's report. Education Statistics Quarterly. Vol. 3, Issue 1. Available at: http://nces.ed.gov/programs/quarterly/vol_3/3_1/q4_4.asp. Accessed October 29, 2007.
8. Harrison B. Bounds calls state teacher shortage a crisis. Northeast Mississippi Daily Journal. September 20, 2007.
9. Mississippi Department of Education. Mississippi Education Quick Facts. Available at: <http://www.mde.k12.ms.us/Extrel/news/2007/Education%20Quick%20Facts.doc>. Accessed December 5, 2007.
10. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. 2007 Accountability Results. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed October 17, 2007.
11. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. 2003 Accountability Results. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed October 17, 2007.
12. Ramey C, Ramey S. Early learning and school readiness: Can early intervention make a difference? Merrill-Palmer Quarterly. 2004; 50:473-491.

APPENDIX A: References

13. Shore R. Reducing the high school dropout rate. KIDS COUNT Indicator Brief. The Annie E. Casey Foundation. July 2003. Available at: <http://www.aecf.org/upload/PublicationFiles/brief%20dropout%20rate.pdf>. Accessed October 29, 2007.
14. Lewis Whitfield. CREATE Foundation. Personal Communication (E-mail). October 25, 2007.
15. The Annie E. Casey Foundation. KIDS COUNT State-level data online. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.
16. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "Full Cohort" Analysis - Updated. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.
17. Mississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "True Cohort" Analysis. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.
18. Hayden C. Mississippi lagging behind in graduation rates of males. Clarion-Ledger. June 22, 2006. Local section: 1B.
19. Philadelphia Education Fund. 2005. News Release. New research shows almost half of Philadelphia high school dropouts can be identified as early as sixth grade. Available at: <http://www.philaedfund.org/pdfs/mgmrelease3-17.pdf>. Accessed November 19, 2007.
20. Child Trends DataBank. High school dropout rates. Available at: <http://www.childtrendsdatbank.org/indicators/1highschooldropout.cfm>. Accessed October 19, 2007.
21. Hayden C. 1 in 4 don't finish school. Clarion-Ledger. Main. November 17, 2006: 1A.
22. Helmes R. State works to combat high student dropout rate. Clarion-Ledger. Main. April 9, 2007: 1A.
23. Clarion Ledger. State Farm donation to help reduce dropout rate in Mississippi. October 26, 2007.
24. Miller BM. Critical Hours: Afterschool programs and educational success. May 2003. Nellie Mae Education Foundation. Brookline, MA. Available at: http://www.nmefdn.org/uploads/Critical_Hours.pdf. Accessed October 31, 2007.
25. Barnett B, Arroyo C, Devoe M, Duggan A. Reduced school dropout rates among adolescent mothers receiving school-based prenatal care. Archives Pediatric Adolescent Medicine. 2004;158(3):262-268.
26. Editorial Projects in Education Research Center. More Than 1.2 Million Students Will Not Graduate in 2007; Detailed graduation data available for every U.S. District and State. http://www.edweek.org/media/ew/dc/2007/DC07_PressPacket_FINAL.pdf. Accessed December 5, 2007.
27. Mary Armstrong. Mississippi Department of Health. Personal communication (E-mail). October 24, 2007.
28. Child Trends DataBank. Physical fighting by youth. Available at: <http://www.childtrendsdatbank.org/indicators/22PhysicalFighting.cfm>. Accessed October 3, 2007.
29. Hester, T. Senator pushes for quick action on school security. Newsday.com. October 28, 2007. Available at: <http://www.newsday.com/news/local/wire/newsjersey/ny-bc-nj-legislativeprevie1028oct28,0,1568457.story>. Accessed October 31, 2007.
30. Child Trends DataBank. Students carrying weapons. Available at: <http://www.childtrendsdatbank.org/indicators/19StudentsCarryingWeapons.cfm>. Accessed October 3, 2007.
31. Youth Violence Facts at a Glance. Centers for Disease Control and Prevention. Summer 2007. Available at: http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf. Accessed October 29, 2007.
32. Feder L. Bullying as a public health issue. Editorial. International Journal of Offender Therapy and Comparative Criminology. 2007;51:491. Available at: <http://ijo.sagepub.com>. Accessed October 31, 2007.

