

Bainum Family Foundation

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Infants and Toddlers in the District of Columbia: A Statistical Look at Needs and Disparities



By David Murphey and P. Mae Cooper, Child Trends | 2015
Commissioned by the Bainum Family Foundation



Acknowledgments

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On behalf of the Bainum Family Foundation, I am pleased to present "Infants and Toddlers in the District of Columbia: A Statistical Look at Needs and Disparities."

The Bainum Family Foundation, previously known as the Commonweal Foundation, has long provided educational supports and services in Washington, D.C. Although historically our focus has been on older youth, last December, at the White House Invest in U.S. conference, the Foundation pledged \$10 million over the next five years to improve early learning opportunities in the District. Our initial step in this work was to commission Child Trends to evaluate data on infants and toddlers and provide us with a starting point. This report takes a critical look at the challenges that face our city's youngest children and their families.

The central finding of the report is that for infants, toddlers, and their families, the District is a tale of two cities, with wide disparities between neighborhoods in terms of support for healthy births, quality child development, and school readiness. These data, along with conversations with experts, advocates, and service providers, demonstrate a great need to improve support for children and families, particularly in Wards 7 and 8.

For children to succeed in school, their careers, and their personal lives, they require a combination of strong academic preparation and a host of wrap-around supports and services to meet their physical, psychological, and social needs. Yet few such supports exist in high-poverty areas. For this reason, the Foundation is committed to improving the availability of high-quality early learning and wrap-around supports for infants, toddlers, and their families. These developmental supports can mitigate the harm and improve the odds for young children. With leadership from public policymakers, the District can take these support systems to scale and give our community's next generation a brighter future.

In terms of immediate next steps, the Foundation will engage in partnerships to advance the following objectives:

1. **Practice** — Build the capacity of community-based early learning providers to deliver evidence-based infant and toddler care, and to increase the availability of community-based supports for these children and their families — services that include home visiting and mental wellness services.
2. **Policy** — Join in partnership with other community voices to advocate for public funding and support to provide quality and sustainable early learning and wrap-around supports for all infants and toddlers and their families.
3. **Research** — Conduct and support research that identifies innovations in early learning and development, how to scale them, and how to document and learn from the results.

I believe that this approach holds great promise to improve opportunities for our most vulnerable residents. We look forward to creating a circle of collaborations with parents, service providers, funders, policymakers, and other community stakeholders to ensure the success of all of our children.

Sincerely,

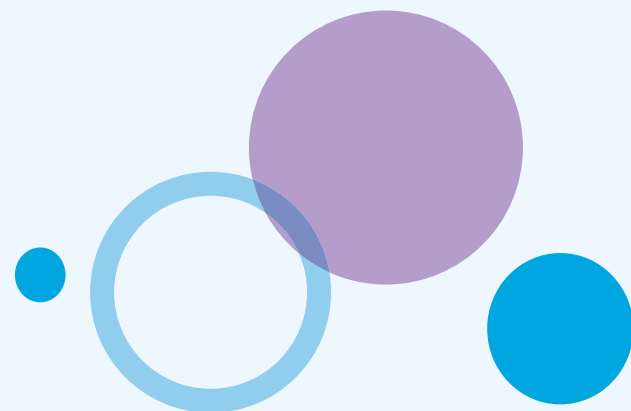
Barbara Bainum

Barbara Bainum, LCSW-C,
Chair, CEO and President



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Executive Summary

Each year, approximately 9,000 babies are born in the District, and the well-being of these infants and toddlers is undermined by glaring inequities, largely associated with their neighborhood.

The period of infancy and toddlerhood (conventionally defined as the first three years of life) is a time of enormous potential — and thus a time of special responsibility for the adults who care for these children. In all the major domains that comprise what it means to be human, development during this stage of life is rapid, dynamic, and keenly sensitive to inputs from the biological, physical, and social environment. Current neuroscience, and our understanding of the complex interplay of genetic code and experience, have made us keenly aware that this time is one when fundamental patterns of responses and behaviors, for better and for worse, become established. These patterns can create developmental trajectories that become increasingly resistant to change as children enter school age, adolescence, and adulthood. Thus, the infant-and-toddler period offers the greatest opportunity to help set children on a path to flourish.

The “achievement gap” — which is so often discussed in terms of higher education, high school graduation, third-grade reading achievement, and kindergarten readiness — begins in infancy.¹

Research finds that economic hardship, particularly early in life, can be damaging to children’s brain development, and therefore contributes to the achievement gap. In addition, race and ethnicity, parental education, and family structure often play leading roles in creating disparities. All of these factors are closely associated with each other, and they are often present from before birth; therefore, our commitment to opportunity, to be effective, has to start at the beginning of life.

To better understand the achievement gap and its causes, it is essential to focus on indicators of both well-being and hardship. Indicators help keep us — all those with a stake in expanding infant and toddler well-being — honest with respect to both our shortcomings and our progress. Indicators are ideal, therefore, for laying the foundation for an informed conversation and for further investigation. Indicators can tell us “who” and “what” (and sometimes “when”), although not “why” or “how.” In this report, we aim to create a composite portrait of the well-being of the District of Columbia’s infants and toddlers, with a particular focus on indicators that research shows influence health, development, and learning in the early years. These indicators focus on poverty, health, and family characteristics. In addition, this report concludes with information on preventive and early learning supports in the District. When data were available, the report points out disparities across geographic regions and by race and ethnicity.

The report draws primarily from readily accessible data sources, such as national surveys conducted by the U.S. Census Bureau. In some instances, administrative data, including data provided by offices of the District government, are presented. It should be noted that this report does not include data for all factors that affect development, nor data on the strengths of young children and families, or on the assets of the communities in which they reside. There is also a lack of data on all of the important services, supports, and resources that exist in the District for infants, toddlers, and their families. In fact, the authors consulted with individuals both within and outside government who acknowledge the need for more comprehensive data on children under 3 and their families. These data are needed in order to shape public policy and design effective programs for the youngest children. Notwithstanding these limitations, the data that were available show there is significant cause for concern.

In our examination of the status of infants and toddlers in the city, we found the following:

- Nearly 90 percent of the infants and toddlers in the least advantaged areas of the city (Wards 7 and 8) live in neighborhoods of concentrated poverty, whereas only 4 percent of their counterparts in the advantaged areas (Ward 3) do.
- While the child population is much more diverse here than in the nation as a whole, there is substantial geographic segregation by race, and the poorest neighborhoods in the city have a population that is over 90 percent African American.
- In the District, there is a strong correlation between poverty rates and the prevalence of young children, which highlights a need to direct services and supports to young children and their families in high-poverty neighborhoods.
- The proportion of infants and toddlers who live in two-parent families ranges, by region, from a high of 93 percent in the most advantaged areas to a low of 15 percent in the least advantaged areas.
- The rate of low birthweight for infants born to black women in the District is more than double the rate for infants born to white women.
- While in the most advantaged area of the District, 97 percent of infants and toddlers have college-educated parents, in the least advantaged areas only 20 percent do.
- Nearly half (49 percent) of infant deaths occurred in Wards 7 and 8; Wards 2 and 3 together accounted for just 2 percent.²

These findings demonstrate substantial disparity in the well-being and future prospects of infants and toddlers in the District, and this city can ill afford to let a sizable portion of its youngest children face such limited opportunity. Clearly, there is much more work to do to ensure that all of the District’s young children can realize their full potential.



Introduction

While the District of Columbia is unique in some ways, its youngest children are like all other children in that they need health, safety, nurturing, and responsive care, and a loving community of family, friends, and neighbors who are attuned to their interests.

The District is an acknowledged leader when it comes to providing universal access to prekindergarten programs for 3- and 4-year-olds (with an 86 percent participation rate), and getting its children covered by health insurance (with a 98 percent coverage rate).³

But today's science is clear that the first years of life require a robust set of developmental supports in order for children to reach their potential; therefore, the District's early learning system must begin even before pre-kindergarten (pre-K).

These supports include high-quality environments that promote health, development, and learning, and they begin with the home environment.⁴

Even more than most other major cities, the District is composed of starkly different neighborhoods. Infants and toddlers in the District are even more racially and ethnically diverse than in the country as a whole, and this diversity exists in the context of substantial geographic, racial, and socio-economic segregation. Many observers, in fact, see the District as two distinct cities: one with numerous advantages of human, social, and economic capital, and the health and well-being that accompany those; the other, a place that is beset by multiple risks to healthy development that accompany children from their first days of life. Within these economically disadvantaged communities, children under 3 experience significant disparities in access to the social, family, educational, and community resources that create the conditions for healthy child development.

What we know of early brain development tells us that the first three years of life are the time when

positive patterns — for relationships, learning, and self-regulation — are best established. If the District is to have a healthy, prosperous future, the needs of all its infants and toddlers must be addressed. The purpose of this report is to call attention to the need for a more comprehensive set of supports, services, and policies for infants, toddlers, and their families. Stakeholders must address head-on the entrenched disparities that create, essentially, “two Districts,” roughly divided into east and west of the Anacostia River. This division, reflected by race and income, is also reflected in multiple indicators of well-being in this report.

The District's substantial investment in education reform, including pre-K, seeks to reduce these disparities. However, the research shows that, in order to eliminate the achievement gap, interventions must begin much earlier in life. The data in this report should prompt a deeper look at underlying causes of poor outcomes, and how the current array of supports for infants, toddlers, and their families measures up to what is known about effective strategies to close the opportunity gaps for our youngest children.

The report also highlights programs that offer real potential to mitigate the harmful effects of disadvantage. In some areas, like health insurance coverage, the District is already doing well. In others, like home visiting for new parents, high-quality child care, and Early Head Start, capacity in the District remains well below the level of need.

Public Use Microdata Areas (PUMAs) Within the District of Columbia

The **East PUMA** is composed of all of Wards 7 and 8, except for a small part of Ward 7 that is northwest of the Anacostia River.

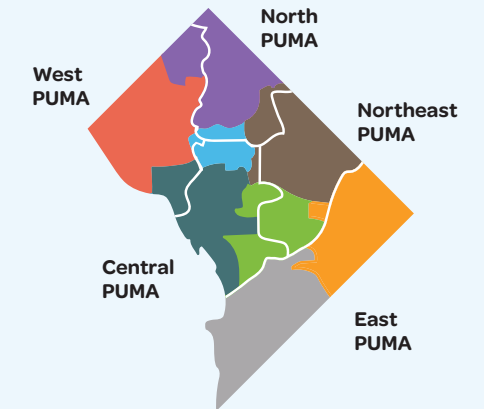
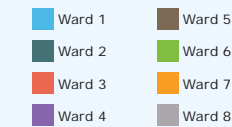
The **Northeast PUMA** is composed of most of Wards 5 and 6, and the part of Ward 7 northwest of the Anacostia River.

The **North PUMA** is composed of all of Ward 4 that is south and west of Rock Creek Park, and some northern areas of Wards 1 and 5.

The **Central PUMA** is composed of most of Wards 1 and 2, the most western parts of Ward 5, and the parts of Ward 6 south of I-695 and west of I-395.

The **West PUMA** is composed of all of Ward 3, the northwestern third of Ward 2, and the parts of Ward 4 not in the North PUMA.

More information is available at http://www.census.gov/geo/maps-data/maps/2010puma/st11_dc.html.



A Note on Geographic Analysis in D.C.

The story of the District's disparities is closely tied to geography. Typically, the geography of the District is discussed in the context of its eight political wards. However, data on infants and toddlers are not always available by ward due to the small population (statistically speaking) of most wards. Estimates of the number of children younger than 3 range from 1,510 in Ward 2 to 4,481 in Ward 8; however, to protect confidentiality government agencies are prohibited from releasing untabulated data for geographic units that have fewer than 100,000 people. While some of the data included in this report are available by ward (for example, data on concentrated poverty), in other cases we have used alternative strategies to provide sub-city-level information on infants and toddlers.

One such strategy is to aggregate samples across multiple years. We have used this approach where noted. Another strategy is to use larger geographic regions that combine parts of multiple wards, such as public-use microdata areas (PUMAs). In the District, there are five of these. Their boundaries do not line up perfectly with ward boundaries, but they do coincide to a fair degree, as explained in the above graph.

As with ward-level data, PUMAs paint a picture of deep disparity in the experiences of young children.

For example, in the West PUMA (Ward 3 and small parts of Wards 2 and 4), 97 percent of infants and toddlers live with at least one parent who has a bachelor's degree. In the East PUMA (primarily Wards 7 and 8), only 20 percent do. A similar disparity is seen for the

percentage of infants and toddlers living in two-parent households, which is 93 percent in the West PUMA and 15 percent in the East PUMA. These data are discussed in further detail later in the report.⁵

Neighborhood segregation contributes unique effects — both positive and negative — to child well-being.

