

# South Carolina Early Childhood Data Report

February 2019



INSTITUTE *for* CHILD SUCCESS

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(by)

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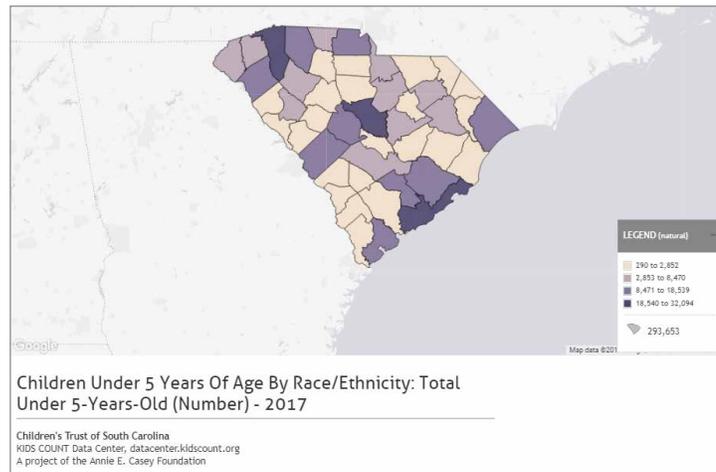
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## (introduction)

The earliest years of a child’s life, beginning before birth, are among the most impactful in influencing the child’s lifespan potential and outcomes. This means that a child’s environment should include positive factors to encourage development, as well as buffer against life’s inevitable stressors (1, 2). This data book serves to share information about the environmental factors impacting children, ages 8 and under, in South Carolina, compared to North Carolina, Georgia, and the United States as a whole.

In 2018, South Carolina ranked 38th in the nation for child well-being, according to an assessment by the Annie E. Casey Foundation, in the 2018 Kids Count Profile, which is a marked improvement from 2014, when South Carolina was ranked 45th (4). An emphasis on improving the well-being of children from birth to age 5 is critical to increasing the potential for South Carolina’s future adults. In 2017, South Carolina had a population of a little over 5 million, of which 1.1 million were under the age of 18 (5). Children under the age of 5 comprised 26 percent of the child population with 291,414 individuals (5). This report provides a snapshot of the well-being of these youngest citizens of the state.



**Figure 1.** Children under 5 years of age by race/ethnicity: Total under 5-years-old (number) – 2017 (3)

## (methods)

### Understanding the indicators

There is no one comprehensive indicator of child well-being. Rather, well-being spans physical, social-emotional, and cognitive health and development. Since children do not grow up in a vacuum from their parents or communities, there are a variety of factors that influence overall well-being and long-term flourishing. We began this process by reviewing the indicators used in the previous 2014 edition (6) and consulting with other experts in the field, including physicians, researchers, government agency staff, and the ICS Research Committee to revise indicators based on new research since 2014 and identify the best-fit data sources. For the first report, the Institute for Child Success selected a set of indicators based on research showing links to both immediate well-being and long-term outcomes (6, 7), a nomenclature that was largely preserved in this edition, which is intended to be an update of the 2014 report. Where possible, an effort was made to identify both individual and systems-level indicators which provide a picture not only of the outcomes for families and children but also the structural factors that impact these outcomes.

This report centers on the experience of children and families in South Carolina. Comparative data are provided for the neighboring states of North Carolina and Georgia as a means of providing regional context, as well as national data. Efforts have been made to utilize the same data source for all four geographies or ensure that the indicators are measured in similar ways. Where clear comparative data is not available, this is noted. For the full list of indicators, please see Table 3 beginning on page 28.

Throughout this report, the research team identified a number of data points of interest that could not be collected from sources allowing for comparison or otherwise did not meet standards of reliable data. In the absence of said data, this report makes use of proxies, secondary indicators with available data that provide some reference point, albeit one not as clear or direct as the primary indicators would provide. For example, our team was interested in the prevalence of Fetal Alcohol Syndrome in babies born across all four geographies. We could not identify a reliable dataset that measured this. We have reported on a related indicator (“mothers reporting alcohol during last 3 months of pregnancy”) to provide some context on the possible scope of this issue, but these indicators are not interchangeable. Discovering and filling gaps in statistics can help paint a broader and more useful portrait of child well-being in our state. Improving the quality and accessibility of early childhood data in South Carolina and nationwide should continue to be a goal for all stakeholders in the early childhood arena.

In particular, we experienced challenges in collecting data reflecting the mental and emotional well-being of young children in South Carolina. Very young children can be and are diagnosed with emotional and behavior disorders. However, in the absence of reliable statistics concerning these children, this report recognizes that children develop within the context of families and that as such, their emotional well-being is contingent upon the emotional health of their families (8).

### Defining the Categories of Indicators

Table 1 below highlights the four major categories of indicators in this report, along with sub-categories on indicator types. This report and the full data table (Table 3 beginning on page 28) follow the order presented here.