APPENDICES

APPENDIX A: References

33. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results. Available at: <http://www.cdc.gov/yrbss>. Accessed November 1, 2007.
34. U.S. Department of Health and Human Services. Healthy People 2010 Midcourse Review. Available at: <http://www.healthypeople.gov/>. Accessed November 1, 2007.
35. State of Mississippi Attorney General's Office. Attorney General Jim Hood joins national task force to examine legal and policy barriers to ensuring school safety [press release]. May 25, 2007. Available at: <http://www.ago.state.ms.us/pressreleases/naagschoolsafety.pdf>. Accessed October 29, 2007.
36. Garbarino J, Bradshaw C, Vorrasi J. Mitigating the effects of gun violence on children and youth. Children, Youth and Gun Violence. The Future of Children. Vol 12(2):72-85. Available at: http://www.futureofchildren.org/usr_doc/tfoc_12-2f.pdf. Accessed November 16, 2007.
37. American Psychological Association. Bullying. Public Interest Policy. March 2005. Available at: <http://www.apa.org/ppo/issues/bullying.html>. Accessed October 31, 2007.

APPENDIX B: Data Sources, Definitions & Notes

SAFETY

Data source(s):

^aCenters for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results. Available at: www.cdc.gov/yrbss. Accessed November 1, 2007.

Note(s):

^bDetermining statistical significance (YRBSS):

The Centers for Disease Control and Prevention's (CDC) Youth Risk Behavioral Surveillance System (YRBSS) is a state-level survey. Statistically significant differences between two survey years for one location (e.g., MS 1993 vs. MS 2003) or between two survey locations (e.g., MS 2003 vs. US 2003) were determined using the YRBSS "Youth Online: Comprehensive Results" comparison feature available at <http://apps.nccd.cdc.gov/yrbss>. The CDC performs a t-test on the entire survey sample to determine statistically significant differences. This is a more accurate statistical test as it is based on the entire sample data set.

In cases where significance calculations were not available online nor was the survey data set available (e.g., comparing males and females in MS), we examined the confidence intervals that were provided on the YRBSS Web site. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

WELL-BEING

Data source(s):

^aPopulation Reference Bureau. Analysis of data from the U.S. Census Bureau. Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2005 American Community Survey. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^bPopulation Reference Bureau. Analysis of data from the U.S. Census Bureau. Current Population Survey (March supplement), 1990 through 2005. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^cPopulation Reference Bureau. Analysis of data from the U.S. Census Bureau. Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2006 American Community Survey. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^dU. S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE). Estimates for Mississippi Counties "Under age 18 in poverty, 2004". Available at: <http://www.census.gov/hhes/www/saipe/>. Accessed November 1, 2007.

Definition(s):

^aChildren in single-parent families:

Children under age 18 who live with their own single parent, either in a family or subfamily. Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation.

^fFemale-headed families receiving child support:

Families headed by an unmarried woman (living with one or more of her own children under age 18) receiving child support payments during the previous calendar year. "Own children" include never-married persons under age 18 who are the sons or daughters of the householder (head of household). The householder's stepchildren and adopted children are also counted as "own children." Families categorized as receiving child support include those receiving partial payment, as well as those receiving full payment. It also should be noted that there is no child support award in place in many of these families. Figures represent 3-year averages of data.

^gGrandchildren in the care of grandparents:

The share of children under age 18 living in households where grandparent(s) provide primary care for one or more grandchildren in the household.

APPENDICES

APPENDIX B: Data Sources, Definitions & Notes

^bChildren living in families where no parent has full-time, year-round employment:

The share of all children under age 18 living in families where no parent has regular, full-time employment. For children living in single-parent families, this means the resident parent did not work at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey. For children living in married-couple families, this means neither parent worked at least 35 hours per week, at least 50 weeks in the 12 months prior to the survey. Children living with neither parent were listed as not having secure parental employment because those children are likely to be economically vulnerable. Children under age 18 who are householders, spouses of householders, or unmarried partners of householders were excluded from this analysis.

^cChildren living in low-income households where no adults work:

Children under age 18 who live in low-income households where no adult worked (full- or part-time) in the 12 months prior to the survey. Low-income households are those whose income is less than 200 percent of the U.S. poverty line as determined by the U.S. Office of Management and Budget. The Federal poverty definition consists of a series of thresholds based on family size and composition. In calendar year 2004, a family of two adults and two children were considered low-income if their annual income fell below \$38,314. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in the percentage calculation. The data are based on income received in the 12 months prior to the survey.