In one study, every additional year children spent in an “advantaged” neighborhood — defined by less income and race segregation, as well as by lower levels of income inequality, better schools, fewer violent crimes, and a greater share of two-parent households — improved their chances of success. Conversely, growing up in “high need” neighborhoods had cumulatively negative effects.⁶ In the District, as in the U.S. as a whole, parents of black infants and toddlers are much less likely than parents of young white children to consider their neighborhood safe. More than one in four (26 percent) District parents of young black children say their child is “never” or only “sometimes” safe in their neighborhood.⁷ Particularly when children are very young, their lives are likely to be bounded by their own neighborhoods and the supports available there. This means that early childhood services, family and community resources, and public health supports should be responsive to neighborhood context.



Demographics, Income, and Poverty

The stark disparity in resources and opportunities compels us to consider what society must do to provide children with equitable opportunities to succeed.

By the Numbers

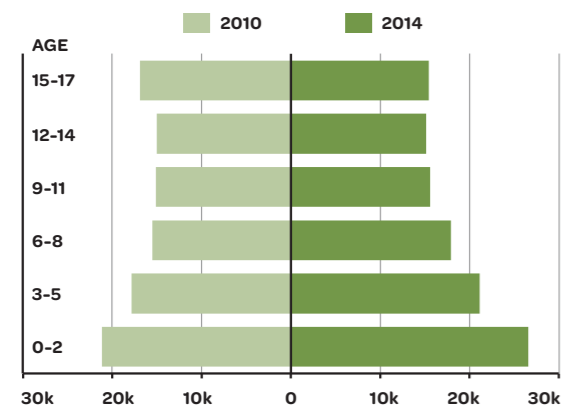
The District's poorest neighborhoods are rich in young children, and for these children and their families, the challenge of poverty is about more than material resources.

Sustained poverty imposes chronic stress on families, which affects parental health and functioning, and potentially undermines relationships between parents and between parents and children.

The list of negative child outcomes associated with poverty is long, including an increased likelihood of illness and injuries, psychological and behavioral problems, diminished cognitive development, diminished school achievement, and shorter life expectancy.⁸

Along with overall growth in recent years, the District's population is trending younger, with significant growth in the number of infants and toddlers. In 2014, the District was home to about 26,500 children under the age of 3. This group has grown by 26 percent since 2010, an increase that exceeds that of children in all other age groups.⁹

Number of Children by Age Group: District of Columbia, 2010 vs. 2014



Source: United States Census Bureau¹⁰

Infants and Toddlers in D.C. by Race (2014) and Immigration Status (2009-2013): District of Columbia and U.S.

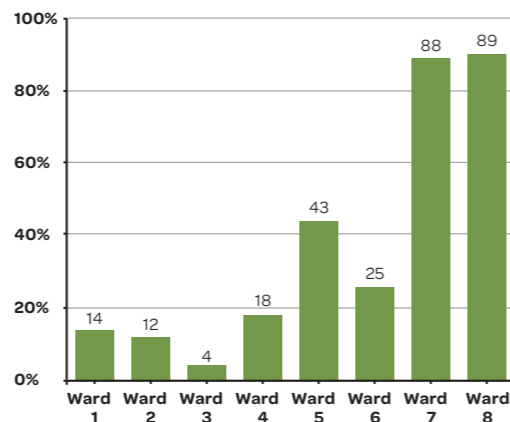
	D.C. Number	D.C. Percentage	U.S. Percentage
Total	26,485	100.0	100.0
White	7,862	29.7	49.8
Latino	4,489	16.9	25.7
Black	11,698	44.2	13.8
More than one race	1,423	5.4	4.8
Other	1,013	3.8	5.9
Living with one or more immigrant parents (average 2009-2013)	6,199	27.6	24.6

Source: U.S. Census Bureau.¹¹ All data in this table are for 2014 except for data on immigrant parents, which reflect averages from 2009-2013.

Concentrated Poverty

The conditions associated with poverty operate at multiple levels: child, family, and neighborhood. Beyond the damaging effects of family-level poverty on young children, research finds that children in communities with large proportions of residents living in poverty face additional disadvantages. These disadvantages are demonstrated by outcomes that are worse than those found in more affluent communities, including outcomes related to physical and mental health (e.g., asthma, diabetes, and depression), higher crime rates, housing quality, and school quality.¹² In the District, 43 percent of infants and toddlers live in areas of concentrated poverty, which is defined as a census tract where the poverty rate is 20 percent or more. The corresponding national figure for infants and toddlers is 33 percent.¹³

Percentage of Infants and Toddlers Living in Concentrated Poverty:* by Ward, 2009-2013



Concentrated poverty is defined as a census tract where at least 20% of people have incomes below the federal poverty level.

Source: American Community Survey.¹⁴

Infants and Toddlers by Income and Poverty Level: District of Columbia and U.S., 2009-2013

	D.C. Number	D.C. Percentage	U.S. Percentage
Living in poor** families	5,800	25.1	25.2
Living in non-low-income families	13,125	56.7	52.0
Living in low-income*** families	10,026	43.3	48.0

**Poverty is defined as the federal poverty level, which in 2015 was an income no greater than \$24,250 for a family of four.

***Low-income is defined as those earning less than twice the federal poverty level, in which case a family of four with two children earned no more than \$48,500.

Source: American Community Survey.¹⁴



A Tale of Two D.C. Neighborhoods

It is less than five miles from Rock Creek Park, on the west side of the District, to the birthplace of Frederick Douglass on the east side of the city. Yet for young children, these five miles represent a huge distance in terms of the worlds in which they live, and in terms of their opportunities. The data clearly show that, despite the level of poverty, the East PUMA is rich in children (32 percent of all infants and toddlers in the District), as compared with the West PUMA, which is home to 15 percent. In terms of the proportion of children, the East PUMA needs nearly twice as many schools, child development facilities, parks, libraries, recreational programs, and family-friendly gathering places as the West PUMA. It represents a subsequently greater share of the city's next generation and future.

Due to family income, however, if children from the East PUMA are to be able to participate in such services and supports, they must be at minimal cost to families, in terms of required tuition, fees, equipment, supplies, or transportation. In addition, these supports must be culturally and racially responsive, and geared toward families that often do not have the financial resources or educational backgrounds that can help connect children to opportunity.

Families in the East PUMA do want their kids to succeed and are willing to do everything in their power to make this happen; in this way, they are no different from families in the West PUMA. The stark disparity in resources and opportunities, however, compels us to consider what society must do to provide children with equitable opportunities to succeed. Furthermore, we must be prepared to engage in quantitatively and qualitatively different strategies and investments on the east and west sides of the District.



Infants, Toddlers, and the Families That Raise Them

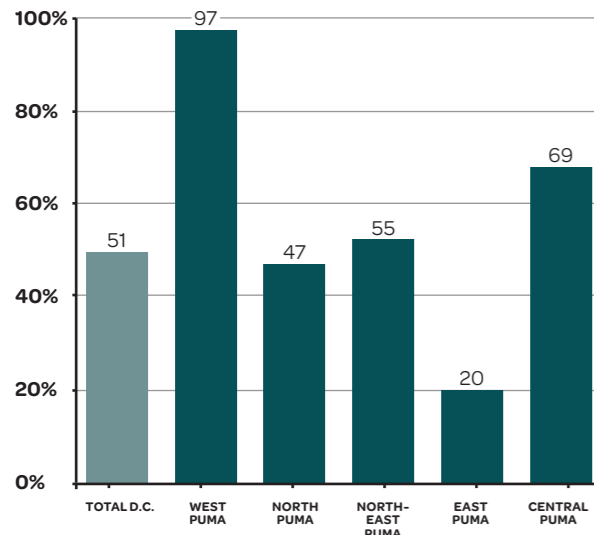
Children's success in life is strongly influenced by maternal age, family structure, and levels of parental education and employment. These factors show major disparities between the east and west sides of the District.

Parental Education

The education level of a parent is one of the most powerful predictors of child well-being. Higher levels of education are associated with greater financial, material, and social resources, and also with better parental health, and with parenting that is more sensitive to children’s developmental needs.¹⁵

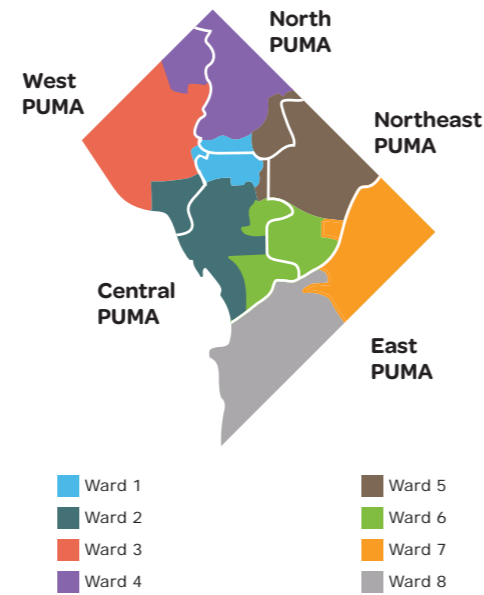
Nearly all District infants and toddlers in the West PUMA (97 percent) have one or more parents who have at least a college-level education. In contrast, in the East PUMA, only 20 percent of infants and toddlers have this benefit.¹⁶

Percentage of Infants and Toddlers Living With at Least One Parent With a Bachelor’s Degree: by PUMA, 2009–2013



Source: American Community Survey¹⁷

The Connection Between PUMAs and Wards



Parental Employment

For nearly all families with young children, parental employment is a necessity for meeting basic needs. Nationwide, 61 percent of mothers with children under 3 are in the labor force.¹⁸ For low-income families, employment is not a guarantee of escape from poverty, but it is associated with higher family income and greater access to private health insurance. At the same time, in some cases, long hours of employment among mothers with very young children have been associated with modestly negative child outcomes.¹⁹ In the District, the proportion of infants and toddlers living in families where all resident parents are employed varies from a high of 66 percent in the Northeast and West PUMAs to a low of 53 percent in the East PUMA.²⁰

In terms of employment income, mothers of infants and toddlers are overrepresented in low-paying jobs.

One analysis of 2013 data found that mothers of children at birth to age 3 constituted 3.5 percent of the District’s overall workforce, but 4.7 percent of the low-wage workforce. Similarly, data show that low-wage jobs are held by 11 percent of all District workers, but 14 percent of mothers of infants and toddlers.²¹

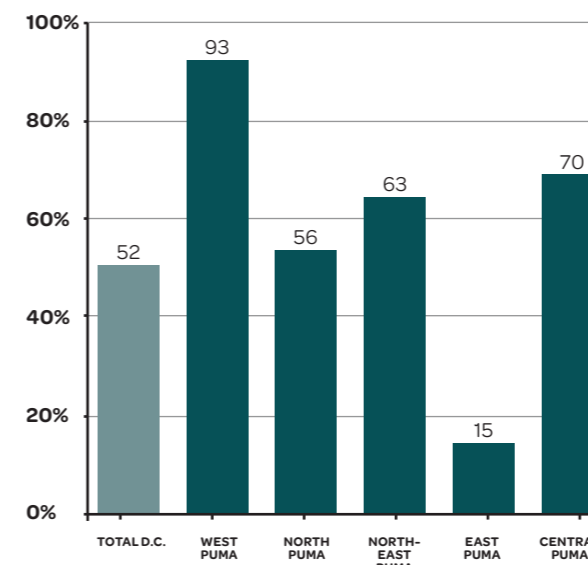
Yet another way to examine parental employment in the District is to ask what proportion of infants and toddlers lived with one or more parents who worked full-time at least 50 weeks during the past year. In the West PUMA, 95 percent of the youngest residents had at least one parent with secure employment; in the East PUMA, only 45 percent were in that category.²²

Family Structure

Both mothers and fathers play important roles in the growth and development of children. A child’s well-being is closely linked to both the number and the type (e.g., biological parents or stepparents) of his or her resident parents, as well as the quality of the parents’ relationship with each other. These linkages are crucial to child well-being because, more than at any time in recent U.S. history, young children are being raised outside of marriage, and often by one parent only.²³

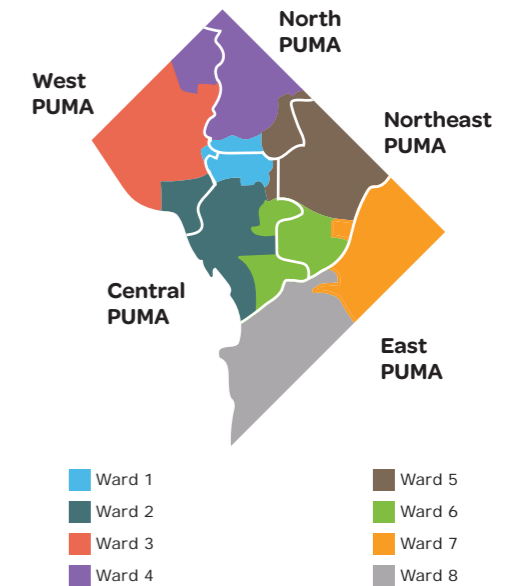
Young children living with no biological parents or in single-parent households are less likely than children with two biological parents to exhibit behavioral self-control, and more likely to be exposed to high levels of aggravated parenting than are children living with two biological parents.²⁴ Single-parent families have much lower incomes, on average, than do two-parent families, while the incomes of families headed by cohabiting partners fall in between those of the other groups. According to research, however, these income differentials account for only part of the negative effects on many areas of child and youth well-being, which include health, educational attainment and assessments, behavior problems, and psychological well-being.²⁵

Percentage of Infants and Toddlers Living With Two Parents: by PUMA, 2009–2013



Source: American Community Survey²⁶

The Connection Between PUMAs and Wards



Compared with national figures, the families of District infants and toddlers include a somewhat smaller share of two-parent households, and a somewhat larger share of single-mother households. Within the District, however, there are large disparities in family structure.²⁷ In the West PUMA, 93 percent of infants and toddlers live with two parents, whereas in the East PUMA, that figure is just 15 percent. In the North, Northeast, and Central PUMAs, 56 to 70 percent of infants and toddlers live with two parents.²⁸ Furthermore, the percentage of the District’s youngest children who live with neither parent is higher than the national average, as is the share who live in households headed by a grandparent.