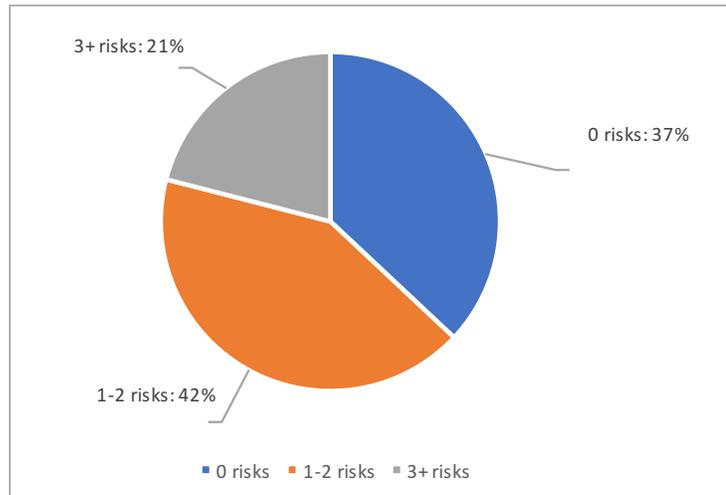
**Table 1: Early Childhood Well-Being Indicators**

Family Environment	Physical Health	Emotional Well-Being	Cognitive Development
Family income	Prenatal care	Maternal depression	Developmental Delay
Parent education	Substance use	Abuse and neglect	Child care
Parental employment	Domestic abuse		Head Start
Teenage motherhood	Preterm births		Pre-kindergarten
Family engagement	Low birth weight		
	Infant mortality		
	Breastfeeding		
	Immunizations		
	Medical care		
	Oral health		
	Obesity and Activity		

*Family Environment.* All families and their circumstances are unique, as is the interplay with their environment and the systems with which they interact. However, research tells us that a number of family and child characteristics are linked to poor child health, academic, and developmental outcomes. The National Center for Children in Poverty at Columbia University identifies these “risk factors” as:

- living in poverty,
- single parent,
- teen mother,
- low parental education level,
- non-employed parents,
- residential mobility,
- households without English speakers, and
- large family size.

Well over half of the state’s children under age 6 experience at least one of these risk factors, as shown in Figure 2.



**Figure 2.** Children under Age 6 Experiencing Multiple Risks in South Carolina, 2016 (9). The state data for Figure 1 were calculated from the 2012-2016 American Community Survey.

*Physical Health.* Child development begins in utero, as individual’s prenatal experiences lay the foundation for future development. Development is a compounding process, meaning small deficits and delays can have long term impacts if left unaddressed. Physical health has a bidirectional cognitive and emotional health, particularly in early development. This section examines health indicators beginning before birth and continuing until age 5.

*Emotional Well-Being.* The emotional well-being of all members of a family unit is key to the positive development of a child (10, 11). In this report, we focus mostly on maternal depression, as well as abuse and neglect, although this should not negate the importance of fathers, siblings, or other members of a family unit in the effect on a child.

*Cognitive Development.* From birth to age 5, children undergo tremendous cognitive changes in areas such as attention, language, memory, perception, and learning. Proper development contributes to their success in later childhood and into adulthood, especially to their success in school and the workplace.

## Report Structure

In the Results and State Comparisons section, this report first summarizes the available data on each indicator and gives context by comparing South Carolina to North Carolina, Georgia, and the US average. In the next section, Discussion and Policy Implications, we dig deeper beneath the statistics to identify key policies, programs, and opportunities in South Carolina which may be shaping these trends. The goal of this report is not to be a comprehensive summary of all of South Carolina’s investments in children, and we refrain from making programmatic recommendations in the interest of space. Rather, the goal of this report is to help families, service providers, policymakers, and funders in the state identify where South Carolina’s families are thriving and where there are opportunities for growth.

## (results and state comparisons)

Table 3 *State Indicators and Statistics* provides an overview of all the data found in this data book's analysis, including over 80 indicators of child and family well-being, with a side-by-side comparison of South Carolina, North Carolina, Georgia, and United States (national) statistics. Every effort has been made to ensure accurate, up-to-date information in these indicators as well as in the selection of sources. Indicators are represented the way they were in their original data sources. Footnotes are provided throughout the table to clarify acronyms and explain when the publication year and the year of data collection differ. For more information on an individual indicator, please access the original data source as cited.

### **Family Environment**

#### *Family Income*

The median income for South Carolina families with children was \$58,000 in 2017, almost 19 percent less than the US median family income of \$71,400. Nearly a quarter – 23 percent – of South Carolina children under the age of 18 live in poverty, defined as family income of less than \$24,600 for a family of four. This is higher than the national rate (18 percent) as well as the 21 percent rate in both North Carolina and Georgia. While federal poverty guidelines determine eligibility for various programs, they are generally an understatement of family economic situations. Another measure of financial well-being is measuring low-income status, defined as living at or below twice the federal poverty level. More than half of South Carolina's children under age 6 qualify for "low-income" status (54 percent), compared to 43 percent at the national level.