^dChildren in poverty (100%):

The share of children under age 18 who live in families with incomes below the federal poverty level, as defined by the U.S. Office of Management and Budget. The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, the poverty threshold for a family of two adults and two children was \$17,463. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 18 (such as foster children).

^eMedian family (with child) income: Currency:

Median annual income for families with related children under age 18 living in the household. "Related children" include the householder's (head of the household) children by birth, marriage, or adoption; as well as other persons under age 18 (such as nieces or nephews) who are related to the householder and living in the household. The median income is the dollar amount that divides the income distribution into two equal groups - half with income above the median, half with income below it.

Note(s):

^fDetermining statistical significance (KIDS COUNT indicators):

Significant differences between two years for one location (e.g., MS infant mortality rate for 2000 vs. 2004) were determined using 2007 Data Book Indicator trend calculations made by the Population Reference Bureau (PRB). Some KIDS COUNT indicators, such as percent of low-birth-weight babies, were based on counts, not survey results extrapolated to the population. In determining significance between two years, the PRB adopted the methodology used by the reporting federal agency. In the case of percent of low-birth-weight babies, PRB adopted the methodology used by the CDC to test for differences between two percentages.

In cases where significance calculations were not calculated by the PRB (e.g., comparing the MS infant mortality rate for 2004 to the US infant mortality rate for 2004), we examined the confidence intervals provided by the PRB. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

While the methodology used by the PRB is a more sophisticated and accurate test of statistical significance, relying simply upon confidence intervals will generally yield the same conclusion regarding significance.

^g2004 poverty estimates (%) for children under age 18:

For further information regarding estimation procedures, see the U.S. Census Bureau Small Area Income and Poverty Estimates Web site at: <http://www.census.gov/hhes/www/saie/>.

APPENDIX B: Data Sources, Definitions & Notes

HEALTH

Data source(s):

^aCenters for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results. Available at: www.cdc.gov/yrbss. Accessed November 1, 2007.

^bMcMillen R, Nagel J, Valentine N. Cigarette Smoking: 1998-2006. The Mississippi Youth Tobacco Survey. Social Science Research Center. Mississippi State University.

^cMississippi State Department of Health. Public Health Statistics. Available at: <http://www.msdh.state.ms.us/phs/statisti.htm>. Accessed September 12, 2007.

^dChild Trends analysis of 1990-2004 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics. Birth Statistics: U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. Population Statistics: U.S. Census Bureau. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^eChild Trends analysis of 1990-2004 Natality Data Set CD Series 21, numbers 2-9, 11-12, 14-16 (SETS versions), and 16H and 17Ha (ASCII version), National Center for Health Statistics. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^fU.S. Centers for Disease Control and Prevention, National Center for Health Statistics. 2004 data: Population Reference Bureau. Analysis of data from the Multiple Causes of Death Public Use Files for 2004 CD-Rom and Births: Final Data for 2004, National Vital Statistics Reports, Vol. 55, No. 1 (September 29, 2006), Table 10; 2003 data: Population Reference Bureau. Analysis of data from the Multiple Causes of Death Public Use Files for 2003 CD-Rom and Births: Final Data for 2003, National Vital Statistics Reports, Vol. 54, No. 2 (September 8, 2004), Table 10; 1996 - 2002 data: Deaths, Final Data for [appropriate year], National Vital Statistics Reports, Volumes 47-53; 1994 - 1995 data: Advance Report of Final Mortality Statistics, [appropriate year], Monthly Vital Statistics Report, Volume 45, Numbers 3 and 11. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^gMississippi State Department of Health. Public Health Statistics. 2005 Vital Statistics. Available at: <http://www.msdh.state.ms.us/phs/statisti.htm>. Accessed August 24, 2007.

^hDeath Statistics: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Population Statistics: U.S. Census Bureau. For further information on specific data sources and notes for each year, visit the KIDS COUNT State-level data Web site for this topic at: http://www.kidscount.org/sld/compare_results.jsp?i=80. Accessed November 1, 2007.

ⁱDeath Statistics: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). Population Statistics: U.S. Census Bureau. For further information on specific data sources and notes for each year, visit the KIDS COUNT State-level data Web site for this topic at: http://www.kidscount.org/sld/compare_results.jsp?i=100. Accessed November 1, 2007.