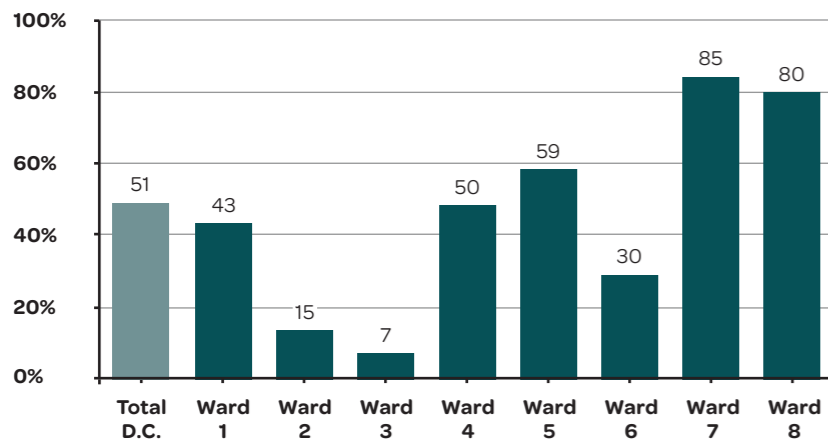
Children in Grandparent-Headed Households

More than 4,000 of the District’s infants and toddlers (18 percent) live in a household that is headed by a grandparent.²⁹ In recent years, more U.S. children are living with grandparents, who also may have primary responsibility for these children’s care. The circumstances surrounding children’s residence with grandparents are diverse, influenced by families’ economic security, family structure, health conditions of parents and/or children, and cultural norms. There can be both advantages and disadvantages associated with children living with grandparents, but a disproportionate share of grandparent-headed families have incomes below the poverty level.³⁰

Births to Unmarried Women

For today’s young adults, parenthood and marriage are choices that are less closely linked than in previous generations.³¹ However, statistically speaking, the available research still finds that infants born to unmarried mothers are at greater risk for economic hardship and other related poor outcomes.³²

Percentage of Births That Are to Unmarried Women: by Ward, 2012



Source: D.C. Department of Health³³

In the District, more than half of all births (51 percent) are to women who are unmarried. This proportion has shown an overall decline since 2007, but it is still considerably higher than the national figure (41 percent). The proportion of infants born to unmarried women varies from 7 percent in Ward 3 to 85 percent in Ward 7 and 80 percent in Ward 8. Wards 3 and 7 are the only wards in which this proportion has not declined in recent years.³⁴



Maternal Age

Childbearing in the District is distinctive for high rates at the two ends of the age spectrum: women under 20 and women in their thirties and forties. For women under 20, birth rates in the District have been declining in recent years, though less rapidly than national rates, and they are still high by national standards.³⁵

Children born to teen mothers are more likely to be born prematurely, to have a low birthweight, and to die as infants compared with children born to mothers in their 20s and early 30s.

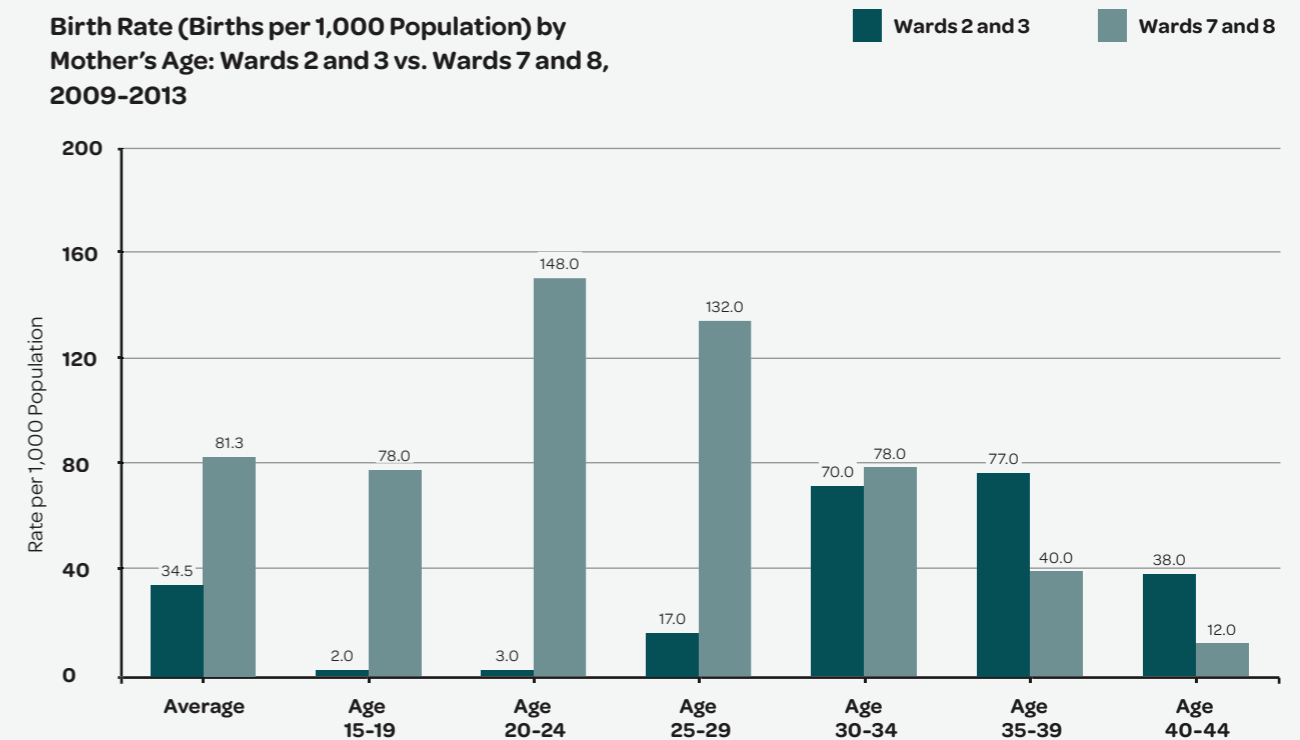
In addition, teen mothers are more likely to be educationally and economically disadvantaged.³⁶

In the District, however, high teen birth rates are driven largely by very high rates in a few wards. By ward, birth rates among teens vary from just over two per thousand females ages 15 to 19 (in Wards 2 and 3) to 78 per thousand (in Wards 7 and 8). Telling the story another way, the District’s rate of births to white teens in 2013 was lower than that for any state, whereas the rate for black teens was 31st among 46 reporting states (including the District).³⁷

At the other end of the age spectrum, advancing parental age is associated with declining fertility and increased risk of genetic mutations in sperm and egg cells. Use of fertility-enhancing treatments is increasing, particularly among older women. These developments may raise health risks for parents and/or their infants. Research has shown that increasing mothers’ age and, to a lesser extent, increasing age among fathers, is linked with a greater risk for pregnancy complications and other negative outcomes, including infant mortality and autism spectrum disorders.³⁸

For infants and toddlers, the implications of “midlife” parenting are not well studied. Intuitively, older parents may have, on average, the advantages of greater economic resources, more stability in life circumstances, and the wisdom stemming from higher educational attainment as well as life experience, compared with younger parents. On the other hand, older parents may be more challenged by the physical demands of caring for young children. In the District, birth rates for older women (at ages 40 to 44) are highest (38 per thousand) in Wards 2 and 3, while they are lowest (12 per thousand) in Wards 7 and 8.³⁹

Birth Rate (Births per 1,000 Population) by Mother’s Age: Wards 2 and 3 vs. Wards 7 and 8, 2009-2013



Source: D.C. Department of Health⁴⁰

Starting Life: Sharp Contrasts in Birth Rates by Mother's Age

Education, income, and race play major roles in childbearing practices in the District and across the nation. Compared to more-educated women, less-educated women tend to have children at younger ages, are less likely to be married when they have children, and are much more likely to be in poverty (or be placed into poverty) with the birth of a child. Childbearing occurs at younger ages for African American, Hispanic, and Native American families as compared with white families, and Asian American families delay childbearing the longest. Much of these differences are related to socio-economic status (income and education), but they also relate to cultural responses and expectations.

When looking at overall health outcomes, both adolescent mothers and older mothers (35 and older) are more likely to have complications in their pregnancies that lead to preventable health conditions and preterm, low birthweight deliveries. Older women, in particular, are at higher risk of a variety of biomedical complications and negative birth outcomes, as are very young women (under age 15). Research points to the need for additional attention to potential complications when providing prenatal care and surveillance for very young and for older women, as well as for women who have had multiple children, have experienced miscarriages, and who became pregnant again shortly after a prior birth. That said, there is increasing knowledge in the biomedical field related to how to respond to these different risk factors effectively.

At the same time, these biomedical concerns contribute only a small fraction to the likelihood of a healthy birth.

Most of the factors jeopardizing healthy births are not genetic or biomedical in origin; instead, they are related to environmental factors, the overall health of the pregnant mother, and her ability to maintain a healthy lifestyle during pregnancy.

For example, research has shown that stress-related hormones transmitted through the placenta to a fetus can adversely impact its birthweight and immunosuppressant responses, resulting in conditions such as asthma. Women experiencing racial discrimination are exposed to additional stress that can compound problems in maintaining their own health.

In general, pregnancy should be a time of excitement and joy, but it also can be one of anxiety and uncertainty — and this is more likely to occur when expectant mothers are very young, not in a committed relationship, and struggling to survive economically. In addition, the other major risk factors endangering a healthy pregnancy are those related to environmental hazards and toxins, access to healthy foods and exercise, and social support during pregnancy. These are also the greatest risk factors endangering infants' own early development and growth.





Health and Well-Being

The healthy development of infants and toddlers is influenced by the health, nutrition, behaviors, and well-being of their mothers during pregnancy and early childhood.

Prenatal Care

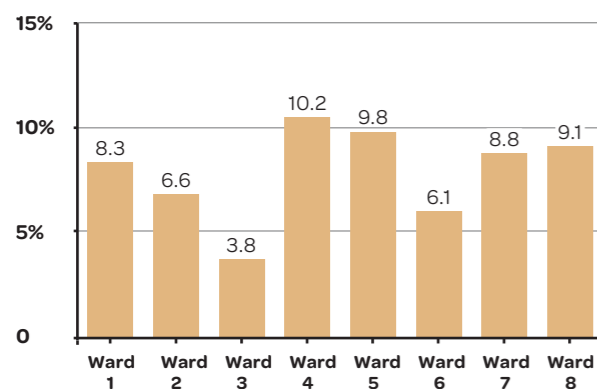
The healthy development of infants and toddlers is influenced by the health, nutrition, behaviors, and well-being of their mothers during pregnancy and early childhood. Children reared in safe and nurturing families and neighborhoods, free from maltreatment and other social adversities, are more likely to have better outcomes as adults.⁴¹

The shared well-being of mother and child begins with prenatal care. Pregnant women who receive no prenatal care, or whose care begins only in the last trimester of pregnancy, are more likely to have infants with health problems.