Definition(s):

^jTeenage pregnancy rate:

Live births plus reportable spontaneous fetal deaths plus induced terminations per 1,000 females in specified age/race group.

^kTeen births for 15 to 19 age group:

Births to teenagers between ages 15 and 19 per 1,000 females in this age group. Data reflect the mother's place of residence, rather than the place of the birth.

^lLow-birth-weight babies:

Live births weighing less than 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of birth. Births of unknown weight were not included in these calculations. For more detail on all reporting issues refer to Definitions, Data Sources, and Reporting Issues for States at: http://www.kidscount.org/sld/rs_state_def.jsp.

APPENDICES

APPENDIX B: Data Sources, Definitions & Notes

^mInfant mortality rate:

Deaths occurring to infants under 1 year of age per 1,000 live births. The data are reported by place of residence, not place of death.

ⁿInfant, neonatal, and postneonatal mortality rate:

Infant deaths are those of children under one year of age; neonatal deaths are those of infants under 28 days of age; postneonatal deaths are those of infants ages 28 days to 1 year. Deaths per 1,000 live births.

^oChild death rate:

Number of deaths to children between ages 1 and 14, from all causes, per 100,000 children in this age range. The data are reported by place of residence, not place of death.

^pTeen death rate:

Number of deaths from all causes to teens between ages 15 and 19, per 100,000 teens in this age group. The data are reported by place of residence, not the place where the death occurred.

Note(s):

^aDetermining statistical significance (YRBSS):

The Centers for Disease Control and Prevention's (CDC) Youth Risk Behavioral Surveillance System (YRBSS) is a state-level survey. Statistically significant differences between two survey years for one location (e.g., MS 1993 vs. MS 2003) or between two survey locations (e.g., MS 2003 vs. US 2003) were determined using the YRBSS "Youth Online: Comprehensive Results" comparison feature available at <http://apps.nccd.cdc.gov/yrbss>. The CDC performs a t-test on the entire survey sample to determine statistically significant differences. This is a more accurate statistical test as it is based on the entire sample data set.

In cases where significance calculations were not available online nor was the survey data set available (e.g., comparing males and females in MS), we examined the confidence intervals that were provided on the YRBSS Web site. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

^b2001-2005 average teenage pregnancy rates:

The 2001-2005 average teenage pregnancy rates were calculated from the yearly rates available in Table 18B of the Mississippi State Department of Health's 2001 through 2005 Vital Statistics reports. These reports are available online at: <http://www.msdh.state.ms.us/phs/statisti.htm>

^cDetermining statistical significance (KIDS COUNT indicators):

Significant differences between two years for one location (e.g., MS infant mortality rate for 2000 vs. 2004) were determined using 2007 Data Book Indicator trend calculations made by the Population Reference Bureau (PRB). Some KIDS COUNT indicators, such as percent of low-birth-weight babies, were based on counts, not survey results extrapolated to the population. In determining significance between two years, the PRB adopted the methodology used by the reporting federal agency. In the case of percent of low-birth-weight babies, PRB adopted the methodology used by the CDC to test for differences between two percentages.

In cases where significance calculations were not calculated by the PRB (e.g., comparing the MS infant mortality rate for 2004 to the US infant mortality rate for 2004), we examined the confidence intervals provided by the PRB. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

While the methodology used by the PRB is a more sophisticated and accurate test of statistical significance, relying simply upon confidence intervals will generally yield the same conclusion regarding significance.

^d2001-2005 average infant mortality rates:

The 2001-2005 average rates were available in Table 12B of the Mississippi State Department of Health's 2005 Vital Statistics report. The report is available online at: <http://www.msdh.state.ms.us/phs/statisti.htm>.

APPENDIX B: Data Sources, Definitions & Notes

EDUCATIONAL SUCCESS

Data source(s):

^aMississippi Department of Education. Mississippi Assessment and Accountability Reporting System. 2007 Accountability Results. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed October 17, 2007.

^bMississippi Department of Education. Mississippi Assessment and Accountability Reporting System. 2003 Accountability Results. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed October 17, 2007.

^cMississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "Full Cohort" Analysis - Updated. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.

^dMississippi Department of Education. Mississippi Assessment and Accountability Reporting System. "True Cohort" Analysis. Available at: <http://www.mde.k12.ms.us/account/ORS/RPTS.htm>. Accessed September 24, 2007.