Mothers who do not receive prenatal care are three times more likely to give birth to a low-birthweight infant, and their infants are five times more likely to die.

In addition, the frequency and timing of prenatal care are important, especially as they are needed to respond effectively to specific maternal risk factors.⁴² The percentage of pregnant women in the District who receive late or no prenatal care is high by U.S. standards: 10.5 percent in 2013, compared with 6.1 percent nationwide. Only Nevada (out of 42 other reporting jurisdictions) had a higher rate than the District on this indicator. Among black women receiving late or no prenatal care, the District's percentage (15.3 percent) was higher than all 37 reporting jurisdictions, except Nevada and North Dakota. Among white women (on the basis of 42 reporting jurisdictions), the District's percentage (3.9 percent) was near the median.⁴³ In 2012, the highest proportion of pregnant women receiving late or no prenatal care was 10.2 percent in Ward 4, compared with 3.8 percent in Ward 3.⁴⁴

Percentage of Births in Which the Mother Received Late* or No Prenatal Care: by Ward, 2012

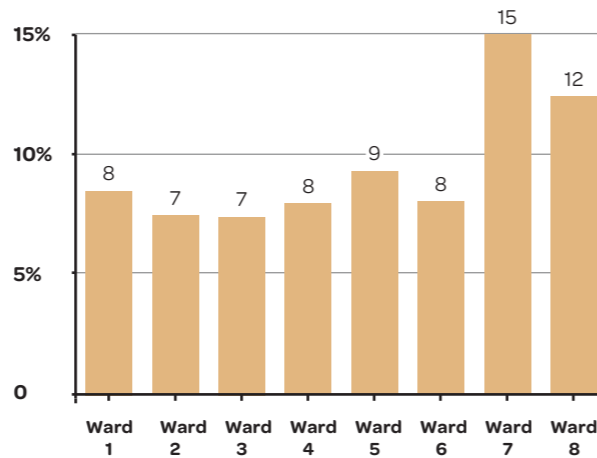


*Late care is defined as no prenatal care before the third trimester. Source: D.C. Department of Health⁴⁵

Low Birthweight

Low birthweight (defined as less than 5.5 pounds) is strongly associated with poor developmental outcomes in infancy and adulthood. Low weight is often associated with infants delivered preterm (before the 37th week of pregnancy), but also can occur with full-term births. According to research, a number of factors appear to contribute to the likelihood of low birthweight, including a mother's smoking during pregnancy, low weight gain during pregnancy, low pre-pregnancy weight, and stress during pregnancy.⁴⁶

Percentage of Births With Low Birthweight:* by Ward, 2012



*Low birthweight is defined as less than 2,500 grams (approximately 5.5 lbs.) at birth. Source: D.C. Department of Health⁴⁷

Only five states have a higher proportion of low-birthweight infants than the District, although the District's rate has improved in recent years, while the national rate has remained relatively unchanged.

However, racial disparities are prominent in the District: the rate for black women (12.3 percent) is more than double the rate for white women (5.8 percent), and the rate for Ward 7 (15.0 percent) is more than double the rate for Ward 3 (7.3 percent).⁴⁸

Preterm Births

Rates of preterm births show a similar pattern, with the gap between the District and the nation narrowing in recent years. Babies born preterm are at risk for a number of negative outcomes.

Preterm birth is the leading cause of infant mortality, and infants born preterm have higher rates of health complications and lifelong disabilities, including developmental disabilities, learning and behavioral problems, cerebral palsy, lung problems, vision and hearing loss, diabetes, high blood pressure, and heart disease.

Children born preterm may also have increasing difficulties with the more complex cognitive functioning that is called on as they grow older, and these difficulties may appear even before school age.⁴⁹

The District's rate of preterm births (13.3 percent) was higher than that of all but five states. The rate for black women (17.0 percent) was more than double the rate for white women (8.0 percent).⁵⁰ In 2012, 15 percent of babies in Ward 7 were born preterm, compared with 7 percent in Ward 2.⁵¹

Child Maltreatment

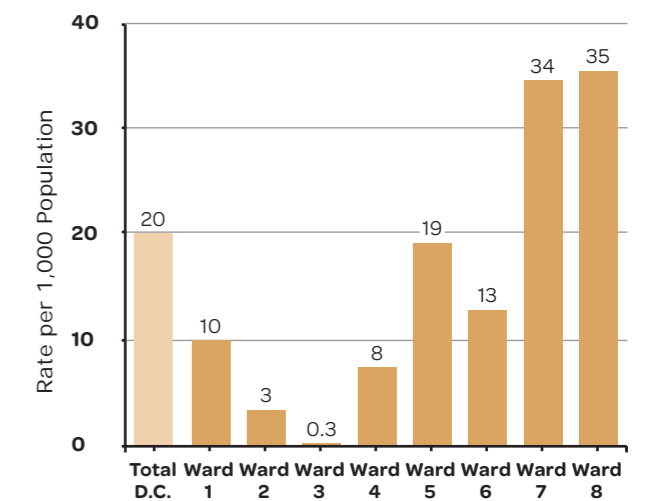
By far, the most prevalent form of maltreatment is neglect, which is defined as "the absence of sufficient attention, responsiveness, and protection that are appropriate to the ages and needs of a child."⁵² Neglect can take increasingly serious forms, from occasional inattention to chronic under-stimulation to a failure in providing for a child's basic needs. More serious forms of neglect disrupt the normal development of the child's brain, and greatly increase the risk for emotional, behavioral, and cognitive problems in later life.⁵³

Child maltreatment is influenced by a number of factors, including poor knowledge of child development, substance abuse, domestic violence, and mental illness.

Although maltreatment occurs in families at all economic levels, abuse (and, especially, neglect) are more common in poor and extremely poor families than in families with higher incomes.

In 2013, 457 District infants and toddlers were victims of abuse or neglect, as determined by Child Protective Services. For the past five years, the District's rates for child maltreatment in this age group have been consistently higher than the national average; however, they do show a declining trend.⁵⁵ By ward, the rate (per thousand population) of infants and toddlers considered victims of substantiated maltreatment varies by a factor of more than 100: from a low of 0.3 per thousand in Ward 3 to a high of 35.4 per thousand in Ward 8.⁵⁶ Furthermore, reported rates are generally considered an underestimate of the true prevalence of maltreatment.

Infant and Toddler Maltreatment Rate (Substantiated Cases per 1,000 Population): District of Columbia and by Ward, 2009-2013



Source: D.C. Child and Family Services Agency⁵⁴

Foster Care

A child's placement into foster care is a marker of serious family distress, which often results in child maltreatment.

In addition, maltreatment often recurs. An analysis of national data showed that of birth families with babies in foster care placements, nearly two-thirds had prior involvement with the child welfare system. Other risk factors often co-occur with maltreatment. For example, this analysis showed that caseworkers reported active

alcohol or drug abuse by caregivers for 60 percent of birth families; domestic violence was reported in 46 percent of birth families; and 42 percent of infants were being cared for by an adult with a serious mental health or emotional problem.⁵⁷

District data show that 142 infants and toddlers were in foster care at the end of 2013, 42 of whom were under the age of 1. This number translates to a rate of 5.4 per 1,000, which is lower than the national figure of 7.3 per 1,000. Nearly 80 percent of the District's 112 foster children were black.

Infants and Toddlers in Foster Care at the End of the Year: District of Columbia and U.S., 2013

	TOTAL NUMBER				RATE PER 1,000 POPULATION			
	All Races		Non-Hispanic Black		All Races		Non-Hispanic Black	
	D.C.	U.S.	D.C.	U.S.	D.C.	U.S.	D.C.	U.S.
Infants	42	26,654	30	5,477	4.6	6.8	7.7	10.0
Infants and Toddlers	142	86,501	112	18,301	5.4	7.3	8.8	11.2

Source: Adoption and Foster Care Analysis and Reporting System (AFCARS) and U.S. Census Bureau⁵⁸





Foster Care: Progress Made, Challenges Remain

Historically, the District has had high rates of placement of children into foster care compared with the country as a whole. Between 2004 and 2013, however, the District has reduced the number of children in foster care by half, which is a far greater reduction than that achieved by the nation as a whole. That said, the District has had a higher rate of placement of young children (birth through 4) into foster care than the country as a whole.⁵⁹ More importantly, in the nation, and especially in the District, there are large disparities in the rates of foster care placement among children of different races and ethnicities. Black families are more likely to have children placed into foster care than white families. In part, these disparities reflect the fact that race and income are correlated, that earning a lower income makes it more difficult to provide a safe home, and that living in an unsafe home is a type of neglect that may lead to a foster care placement.

Placements into foster care are generally at their highest rates in the first few years of life (birth through 2), and again in the years immediately before the age of emancipation (typically age 15 through 17), when children are no longer required to participate in the foster care system. When the public thinks of children going into foster care, they often think of high-visibility cases of parental cruelty with horrific results, particularly for younger children. In fact, these extreme cases are very rare, although they require immediate response. Such predatory parental behavior also can and does occur across income and socio-economic levels and requires vigilance to detect and address.

That said, infants and toddlers are the age groups most likely to enter foster care, not because of parental cruelty or predatory behavior, but because their parents are unable to provide for their basic safety, care, and supervision.

This inability to care sometimes manifests as abandonment, but most commonly as physical neglect (i.e., inadequate supervision and care). According to an analysis of national data, 57 percent of families of infants and toddlers in foster care had difficulty paying for necessities, 79 percent had high stresses in the family, 70 percent had poor parenting skills, 61 percent had some drug or alcohol abuse, 46 percent had either current or prior reports of domestic violence, and 41 percent had recent arrests (in some instances involving incarceration that resulted in foster care placement for their children).⁶⁰

Again, the District has made progress in reducing its overall numbers and rates for children placed into foster care, but the larger reductions have been made among older youth. A crucial factor for the healthy development of an infant or toddler is a safe, stable, and nurturing home environment. In a few instances, placement into foster care may be needed to provide immediate safety, but steps must also be taken to minimize disruptions and ensure an infant or toddler has stability, security, nurturing, and permanency, which in most instances is with their birth families.

Infant and Toddler Mortality

In the U.S., children are much more likely to die during the first year of life than at older ages.

For example, in 2013 (the most recent year for which we have these data) the U.S. death rate for children under age 1 (595 deaths per 100,000 children) was more than 13 times higher than the death rate of children ages 15 to 19 (45 deaths per 100,000 children), which is the group with the next highest rate.⁶¹

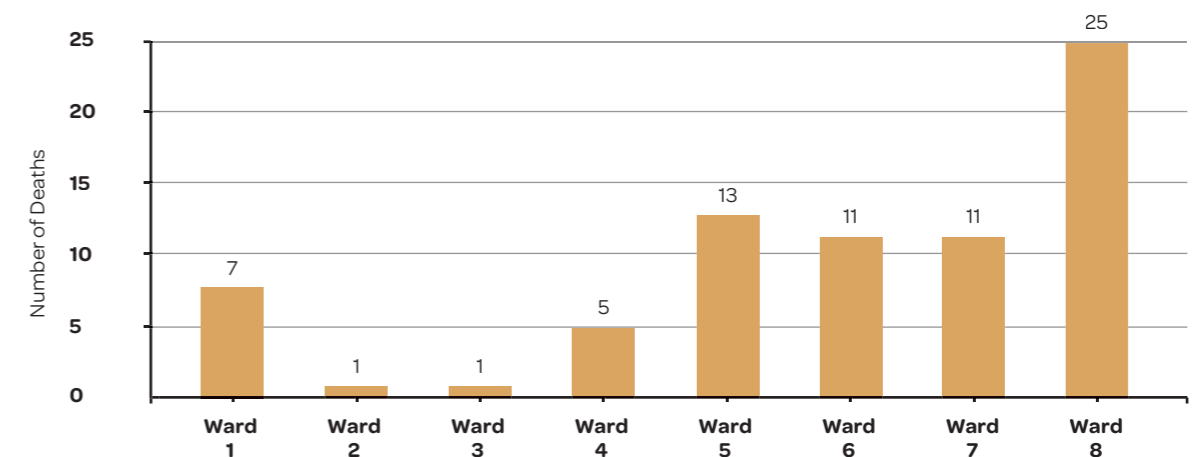
A high rate of death can reflect underlying problems, such as poor access to prenatal care, violent neighborhoods, or inadequate child supervision. It can also point to inequities in access to health care and access to safe places to play, or to exposure to environmental toxins. Among infants, the leading

causes of death include congenital and chromosomal abnormalities, problems related to short gestation and low birthweight, and sudden infant death syndrome (SIDS).