^ePopulation Reference Bureau. Analysis of data from the U.S. Census Bureau. Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2005 American Community Survey. Available at: <http://www.kidscount.org/sld/compare.jsp>. Accessed November 1, 2007.

^fCenters for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results. Available at: www.cdc.gov/yrbss. Accessed November 1, 2007.

Definition(s):

^gPercent of Teens Who Are High School Dropouts (ages 16–19):

The percentage of teenagers between ages 16 and 19 who are not enrolled in school and are not high school graduates. Those who have a GED or equivalent are included as high school graduates in this measure. The measure used here is defined as a "status dropout" rate.

^hTeens not attending school and not working:

Teenagers between the ages of 16 and 19 who are not enrolled in school (full- or part-time) and not employed (full- or part-time).

ⁱChildren in households where the household head is a high school dropout:

The share of all children under age 18 living in households where the household head is a high school dropout.

Note(s):

^jAccreditation statuses:

According to the 2007 "Mississippi Public School Accountability Standards," there are several possible accreditation statuses for Mississippi school districts:

- 1) ACCREDITED is assigned to a district that complies with 100% of the process standards.
- 2) ADVISED is assigned to a district that has process standard deficiencies. The district will be required to develop a corrective action plan to address the deficiencies.
- 3) PROBATION is assigned to a district that was assigned an Advised status the previous school year, and the district has not taken corrective actions or has not removed the process standard deficiencies that resulted in the Advised status. The district will be required to develop a corrective action plan to address the deficiencies.
- 4) WITHDRAWN is assigned to a district that has previously been assigned a Probation status and still does not comply with its corrective action plan.

For additional information on process standards and accreditation policies, see the 2007 Mississippi Public School Accountability Standards document, which is available at: http://www.mde.k12.ms.us/accred/2007_Edition.MS%20Public%20School%20Acct.%20Stds.pdf

^kPerformance classifications:

According to the 2007 Mississippi Public School Accountability Standards, performance classifications are based on "(a) the percentage of students at the school who are performing at criterion levels (basic and proficient) and (b) the degree to which student performance has improved over time (based on an expected growth value for the school)."

For additional information on performance classifications, see the 2007 Mississippi Public School Accountability Standards document,

APPENDICES

APPENDIX B: Data Sources, Definitions & Notes

which is available at: http://www.mde.k12.ms.us/accred/2007_Edition.MS%20Public%20School%20Acct.%20Std.pdf

¹Full cohort analysis (original students plus every student who was added to the group over time) estimates start with 38,833 students in grade nine in the 2001-2002 school year—3,600 ninth graders were added that year followed by 4,826 tenth graders in 2002-2003, 2,668 eleventh graders in 2003-2004, and 1,464 twelfth graders in 2004-2005. That resulted in a full cohort comprising 51,391 students; however, 9,367 students who transferred/died were subtracted from the total, resulting in 42,024. There were 11,169 students who were considered ‘dropouts.’ Thus, 11,169 divided by 42,024 equals 26.6%.

²True cohort analysis (original students in the first 9th grade group) followed the 38,818 students who were in grade 9 in 2001-2002 until their senior year in 2004-2005. 10,112 students were considered ‘dropouts’ or whereabouts were unknown. Thus, 10,112 divided by 38,818 equals 26.0%.

³Estimated 4-year graduation rate:

Counts students in the cohort who earned a regular diploma by the end of May 2005 – some others will earn their diplomas by the end of the summer.

⁴Estimated ultimate graduation rate:

Applies the “9-12” dropout estimate to cohort students who were in grades 9, 10, and 11 at the end of May 2005 (take more than 4 years to graduate).

⁵Estimated dropout rate:

Includes all students coded as dropouts plus all students whose whereabouts were unknown as of May 2005. It is an estimated “9-12” dropout rate.

⁶Determining statistical significance (KIDS COUNT indicators):

Significant differences between two years for one location (e.g., MS infant mortality rate for 2000 vs. 2004) were determined using 2007 Data Book Indicator trend calculations made by the Population Reference Bureau (PRB). Some KIDS COUNT indicators, such as percent of low-birth-weight babies, were based on counts, not survey results extrapolated to the population. In determining significance between two years, the PRB adopted the methodology used by the reporting federal agency. In the case of percent of low-birth-weight babies, PRB adopted the methodology used by the CDC to test for differences between two percentages.