Between 2009 and 2013 in the District, 393 District infants and toddlers died. Eighty percent of these infants were black children, 10 percent were Hispanic, and 11 percent were white. For 2009-2013 (the most recent period available for these data), the infant mortality rate (per 1,000) was 11.6 for blacks, 5.8 for Hispanics, and 2.8 for whites.

Nearly half (49 percent) of infant deaths in 2012 occurred in Wards 7 and 8, whereas Wards 2 and 3 accounted for just two percent.⁶²

Number of Infant (Under 1 Year of Age) Deaths: by Ward, 2012



Source: Centers for Disease Control and D.C. Department of Health⁶³

Preventive and Developmental Supports

The first three years of life present an important opportunity for caregivers and other stakeholders who recognize the power and potential of early childhood development.

Health Insurance Coverage

The first three years of life brim with opportunities for infants and toddlers to develop physically, socially, cognitively, and emotionally. Likewise, this stage of life presents an important opportunity for caregivers and other stakeholders who recognize the power and potential of early childhood development. Below, we present data on several services and programs that are critical for promoting this development.

Children with no health insurance, or with gaps in health insurance coverage, are less likely than those with continuous insurance coverage to have a regular source of health care, they are more likely to have their needs for medical care delayed or unmet, and they are less likely to have prescriptions filled. In particular, gaps in coverage can be especially detrimental for children with chronic health conditions, such as asthma, that require frequent, consistent, and preventive monitoring by health care providers.⁶⁴

In the District, nearly all infants and toddlers (more than 98 percent) have health insurance coverage.

A majority (about 60 percent) are covered by private plans. In the East PUMA (generally Wards 7 and 8), however, a majority (72 percent) are covered by public insurance, which is primarily Medicaid and the State Children's Health Insurance Program (SCHIP).⁶⁵

Preventive Dental Care

Oral health (which includes dental health) is a dimension of care and well-being that is sometimes overlooked. However, dental cavities (tooth decay) can be considered a chronic disease of childhood, with prevalence rates higher than those for asthma or allergies. Untreated oral diseases can lead to problems in eating, speaking, and sleeping. Poor oral health among children has been tied to poor performance in school and poor social relationships. For example, children with chronic dental pain may have difficulty concentrating, poor self-image, and problems completing schoolwork. Children with early childhood dental problems also often weigh less than other children.⁶⁶

The American Academy of Pediatric Dentistry recommends that all children visit the dentist within six months of the eruption of their first primary tooth, or no later than their first birthday.⁶⁷

According to the D.C. Department of Health, in Fiscal Year 2014, 21 percent of Medicaid-eligible infants and toddlers received preventive dental care, up slightly from 18 percent in Fiscal Year 2010.⁶⁸ This is considerably higher than the national average, 12 percent, for this population.⁶⁹ However, given the important link between untreated oral disease and children's learning and development, the fact that only two of 10 children under age 3 insured by Medicaid received preventive dental care is a cause for concern.

Early Intervention Services

Early Intervention (EI) services, also known as the Program for Infants and Toddlers with Disabilities, was established in 1986 as part of the Individuals with Disabilities Act. Funding provided by the program varies from year to year, depending on U.S. Census-based estimates of the number of infants and toddlers in the general population.⁷⁰

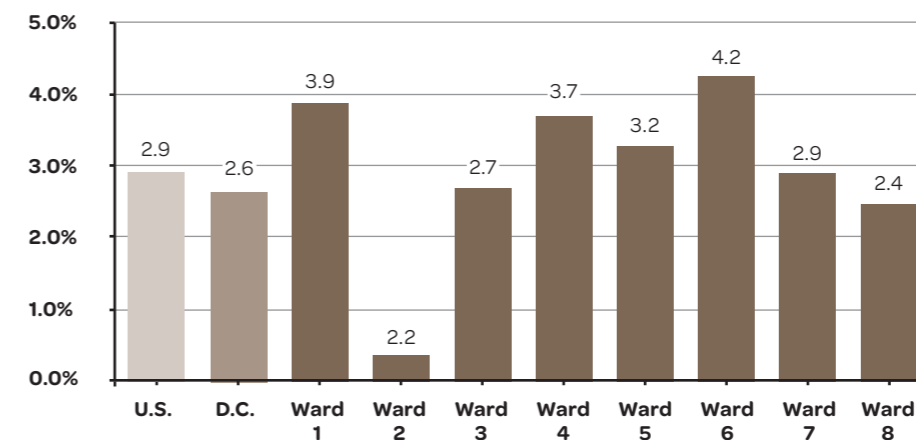
The purpose of the EI program is to improve outcomes for infants and toddlers with disabilities through provision of direct services to the child as well as services to the family.⁷¹

EI services are offered, through states and territories, to children with identified disabilities or, in some states, to those who are at risk for developing a disability, from birth to age 3.

States' eligibility criteria for early intervention services vary,⁷² as do the services they offer. For example, EI services may include medical treatment, occupational and physical therapy, and speech and language services. Early intervention is tailored to the individual needs of the child, and the wishes of the family, and occurs in the child's natural environment, typically the home or community settings.

According to the Office of the State Superintendent of Education, as of Fiscal Year 2014, the District had 697 infants and toddlers receiving EI services, or 2.6 percent. Comparable national-level data show receipt at 2.9 percent. Three-quarters of these youngest District residents received services at home, with the remainder getting services in community-based or other settings, whereas comparable national figures show that 87 percent of infants and toddlers receiving EI services

Percentage of Infants and Toddlers Receiving Early Intervention (Part C) Services: by Ward, Fiscal Year 2014



Source: American Community Survey and D.C. Office of the State Superintendent of Education⁷⁵

are served at home.⁷³ In addition, 2014 District data show that the proportion of children receiving EI services varies from a low of 2.2 percent (in Ward 2) to a high of 4.2 percent (in Ward 6).⁷⁴

Home Visiting Programs

In many European countries, a home visit by a nurse or paraprofessional is offered to (and generally welcomed by) all families with newborns, especially when the newborn is a parent's first child. Parents receive advice and information about health and safety, child development, and other parenting concerns. In the U.S., home visiting programs are increasingly part of communities' efforts to improve outcomes for those families identified as the most at risk.

When well implemented, home visiting programs in the U.S. have been shown to reduce rates of low birthweight, child maltreatment, and childhood injuries; increase access to health care; increase the interval between births; improve parenting practices; and improve children's learning and behavior.⁷⁶

The D.C. Home Visiting Council conducted a survey that showed that in Fiscal Year 2015, District agencies

administered several home visiting program models that the federal government has found to be evidence-based, which means that a strong body of research shows positive outcomes for children and families served through those models. Taken together, it is estimated that these programs reach approximately 800 families with infants and toddlers in the District each year.

The demand for home visitation services in the District is more challenging to estimate, because services are typically arranged based on funding availability, rather than on the basis of a precise, on-going, and unduplicated count of families that could benefit. A look at several methodologies used in other states to calculate the need for home visitation services revealed that there is not a consistent standard across states for calculating the target population for home visiting programs. After consultation with local experts, and an analysis of data on indicators of developmental risk, we estimate that the target population in the District for home visitation programs is approximately 5,400 families with children under the age of 3.⁷⁷

This means that by conservative estimates, the District is currently meeting about 15 percent of the need for home visiting programs.

Moving forward, the District should set a consistent method for tracking the target population for home visiting services, particularly for families with infants and toddlers, given that those children are least likely to be in any formal early learning and care arrangement.





Early Learning

Numerous studies have documented an association between positive child development and high-quality education and care. The strongest evidence of this link comes from studies of intensive and comprehensive programs targeting the most vulnerable children.

Child Care

Numerous studies have documented an association between positive child development and high-quality education and care. The strongest evidence of this link comes from studies of intensive and comprehensive programs targeting the most vulnerable children.⁷⁸

One of the greatest challenges faced by families with infants and toddlers is ensuring that their children are in safe, stable, and nurturing environments, particularly during periods of time when they cannot care for them.

In many instances, families (and particularly single-parent families and low-income families) struggle mightily to achieve this end as they seek to fulfill both their caregiving and breadwinning roles. From the perspective of families, there is often a huge mismatch between what they would like to do and what they can afford to do in order to ensure that their infants and toddlers have high-quality care that promotes their learning and development.

States invest in multiple strategies to improve the accessibility, quality, and affordability of child care. First, they operate licensing systems designed to ensure the health and safety of children. Second, they use local

funds and resources received from the federal Child Care and Development Fund to provide subsidies that help low-income working families pay for child care. In addition, states use this fund for improving the quality and availability of programs serving infants and toddlers. Finally, states may invest in professional development systems and services. These systems and services, commonly referred to as a Quality Rating and Improvement System (QRIS), articulate standards for high-quality care, provide supports for providers and programs to achieve those standards, and provide parents access to ratings of program quality.

The Office of the State Superintendent for Education (OSSE) in the District oversees the licensing program, the child care subsidy program, and the District's QRIS. This QRIS, called *Going for the GOLD*, assigns Bronze, Silver, or Gold ratings to all licensed child care providers that participate in the child care subsidy program. *Going for the GOLD* links reimbursements to providers based on their quality rating, meaning that providers achieving a higher rating receive more funds than providers with lower ratings. These funds are used to finance the higher costs associated with a higher quality of care.

OSSE's data on the capacity of regulated child care providers indicate that there are, on average, 7,000 child care slots for infants and toddlers in the District, as of 2015. Of these, approximately 4,200 accept subsidy payments.⁷⁹

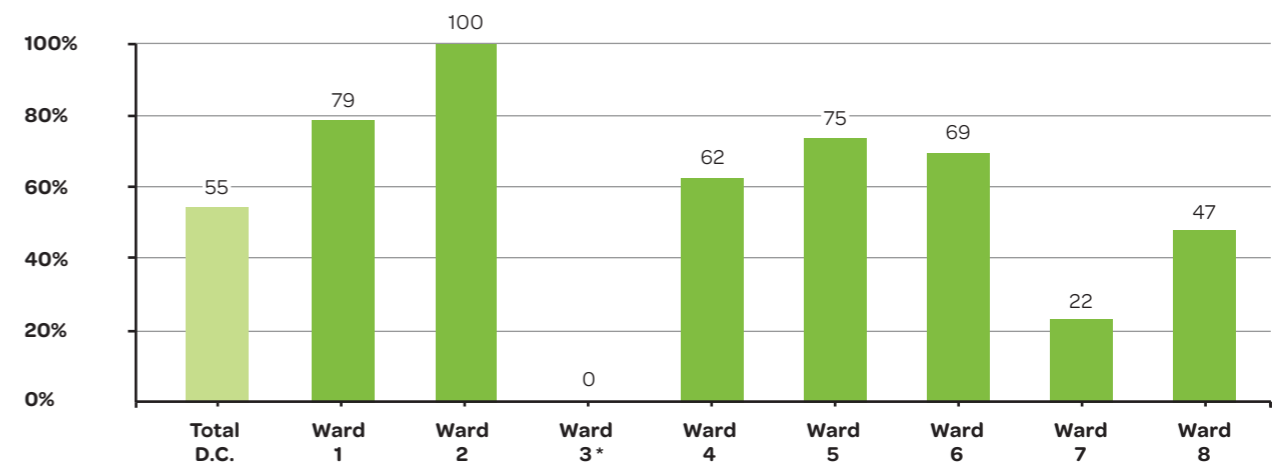
Given that there are more than 26,000 children under age 3 in the District, at least half of whom are low-income, and whose families would struggle to pay the cost of child care on their own, the supply of licensed slots that accept subsidy payments is likely insufficient to meet the demand of the families that could benefit from this support.

OSSE is also responsible for reporting data on the quality ratings assigned in the *Going for the GOLD* system. In 2015, Wards 7 and 8 had the lowest percentage of Gold-rated child care centers and homes. These data do not necessarily mean that children living in these wards attend lower-quality centers, because, in general, families prefer to have their child care program either close to their home or close to their work, and the data track the location of the center and not the children's home.

Nevertheless, if the subsidized child care slots in Wards 7 and 8, which have the highest poverty rates in the city, serve primarily residents from within those wards, then it is likely that these slots account for a major portion of child care subsidies in the District. That conclusion would be troubling because research indicates that a relatively high level of quality is needed in order to affect child outcomes,⁸⁰ and the children in Wards 7 and 8 do not have access to enough high-quality care in their neighborhoods.



Percentage of Rated Infant and Toddler Child Care Spots That Received a Gold Rating: by Ward, 2015



*No child care facilities in Ward 3 were rated.
Source: OSSE Administrative Data⁸¹

Early Head Start

Early Head Start (EHS) is a federally funded, family-centered, early childhood program that is specifically designed to enhance outcomes for infants and toddlers in families with high needs.

EHS is an evidence-based model, and children who participated in EHS showed statistically significant, positive impacts on standardized measures of cognitive and language development at age 3, as compared with a control group of children eligible for EHS who did not participate.

Families also experienced benefits, including reduced parental stress levels, more positive parent-child relationships, higher levels of employment, and more active pursuit of education. Close adherence to federal Program Performance Standards was associated with better outcomes. EHS services may be delivered in centers, family child care homes, or individual family homes. In addition, EHS programs must allocate at least 10 percent of their enrollment slots to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act.⁸² In the District, approximately 764 infants and toddlers were enrolled in the federal EHS program as of August 2014.

By contrast, estimates based on 2013 data indicate that there were approximately 6,000 infants and toddlers in families living below the Federal Poverty Level.

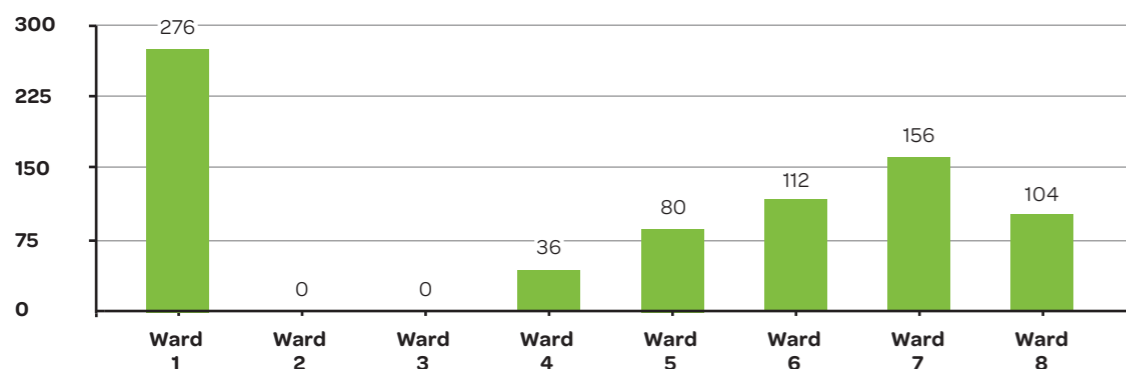
A comparison of these figures would suggest that federal EHS funding is reaching an estimated 12.7 percent of the eligible population in the District.

EHS enrollment is concentrated in programs located in Wards 1, 6, 7, and 8.⁸³ Last year, the District launched an Early Head Start — Child Care Partnerships strategy, which is an effort to expand the evidence-based model of EHS through the child care subsidy program.

This effort, known as the Quality Improvement Network Pilot, has allowed 430 children and families to benefit from EHS comprehensive services at their child care centers and homes.

In addition, the child care partner sites receive training and technical assistance support to meet evidence-based EHS standards of care. This important initiative allows the District to test a strategy for how to increase the quality of child care to better impact children’s learning and development. That said, there are approximately 4,200 subsidized child care slots for infants and toddlers in the District, so although progress is being made to reach EHS standards in subsidized child care, a great need remains for expansion of quality improvement networks.

Number of Infants and Toddlers Enrolled in Early Head Start: by Ward,* 2014



*Ward is based on the location of the child care center. For home-based services, children may be served in a different ward. Source: D.C. Office of the State Superintendent of Education⁸⁴

The Need for a High-Quality Child Care Workforce

In addition to enabling families to work, child care provides employment to child care workers. Because some child care positions provide entry-level opportunities, these jobs are particularly important in low-income neighborhoods like Wards 7 and 8. For infant and toddler care, many of these positions are in child development homes, where individuals provide care in their own homes, often while raising their own children. If these providers receive greater compensation (and/or training and support that enables them to receive higher compensation), their own children, families, and communities benefit economically as well. In addition, child care workers are often the people to whom others in the community turn for information about child development, and they can be anchors within a community to create child- and family-friendly spaces.

The Bureau of Labor Statistics provides compensation data by jurisdiction (i.e., states, the District, and the nation) for over 200 different occupations, including child care workers and preschool teachers, although these data are not adjusted for the high cost of living in the District. As the table shows, child care workers and preschool teachers are paid somewhat more in the District than in the country as a whole, but at a much lower rate relative to other workers. In fact, child care remains one of the lowest-paid occupations in the U.S. and in the District. These figures apply to all child care workers, the majority of whom serve children over the age of 2. A recent report by the Institute of Medicine, *Transforming the Workforce for Children Birth Through Age 8: A Unifying Foundation*, presents extensive research on the knowledge, skills, and competencies required for an effective and high-quality child care workforce.

The report acknowledged that the skill set is highly complex and specialized, and recommends a bachelor’s degree requirement for child care teachers, including for those who care for infants and toddlers. Clearly, if the District is going to move toward a more highly trained, educated, and qualified workforce, the issue of compensation and benefits for these educators must be addressed.

Comparison of Child Care Worker Compensation

	U.S.	D.C.
All Workers		
Number	135,128,260	674,650
% of Workforce	100	100
Median Hourly	\$16.09	\$31.20
Mean Hourly	\$22.71	\$37.78
Mean Annual	\$47,230	\$78,580
% of Mean: All Workers	100	100
Preschool Teachers (25-2011)		
Number	352,400	970
% of Workforce	0.26	0.14
Median Hourly	\$13.52	\$16.38
Mean Hourly	\$15.40	\$17.08
Mean Annual	\$32,040	\$35,520
% of Mean: All Workers	67.8	45.2
Child Care Workers (39-9011)		
Number	582,970	1,480
% of Workforce	0.43	0.22
Median Hourly	\$9.48	\$12.01
Mean Hourly	\$10.44	\$12.73
Mean Annual	\$21,710	\$26,470
% of Mean All Workers	46.0	33.7

Source: Bureau of Labor Statistics Employment Data — May 2014 Analysis by Charles Bruner, Iowa Child and Family Policy Center.



Conclusion

Everything we know about development in the early years tells us that the District's future rests with its youngest children. Positive early experiences and supportive and nurturing families and communities provide young children with a solid foundation that leads to improved outcomes later in life. These outcomes occur in a number of areas such as health, education, and socio-economic status. Conversely, hardship, adversity, stress, and a lack of quality early learning create significant and persistent disparities in healthy development, and even brain architecture. These differences are evident from the earliest years of life, they increase with age, and they become more costly to remediate over time.

The indicators presented in this report should function as alerts that help us better understand the inequities faced by infants, toddlers, and their families in the District, where advantage and opportunity are skewed along economic, racial, and geographic lines.

A number of indicators that could not be included in this report are needed to further our collective understanding about how to shape evidence-based, equitable, and culturally responsive programs and policies for young children. The reasons for these data gaps are varied. In some instances the data are not collected, analyzed, reported, or publicly available, which highlights important flaws in the District's ability to comprehensively follow young children

in the years before they begin formal schooling. These data gaps include important indicators of family and community strengths and assets that are critical to shaping our responses to the issues presented herein.

Finally, there is a critical need to report data at smaller geographic levels to provide more insights than citywide, PUMA, or ward metrics can offer. This data limitation likely masks important contextual differences, both positive and negative, that are essential for shaping effective interventions and supports.

Notwithstanding these challenges, this report should foster further discussion and collaboration among researchers, practitioners, policymakers, and families. The goal of this collaboration should be to enhance opportunities and support for children and families in the neighborhoods of greatest need so that the District will no longer be a tale of two cities, but instead will be a place where all children can succeed.

This goal is in the interests not only of our children, but of our city as a whole, because the District's future as a healthy, prosperous city depends on our response to the inequities that affect the well-being of our youngest residents.

Introduction

Public Use Microdata Areas (PUMAs) Within the District of Columbia

The **East PUMA** is composed of all of Wards 7 and 8, except for a small part of Ward 7 that is northwest of the Anacostia River.

The **Northeast PUMA** is composed of most of Wards 5 and 6, and the part of Ward 7 northwest of the Anacostia River.

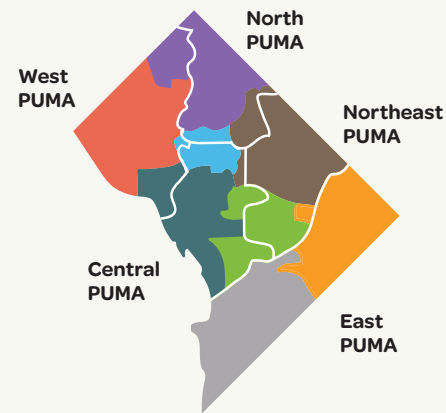
The **North PUMA** is composed of all of Ward 4 that is south and west of Rock Creek Park, and some northern areas of Wards 1 and 5.

The **Central PUMA** is composed of most of Wards 1 and 2, the most western parts of Ward 5, and the parts of Ward 6 south of I-695 and west of I-395.

The **West PUMA** is composed of all of Ward 3, the northwestern third of Ward 2, and the parts of Ward 4 not in the North PUMA.

More information is available at http://www.census.gov/geo/maps-data/maps/2010puma/st11_dc.html.

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8



Demographics, Income, and Poverty

Total population of infants and toddlers (children younger than 3 years) in the District of Columbia, by age, and as a proportion of the total population, 2000-2013

Sources: 2000-2009: Intercensal estimates: <http://www.census.gov/popest/data/intercensal/state/state2010.html> 2010-2013: 2013 census estimates by single-year-of-age: <http://www.census.gov/popest/data/state/asrh/2013/SC-EST2013-ALLDATA6.html>

	2000	2001	2002	2003	2004	2005	2006	2007
Total	19,207	19,781	20,319	20,180	19,588	19,702	20,270	20,252
Less than 1 year	6,577	7,479	7,179	6,781	7,274	7,220	7,321	7,735
1 year old	6,188	6,315	7,100	6,552	6,171	6,691	6,501	6,398
2 years old	6,442	5,987	6,040	6,847	6,143	5,791	6,448	6,119
	2008	2009	2010	2011	2012	2013		
Total	20,542	21,137	21,119	23,179	25,448	26,517		
Less than 1 year	7,888	7,515	7,657	8,924	8,960	9,111		
1 year old	6,817	7,029	6,792	7,633	8,799	8,680		
2 years old	5,837	6,593	6,670	6,622	7,689	8,726		

Infants and toddlers as a percentage of the total population

	2000	2001	2002	2003	2004	2005	2006	2007
D.C.	3.4	3.4	3.5	3.5	3.5	3.5	3.6	3.5
U.S.	4.1	4.1	4.1	4.1	4.1	4.0	4.0	4.0
	2008	2009	2010	2011	2012	2013		
D.C.	3.5	3.6	3.5	3.7	4.0	4.1		
U.S.	4.0	4.0	3.9	3.8	3.8	3.8		

Percentage of infants and toddlers (children younger than 3 years), by family poverty level: District of Columbia and United States, 2006-2013

Note: FPL is the federal poverty level. Source: Child Trends' analysis of 2009-2013 American Community Survey, Public Use Microdata Sample.

Poor (<100% FPL)	2006	2007	2008	2009	2010	2011	2012	2013
D.C.	29.5	21.0	23.4	22.4	27.9	31.2	19.8	22.8
U.S.	21.3	21.4	21.6	23.7	25.5	25.9	25.6	24.8
Low Income (<200% FPL)	2006	2007	2008	2009	2010	2011	2012	2013
D.C.	44.0	42.1	38.6	39.6	47.6	47.1	35.2	42.8
U.S.	43.9	44.0	44.3	46.6	48.5	48.8	48.3	47.4
Not Low Income (200% or more FPL)	2006	2007	2008	2009	2010	2011	2012	2013
D.C.	56.0	57.9	61.4	60.4	52.4	52.9	64.8	57.2
U.S.	56.1	56.0	55.7	53.4	51.5	51.2	51.7	52.6

Percentage of infants and toddlers (children younger than 3 years) who have family incomes higher than 200% of the federal poverty level: District of Columbia by PUMA, 2009-2013

Note: FPL is the federal poverty level. Source: Child Trends' analysis of 2009-2013 American Community Survey, Public Use Microdata Sample.