In cases where significance calculations were not calculated by the PRB (e.g., comparing the MS infant mortality rate for 2004 to the US infant mortality rate for 2004), we examined the confidence intervals provided by the PRB. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

While the methodology used by the PRB is a more sophisticated and accurate test of statistical significance, relying simply upon confidence intervals will generally yield the same conclusion regarding significance.

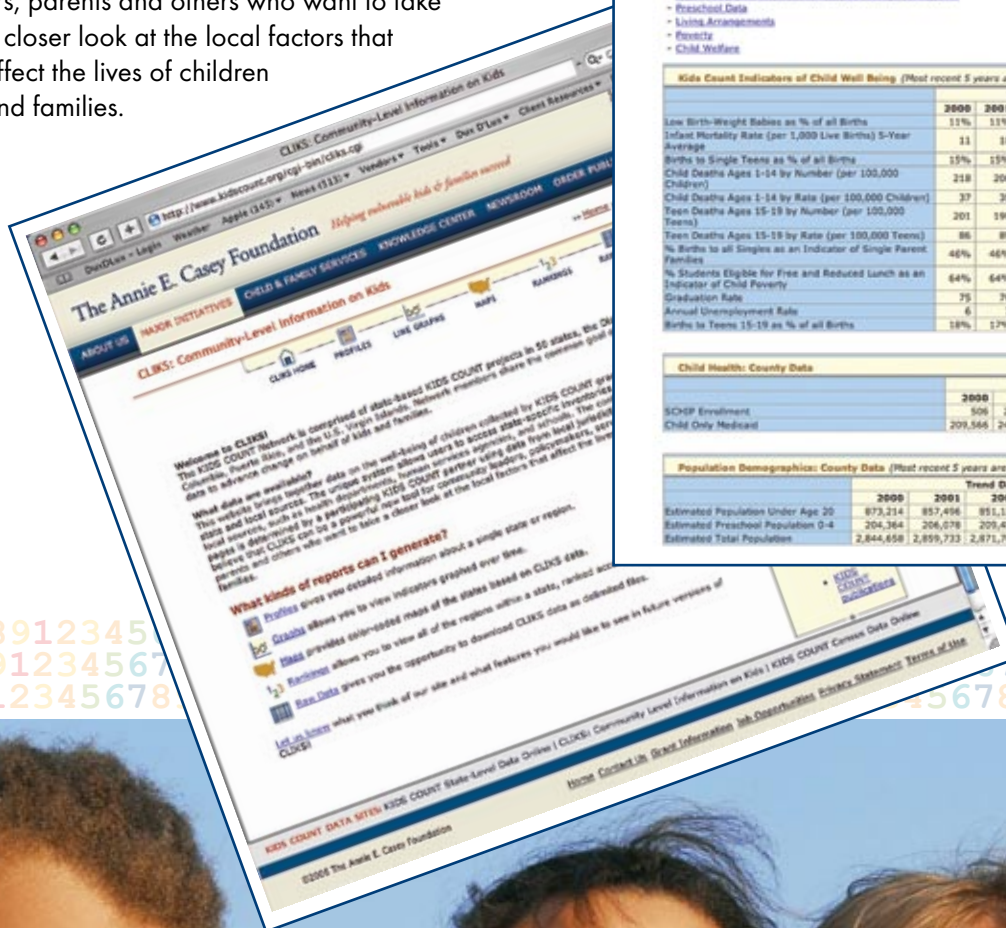
⁷Determining statistical significance (YRBSS):

The Centers for Disease Control and Prevention’s (CDC) Youth Risk Behavioral Surveillance System (YRBSS) is a state-level survey. Statistically significant differences between two survey years for one location (e.g., MS 1993 vs. MS 2003) or between two survey locations (e.g., MS 2003 vs. US 2003) were determined using the YRBSS “Youth Online: Comprehensive Results” comparison feature available at <http://apps.nccd.cdc.gov/yrbss>. The CDC performs a t-test on the entire survey sample to determine statistically significant differences. This is a more accurate statistical test as it is based on the entire sample data set.