West PUMA	97.1
North PUMA	54.2
Northeast PUMA	68.3
East PUMA	28.1
Central PUMA	72.3

Percentage of infants and toddlers (children younger than 3 years) living in concentrated poverty: District of Columbia, by Ward, and United States, 2009-2013

Source: United States Census Bureau. American Factfinder Online Tool, Tables B09001 and B17001, 2013 ACS 5-year estimates. Available at <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

D.C.	42.7
U.S.	32.9
Ward 1	13.7
Ward 2	11.5
Ward 3	3.8
Ward 4	17.5
Ward 5	43.5
Ward 6	24.8
Ward 7	88.4
Ward 8	88.7

Infants, Toddlers, and the Families That Raise Them

Parental Education

Percentage of infants and toddlers (children younger than 3 years), by highest parental education: District of Columbia and United States, 2009–2013

Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

Level of Education	D.C.	U.S.
High school diploma or less	30.9	33.3
Some college, including vocational/technical	18.0	30.9
Bachelor's degree or higher	51.2	35.8

Parental Employment

Percentage of infants and toddlers (children younger than 3 years) living with at least one parent with secure employment:* District of Columbia, by PUMA, and United States, 2009–2013

*Secure employment is defined as having worked full time for 50 to 52 weeks in the past year. Estimate unreliable, because based on fewer than 20 sample cases. Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

	At least one parent with secure employment	Two parents with secure employment
D.C.	64.9	22.1
U.S.	64.9	16.2
West PUMA	94.9	42.8
North PUMA	63.3	21.0
Northeast PUMA	67.8	30.8
East PUMA	44.8	—
Central PUMA	73.0	28.4

Parental employment among infants and toddlers (children younger than 3 years), by family type: District of Columbia, by PUMA, and United States, 2009–2013

Estimate unreliable, because based on fewer than 20 sample cases. Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

	Among those living with single parents: parent employed	Among those living with two parents: both parents employed	Among all: all resident parents employed
D.C.	56.9	62.5	59.9
U.S.	58.8	50.5	53.5
West PUMA	—	63.1	65.5
North PUMA	66.0	58.8	61.8
Northeast PUMA	42.4	81.4	66.0
East PUMA	55.8	38.4	52.9
Central PUMA	—	55.5	57.3

Family Structure

Children in Grandparent-Headed Households

Percentage of infants and toddlers (children younger than 3 years) living with a grandparent head of household: District of Columbia, and United States, 2009–2013

Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

D.C.	17.4
U.S.	16.4

Family Structure

Births to Unmarried Women

Percentage of infants and toddlers (children younger than 3 years) living with two married parents: District of Columbia, by PUMA, and United States, 2009–2013

Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

D.C.	51.8
U.S.	61.2
West PUMA	93.3
North PUMA	56.3
Northeast PUMA	63.2
East PUMA	14.6
Central PUMA	70.0

Percentage of births that were to unmarried women: District of Columbia and United States, 1995–2013

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 1995–2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	65.8	66.1	63.6	62.9	61.7	60.3	57.4	56.5	53.6	55.9
U.S.	32.2	32.4	32.4	32.8	33.0	33.2	33.5	34.0	34.6	35.8
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	56.0	57.6	58.5	57.8	55.8	54.8	53.6	51.1	50.8	
U.S.	36.9	38.5	39.7	40.6	41.0	40.8	40.7	40.7	40.6	

Percentage of births that were to unmarried women: District of Columbia, by Ward, and United States: 2013

Sources: District of Columbia Data: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, Department of Health (2014). 2012 Infant Mortality Rate for the District of Columbia. Available at: http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/2012%20Infant%20Mortality%20Report.pdf. U.S. Data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007–2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

D.C.	51.1	Ward 4	49.6
U.S.	40.7	Ward 5	59.1
Ward 1	43.4	Ward 6	29.9
Ward 2	15.4	Ward 7	85.2
Ward 3	7.4	Ward 8	80.1

Infants, Toddlers, and the Families That Raise Them

Family Structure

Maternal Age

Fertility rate (births per 1,000 females, ages 15–44), and birth rates by age group: District of Columbia, by Ward, and United States, 2012

Source: District of Columbia and U.S. data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007–2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>. Ward level data: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, D.C. Department of Health, tabulated by the Summit Fund.

	Total	15-19	20-24	25-29	30-34	35-39	40-44
D.C.	53.3	32.1	54.2	44.5	80.9	68.9	21.2
U.S.	62.5	26.5	80.7	105.5	98.0	49.3	10.4
Ward 1	46.3	21.4	36.2	35.0	68.0	79.4	33.6
Ward 2	24.0	3.5	4.4	15.0	53.2	72.5	34.4
Ward 3	36.5	1.1	3.4	18.1	82.7	82.0	40.7
Ward 4	91.2	42.3	94.4	113.4	142.0	92.8	31.6
Ward 5	59.6	43.1	73.4	61.0	100.6	51.8	17.2
Ward 6	54.4	47.1	39.2	29.3	86.1	85.8	29.1
Ward 7	81.4	82.2	134.0	143.2	69.6	39.3	11.5
Ward 8	88.2	73.3	151.3	117.1	93.5	40.6	11.6

Teen births (rate per 1,000 women ages 15–19), and percentage of total births that are to women younger than 20 years: District of Columbia and United States, 2004–2013

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007–2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

Teen Birth Rate

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
D.C.	43.5	42.1	48.1	50.4	51.1	48.5	45.6	42.8	39.0	32.1
U.S.	40.5	39.7	41.1	41.5	40.2	37.9	34.4	31.3	29.4	26.5

Percentage of births

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
D.C.	11.2	11.0	12.0	12.1	12.2	11.7	10.6	9.8	8.5	7.1
U.S.	10.3	10.2	10.4	10.5	10.4	10.0	9.3	8.4	7.8	7.0

Teen birth rate (rate per 1,000 women ages 15–19), and percentage of total births that are to women younger than 20 years: District of Columbia, by Ward, and United States, 2012

Sources: District of Columbia Data: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, Department of Health (2014). 2012 Infant Mortality Rate for the District of Columbia. Available at: http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/2012%20Infant%20Mortality%20Report.pdf. U.S. Data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007–2013 on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

	Teen birth rate	Percentage of births
D.C.	38.6	8.5
U.S.	29.4	7.8
Ward 1	23.2	5.0
Ward 2	3.9	2.2
Ward 3	1.2	0.4
Ward 4	41.2	5.2
Ward 5	40.2	10.2
Ward 6	58.7	5.2
Ward 7	66.8	17.0
Ward 8	82.0	15.9

Percentage of infants and toddlers (children younger than 3 years), by parental age: District of Columbia and United States, 2009–2013

Estimate unreliable, because based on fewer than 20 sample cases. Source: Child Trends' analysis of 2009–2013 American Community Survey, Public Use Microdata Sample.

Mother's Age	D.C.	U.S.
Under 20	3.2	3.5
20-29	32.7	43.9
30-39	53.0	45.2
40 or older	11.1	7.4

Father's Age	D.C.	U.S.
Under 20	—	0.8
20-29	16.8	28.2
30-39	54.3	53.1
40 or older	28.6	18.0

Health and Well-Being

Prenatal Care

Percentage of births where there was late or no prenatal care: District of Columbia and United States, 2010-2013

Note: U.S. data do not include all states. Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

	2010	2011	2012	2013
D.C.	9.3	9.4	10.3	10.5
U.S.	6.2	6.0	6.0	6.1

Percentage of births where there was late or no prenatal care: District of Columbia, by Ward, and United States, 2012

Note: U.S. data do not include all states. Sources: District of Columbia Data: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, Department of Health (2014). 2012 Infant Mortality Rate for the District of Columbia. Available at: http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/2012%20Infant%20Mortality%20Report.pdf. U.S. Data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

D.C.	8.2	Ward 4	10.2
U.S.	6.0	Ward 5	9.8
Ward 1	8.3	Ward 6	6.1
Ward 2	6.6	Ward 7	8.8
Ward 3	3.8	Ward 8	9.1

Low Birthweight

Percentage of infants that had low birthweight: District of Columbia, by Ward, and United States, 2012

Sources: District of Columbia Data: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, Department of Health (2014). 2012 Infant Mortality Rate for the District of Columbia. Available at: http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/2012%20Infant%20Mortality%20Report.pdf. U.S. Data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

D.C.	9.7	Ward 4	7.9
U.S.	8.0	Ward 5	9.2
Ward 1	8.4	Ward 6	7.9
Ward 2	7.3	Ward 7	15.0
Ward 3	7.3	Ward 8	12.2

Percentage of infants that had low and very low birthweight: District of Columbia and United States, 1995-2013

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 1995-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

Low birthweight (less than 2,500 grams)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	13.4	14.3	13.4	13.1	13.1	11.9	12.1	11.6	10.9	11.1
U.S.	7.3	7.4	7.5	7.6	7.6	7.6	7.7	7.8	7.9	8.1
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	11.2	11.5	11.1	10.5	10.3	10.2	10.4	9.6	9.4	
U.S.	8.2	8.3	8.2	8.2	8.2	8.2	8.1	8.0	8.0	

Very low birthweight (less than 1,500 grams)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	3.6	3.5	3.4	3.0	3.4	2.6	2.7	2.7	2.2	2.8
U.S.	1.4	1.4	1.4	1.5	1.5	1.4	1.4	1.5	1.5	1.5
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	2.6	2.5	2.8	2.5	2.1	2.3	2.1	1.7	2.4	
U.S.	1.5	1.5	1.5	1.5	1.5	1.5	1.4	1.4	1.4	

Health and Well-Being

Preterm Births

Percentage of births that were preterm, by gestation duration: District of Columbia and United States, 1995-2013†

†Note: The preterm rates for D.C. differ between the two tables. This may reflect that the data come from two different sources, one of which may reflect revised data. Child Trends was not able to identify the explanation for the discrepancy. Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

All preterm births (<37 weeks gestation)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	18.5	18.4	18.3	18.5	17.4	16.3	16.0	14.6	14.8	14.4
U.S.	11.0	11.0	11.4	11.6	11.8	11.6	11.9	12.1	12.3	12.5
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	15.9	16.0	15.6	15.5	14.2	13.6	13.7	12.8	13.3	
U.S.	12.7	12.8	12.7	12.3	12.2	12.0	11.7	11.5	11.4	

Very preterm (<32 weeks gestation)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	4.9	4.9	4.5	4.3	4.4	3.7	3.8	3.7	2.9	3.5
U.S.	1.9	1.9	1.9	2.0	2.0	1.9	1.9	2.0	2.0	2.0
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	3.3	3.3	3.7	3.2	2.9	3.0	2.9	2.5	2.9	
U.S.	2.0	2.0	2.0	2.0	2.0	2.0	1.9	1.9	1.9	

Moderately preterm (32-33 weeks gestation)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	2.8	2.8	2.9	3.0	2.3	2.2	2.2	1.8	2.3	2.1
U.S.	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	2.2	2.0	1.9	2.3	2.0	2.1	1.6	2.2	1.8	
U.S.	1.6	1.6	1.6	1.6	1.5	1.5	1.5	1.5	1.5	

Late preterm (34-36 weeks gestation)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
D.C.	10.8	10.6	10.9	11.2	10.6	10.4	10.1	9.1	9.7	8.8
U.S.	7.7	7.7	8.0	8.1	8.3	8.2	8.5	8.6	8.8	8.9
	2005	2006	2007	2008	2009	2010	2011	2012	2013	
D.C.	10.4	10.7	9.9	10.1	9.3	8.5	9.1	8.1	8.6	
U.S.	9.1	9.2	9.0	8.8	8.7	8.5	8.3	8.1	8.0	

Percentage of births that were preterm: District of Columbia, by Ward, and United States, 2012†

†Note: The preterm rates for D.C. differ between the two tables. This may reflect that the data come from two different sources, one of which may reflect revised data. Child Trends was not able to identify the explanation for the discrepancy. Sources: District of Columbia Data: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, Department of Health (2014). 2012 Infant Mortality Rate for the District of Columbia. Available at: http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/2012%20Infant%20Mortality%20Report.pdf. U.S. Data: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>.

D.C.	9.9	Ward 4	8.6
U.S.	11.5	Ward 5	8.6
Ward 1	9.2	Ward 6	7.8
Ward 2	7.0	Ward 7	15.1
Ward 3	8.4	Ward 8	12.2

Child Maltreatment

Unique victims of substantiated child maltreatment, birth to age 3, number and rate per 1,000: District of Columbia and the United States, 2009-2013

Sources: Child Trends' analysis based on U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. Child Maltreatment. Available at: <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

Number	2009	2010	2011	2012	2013
D.C.	636	546	463	455	457
Less than age 1	357	264	238	216	213
Ages 1-2	279	282	225	239	244
Rate per 1,000 population	2009	2010	2011	2012	2013
D.C.	27.3	23.4	20.2	18.1	17.2
U.S.	14.6	14.6	15.3	15.2	15.4
Less than age 1	45.5	33.6	26.7	24.7	23.4
Ages 1-2	18.0	18.2	16.1	14.6	14.0

Unique victims of substantiated child maltreatment, birth to age 3, number and rate per 1,000: District of Columbia and by Ward, 2005-2014

	Average case count		Rate	
	2005-2009	2010-2014	2005-2009	2010-2014*
D.C.	552	458	24.8	20.5
Ward 1	39	23	13.6	9.7
Ward 2	14	5	11.1	3.3
Ward 3	1	1	0.4	0.3
Ward 4	38	25	12.3	7.6
Ward 5	75	52	26.8	19.4
Ward 6	49	35	17.8	12.8
Ward 7	93	99	36.7	34.2
Ward 8	160	159	37.6	35.4

*Rates are based on 2009-2013 population estimates. Sources: Maltreatment numbers: Personal communication, Brady Birdsong, CIO, Child and Family Services Agency. Population for calculating rates: United States Census Bureau. American Factfinder Online Tool, Table B09001, 2013 and 2009 ACS 5-year estimates. Available at: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

Health and Well-Being

Foster Care

Children in foster care at the end of the year, birth to age 3:* District of Columbia and United States, 2013

*Age is age at end of year. Source: Foster children: Child Trends' calculations from the Adoption and Foster Care Analysis and Reporting System (AFCARS). Population: Child Trends' calculations from 2014 intercensal population estimates from the Census Bureau. Available at: <http://www.census.gov/popest/data/state/asrh/2014/index.html>.

	Total D.C.	Total U.S.	NH Black D.C.	NH Black U.S.	Total D.C. Rate per 1,000	Total U.S. Rate per 1,000	NH Black D.C. Rate per 1,000	NH Black U.S. Rate per 1,000
Infants and Toddlers	142	86,501	112	18,301	5.4	7.3	8.8	11.2
Infants	42	26,654	30	5,477	4.6	6.8	7.7	10.0

Infant and Toddler Mortality

Estimated life expectancy (in years) of newborns in the District of Columbia and United States, by race and gender, 1999-2001

National Center for Health Statistics. U.S. decennial life tables. Available at: http://www.cdc.gov/nchs/products/life_tables.htm#decennial.

	D.C.	U.S.	D.C.	U.S.	D.C.	U.S.		
Total	73.1	76.9	Males	68.6	74.1	Females	77.6	79.5
Black	69.9	71.8	Black	64.6	68.2	Black	74.5	75.2
White	81.5	77.4	White	78.9	74.8	White	84.3	80.0

Other

Percentage of births where the mother smoked during the pregnancy: District of Columbia, by Ward (counts only), and United States, 2013

Note: U.S. data does not include all states. Sources: U.S. and D.C.: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2013, on CDC WONDER Online Database, January 2015. Available at: <http://wonder.cdc.gov/natality-current.html>. Wards: Stean, P. (May 5, 2015). Babies in Ward 5 at greatest risk of dying in D.C. Washington Post. Available at <http://www.washingtonpost.com/news/local/wp/2015/05/05/babies-in-ward-5-at-greatest-risk-of-dying-in-d-c/>.

D.C.	3.0	Ward 4	18
U.S.	8.5	Ward 5	43
Ward 1	20	Ward 6	18
Ward 2	5	Ward 7	63
Ward 3	1	Ward 8	92

Percentage of infants and toddlers (children younger than 3 years) that experienced household food insecurity: District of Columbia and United States, 2009-2013

	D.C.	U.S.
Marginal food security*	15.3	14.6
Low or very low food security**	17.0	22.0

*Households had problems at times, or anxiety about, accessing adequate food, but the quality, variety, and quantity of their food intake were not substantially reduced. **Households reduced the quality, variety, and desirability of their diets, and the quantity of food intake and normal eating patterns may or may not have been substantially disrupted. Source: Child Trends' analysis of December Current Population Survey, 2009-2013.

Preventive and Developmental Supports

Health Insurance Coverage

Percentage of infants and toddlers (children younger than 3 years) by health insurance coverage status: District of Columbia and United States, 2008-2013

Estimate unreliable, because based on fewer than 20 sample cases. Source: Child Trends' analysis of 2008-2013 American Community Survey, Public Use Microdata Sample.

No Coverage	2008	2009	2010	2011	2012	2013
D.C.	—	—	—	—	—	—
U.S.	8.1	6.4	6.0	5.5	5.1	5.4
Public Coverage	2008	2009	2010	2011	2012	2013
D.C.	42.4	42.7	46.8	42.9	39.3	43.2
U.S.	37.1	42.3	44.9	45.6	45.6	44.8
Private Coverage	2008	2009	2010	2011	2012	2013
D.C.	55.8	60.6	59.4	62.5	61.4	63.9
U.S.	57.4	54.8	52.5	52.2	52.7	53.1

Early Intervention Services

Percentage of infants and toddlers who receive Early Intervention (Part C) services, by type of service: District of Columbia and United States, Fiscal Year 2013

Source: United States Department of Education (2014). Part C and Part B 619 Data Display: District of Columbia 2012-2013. Available at: <https://www2.ed.gov/fund/data/report/idea/partcspap/2014/dc-acc-statedatadisplay-part-c-12-13-2.pdf>.

	D.C.	U.S.
Community-based settings	21.6	7.6
Home	74.5	87.4
Other	3.9	5.1

Infants and toddlers who receive Early Intervention (Part C) services: total, and as a percentage of all children: District of Columbia and United States, Fiscal Year 2014

	Infants and toddlers who receive Early Intervention (Part C) services	Percentage of total infants and toddlers*
D.C.	697	2.6
U.S.	339,000	2.9
Ward 1	78	3.9
Ward 2	36	2.2
Ward 3	64	2.7
Ward 4	142	3.7
Ward 5	90	3.2
Ward 6	96	4.2
Ward 7	86	2.9
Ward 8	105	2.4

*Percentage for wards is based on an estimate of 2009-2013 population. <http://ectacenter.org/~pdfs/growthcompPartC.pdf>. <http://www2.ed.gov/programs/osepidea/618-data/state-level-datafiles/index.html>. Ward data provided by Kerda DeHaan, Office of the State Superintendent of Education, District of Columbia.

Preventive and Developmental Supports

Other

Percentage of infants and toddlers (children younger than 3 years), by household language status: District of Columbia and United States, 2009-2013

Source: Child Trends' analysis of 2009-2013 American Community Survey, Public Use Microdata Sample. Note: A linguistically isolated household is defined as a household in which no person 14 years old and over speaks only English, and no person 14 years old and over who speaks a language other than English speaks English "very well."

Language status	D.C.	U.S.
Linguistically isolated	5.3	7.9
English-only household	73.3	66.7
Spanish speaking	12.2	21.8

Percentage of infants and toddlers (children younger than 3 years) who used electronics or TV for an hour or more, and who were read to every day in the past week: District of Columbia and United States, 2011-2012

Source: Child Trends' analysis of 2011-12 National Survey of Children's Health

	D.C.	U.S.
An hour or more electronics	7.0	9.0
An hour or more TV	38.8	47.3
Read to every day	56.0	46.3

Percentage of children, ages 19-35 months, receiving vaccinations, by vaccine, total, and by poverty status, 2013: District of Columbia and United States

	DTP/DT/DTaP (4 doses or more)+	Polio (3 doses or more)	Measles-Mumps-Rubella	Hib (Primary Series)++	Hepatitis B	Varicella (Chicken pox)	Combined series (4:3:1:3)*	Combined series (4:3:1:3:3:1)**
D.C.	86.2	96.1	96.2	96.2	92.5	95.0	86.1	81.5
U.S.	83.1	92.7	91.9	93.7	90.8	91.2	81.1	77.7
At or above poverty	90.2	95.0	96.8	96.7	92.9	94.9	90.0	84.4
Below poverty	NA	97.7	97.7	94.5	96.1	97.7	NA	NA

+ Diphtheria and tetanus toxoids and pertussis vaccine, diphtheria and tetanus toxoids, and diphtheria and tetanus toxoids and acellular pertussis vaccine. ++ Haemophilus influenzae type b vaccine (Hib). *The 4:3:1:3 combined series measures the number of children who have received 4 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine, 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, and 3 or more doses of Haemophilus influenzae type b vaccine (Hib). **The 4:3:1:3:3:1 combined series measures the number of children who have received 6 key immunizations: 4 or more doses of diphtheria, tetanus, and pertussis vaccine (DTP), 3 or more doses of polio vaccine, 1 or more doses of a measles-containing vaccine, 3 or more doses of Haemophilus influenzae type b vaccine (Hib), three or more doses of hepatitis B vaccine (HepB), and one or more doses of varicella. Source: Centers for Disease Control and Prevention, National Immunization Program, NIS data, tables, Jan-Dec. www.cdc.gov/vaccines/statstsurv/imz-coverage.htm#nis.

Children, birth to 5, who received Supplemental Nutrition Assistance Program (SNAP, or food stamps): Total, and as a percentage of all poor children,* fiscal year 2013

	D.C.	U.S.
SNAP participants, 0-4 (in thousands)	18	6,714.0
Participation rate*	144.9	106.8

*Among families with incomes below 130 percent of the federal poverty level the percentage who received SNAP benefits. Sources: United States Department of Agriculture, Food and Nutrition Service (2014). Characteristics of Supplemental Nutrition Assistance Program households: Fiscal Year 2013. Available at: <http://www.fns.usda.gov/characteristics-supplemental-nutrition-assistance-program-households-fiscal-year-2013>. Population data: Child Trends' analysis of American Community Data.

Early Learning

Child Care

Number of regulated child care slots for infants and toddlers, and slots that accept subsidies: District of Columbia, total and by ward, February 2015

Sources: Total capacity: District of Columbia Office of the State Superintendent of Education, OSSE Division of Early Learning Child Care Licensing Unit (2015). Child care licensing unit report. Available at: <http://osse.dc.gov/publication/child-care-licensing-unit-report>. Accepting subsidies: DC Child Care Connections. Available at: <http://childcareconnections.osse.dc.gov/providersearch.aspx>.

	Total slots	Accept subsidies	Accept subsidies (%)
D.C.	7,052	4,183	59.3
Ward 1	626	570	91.1
Ward 2	1,462	234	16.0
Ward 3	374	35	9.4
Ward 4	1,107	626	56.5
Ward 5	889	635	71.4
Ward 6	653	393	60.2
Ward 7	753	636	84.5
Ward 8	1,188	1,054	88.7

Early Head Start (EHS)

Infants, toddlers, and pregnant women in Early Head Start, by program: District of Columbia, 2014

Source: Calculations based on District of Columbia, Office of the State Superintendent of Education (2015). The state of pre-k in the District of Columbia: 2014 Pre-k report. Table 3.

EHS enrollment August 2014	
Total	655
Ward 1	276
Ward 4	36
Ward 5	80
Ward 6	112
Ward 7	156
Ward 8	104

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- 84** Calculations based on D.C. Office of the State Superintendent of Education (2015), and the state of pre-K in the District of Columbia: 2014 Pre-k report, Table 3.



Every child deserves the opportunity to learn, grow, and succeed in school and in life. We give children who wouldn't otherwise have a chance to thrive the opportunity to do so. More than 16 million U.S. children live in poverty. We help children exit poverty – and we've been doing so for 47 years.

The Bainum story began in 1968 with Stewart Bainum. He wanted to create new opportunities for children to attend quality schools, develop strong relationships, and gain valuable life skills outside of the classroom. Partners, educators, and parents joined his cause, and today thousands of young people who once had nothing have college degrees and jobs.

At the Bainum Family Foundation, we are part researcher, part organizer, part educator, and part investor. We inspire children to ask questions like "What if?" and

"Why not?" — questions that can change their future — and the world.

We support as many children as we can through a circle of collaboration. Our circle is large and welcoming. It includes passionate partners, schools, families, and those who support them. It includes a holistic view of every child, providing integrated services so that they have every opportunity to thrive. And it includes proven expertise to amplify outcomes that strengthen our communities and create opportunities.

Our Services Include:

Early Learning

We believe the first few years (ages 0 to 3) can change everything. Research supports this. We provide high-quality early learning services and technical assistance to service providers to improve the quality and accessibility of early learning. These services include instruction, home visitation, mental wellness, pediatric care, and nutrition.

Wrap-Around Support

We embrace a whole-child approach. Academic learning is important, but just as important are social-emotional development, mental wellness, and physical health. For children in pre-k and early elementary school (ages 3 to 8), we provide after-school and summer enrichment, mental wellness, and nutrition services to promote whole-child development. We also provide technical assistance to other service providers to improve the quality and accessibility of wrap-around services.

Knowledge Building

We can't change a child's life alone. So we support partners in the development, understanding, and application of best practices in education and child development through research, training, and advocacy.





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