In cases where significance calculations were not available online nor was the survey data set available (e.g., comparing males and females in MS), we examined the confidence intervals that were provided on the YRBSS Web site. If the confidence intervals overlapped, it was reasonable to say that the two data points were not statistically significantly different from each other. If the confidence intervals did not overlap, it was reasonable to say that the two data points were indeed statistically different.

www.kidscount.org/cgi-bin/cliks.cgi

This Web site brings together data on the well-being of children collected by KIDS COUNT grantees from state and local sources. The unique system allows users to access state-specific inventories of data from local sources, such as health departments, human services agencies, and schools. The content of state pages is determined by a participating KIDS COUNT partner using data from local jurisdictions. We believe that CLIKS can be a powerful new tool for community leaders, policymakers, service providers, parents and others who want to take a closer look at the local factors that affect the lives of children and families.



CLIKS: Profile for Mississippi (state)

http://www.kidscount.org/cgi-bin/cliks.cgi?action=profile_results&state=MS

The Annie E. Casey Foundation *Helping vulnerable kids & families succeed*

CLIKS: Community-Level Information on Kids

CLIKS HOME | PROFILES | LINE GRAPHS | MAPS | RANKINGS | RAW DATA

Your Profile Results from: **1 Geographic Area: Mississippi (state)**

Profile for Mississippi (state)

- Kids Count Indicators of Child Well-Being
- Child Health: County Data
- Population Demographics: County Data
- Education by Number: County Data
- Education by Percent: County Data
- Economic Development by Number: County Data
- Economic Development by Percent: County Data
- Rapid Start Indicators on Newborn Well-Being: County Data
- Preschool Data
- Living Arrangements
- Poverty
- Child Welfare

These data provided by: MISSISSIPPI kids count

MS KIDS COUNT
Family and Children Research Unit, Social Science Research Center
P.O. Box 5287
Mississippi State, MS 39762
662-325-4801
Ronald.Cossman@ssrc.msstate.edu
<http://www.ssrc.msstate.edu/MSKIDS/COUNT>
Ronald Cossman, Ph.D., Research Director
A division of the SSSRC at Mississippi State University, the Family and Children Research Unit (FCRU) conducts research on issues affecting the health, safety, and well-being of children and families. The FCRU employs an interdisciplinary approach for program planning and evaluation.

	2000	2001	2002	2003	2004
Low Birth-Weight Babies as % of all Births	11%	11%	11%	12%	12%
Infant Mortality Rate (per 1,000 Live Births) 5-Year Average	11	10	10	11	10
Births to Single Teens as % of all Births	15%	15%	14%	16%	17%
Child Deaths Ages 1-14 by Rate (per 100,000 Children)	218	206	218	197	180
Child Deaths Ages 1-14 by Rate (per 100,000 Teens)	37	35	37	33	31
Teen Deaths Ages 15-19 by Rate (per 100,000 Teens)	201	199	218	191	220
Teen Deaths Ages 15-19 by Rate (per 100,000 Teens)	88	89	99	88	102
% Births to all Singles as an Indicator of Single Parent Families	46%	46%	47%	47%	48%
% Students Eligible for Free and Reduced Lunch as an Indicator of Child Poverty	64%	64%	65%	75%	75%
Graduation Rate	75	76	-	81	84
Annual Unemployment Rate	6	7	7	7	6
Births to Teens 15-19 as % of all Births	18%	17%	17%	16%	15%

	2000	2001	2002	2003
SCHIP Enrollment	508	34,024	44,309	54,272
Child Only Medicaid	209,566	240,263	290,110	290,361

	2000	2001	2002	2003	2004
Estimated Population Under Age 20	873,214	857,496	851,131	849,883	826,132
Estimated Preschool Population 0-4	204,364	206,078	209,456	210,550	208,354
Estimated Total Population	2,844,658	2,859,733	2,871,782	2,881,283	2,902,946



www.ssrc.msstate.edu/mskidscount



For information related to research or data:

Dr. Ronald Cossman

Ronald.Cossman@SSRC.MsState.edu

For general information about MS KIDS COUNT:

Dr. Linda H. Southward

Linda.Southward@SSRC.MsState.edu

Social Science Research Center

1 Research Blvd., Ste. 103

Starkville, MS 39759

2007 DATA BOOK



www.ssrc.msstate.edu/mskidscount

The **MISSISSIPPI KIDS COUNT** program is made possible, in part, through grants from the Annie E. Casey Foundation and Mississippi State University's Division of Agriculture, Forestry and Veterinary Medicine. This work is carried out through the Family and Children Research Unit, a division of the Social Science Research Center.