A number of economic support programs are available, particularly for families with young children. Statistics on the reach of these programs focuses on the raw number of families and individuals, which can make it hard to place in context given the varying population sizes across states. Consider that South Carolina is home to 1.5 percent of the nation's total child population.

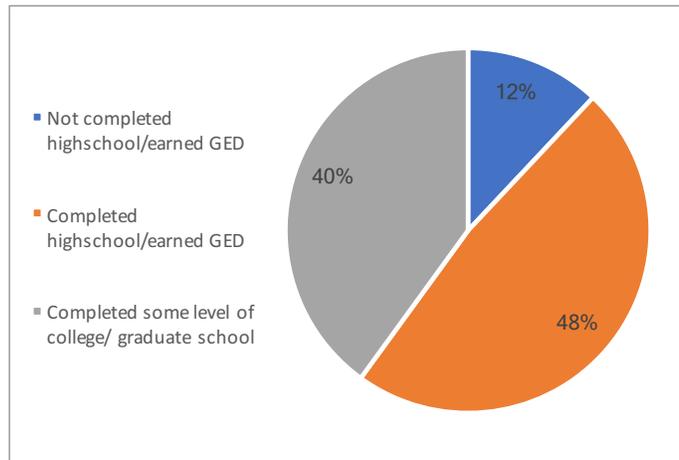
#### *Government Assistance*

Nearly 25,000 women participated in Women, Infants, and Children (WIC) in 2017, reaching 99,332 individuals; this represents 1.4 percent of total participation nationwide, which closely aligns with the proportion of U.S. children living in South Carolina. In 2016, an average of 8,654 South Carolina families were receiving Temporary Assistance for Needy Families (TANF), with 15,825 children under the age of 18. This represents just 0.8 percent of national participation in TANF, less than we may expect given that 1.5 percent of the nation's children call the state home. It is difficult to determine from available statistics whether state difference are related to family eligibility, changes in availability of funds, or a combination of factors.

Free and reduced-price lunches are available within schools for children whose families meet income criteria (up to 130 percent of the federal-poverty level for free meals, and up to 185 percent for reduced-price meals). In 2018, 472,193 children in South Carolina received meals through this funding stream which is about 43 percent of the state's total population under age 18. Nationwide, just 30 percent of the U.S. population under age 18 receives meals through this program.

### *Parent Education*

In 2016, 12 percent of South Carolina parents had not completed high school or earned their GED, similar to the 13 percent reported in 2013 (12). There has been a slight shift into higher education levels among South Carolina parents, with 48 percent having completed high school or received their GED and another 40 percent completing some degree of education after high school, up from 36 percent in 2013 (12). See Figure 3 for a graphic representation of South Carolina parental education. For comparison, the rate of parents without a high school degree is lower in South Carolina than it is in neighboring North Carolina and Georgia (13 percent) and the national average (14 percent). South Carolina's higher education rate is slightly lower than these locations, though (ranging from 41 to 43 percent in comparison locations) (12).



**Figure 3.** South Carolina Parental Education, 2016 (12).

### *Parental Employment*

In 2017, 10 percent of South Carolina children were in households where no parent was in the workforce, slightly higher than statistics across North Carolina and Georgia (9 percent), and nationally (8 percent). A range of issues can impact, and be impacted by, a parent's employment and child care scenario, from day-to-day logistics to family budget. Nearly 13 percent of parents with young children reported that their work life was impacted by childcare issues, noticeably higher than the rates in all comparison locations (only 4.9 percent of Georgia parents reported the same; about 10.4 percent of parents in North Carolina and national reported this impact).

### *Teenage Motherhood*

In 2017, South Carolina had a teen pregnancy rate of 21.7 per 1,000 girls ages 15-19 (down from 25.1 per 1,000 girls in 2011). Fifteen percent of teen births in 2016 were to a teen mother who had already given birth at least once (13). South Carolina's progress on this indicator is part of a larger national trend of reduced teen pregnancy rates. The CDC reports that, nationally, the teen pregnancy rate has declined 51 percent since 2007, or an average of 8 percent per year (14).

### *Family Engagement*

In 2017, 70.6 percent of South Carolina families with children (ages 0-17) ate meals together four or more days per week (15). Just over 40 percent of South Carolina families with young children (ages 0-5) sang songs with them or told stories to them every day (180). In 2017, just over a third (34.8 percent) of South Carolina parents reported reading aloud to their children age 0 to 5 every day, with another 45.3 percent reporting that they read to them less than 3 times per week. (181)

### *Family Structure*

It is difficult to get a clear picture of family structure for children in any state, as data collection cannot capture the range of household structures and family dynamics. In South Carolina, over 16,000 children – about 29 percent of all births – were born into potentially single parent households based on information reported on birth certificates (16). A father’s information can either be recorded on a birth certificate through his marriage to the child’s mother or through completion of an “Acknowledgement of Paternity” (PATAACK) form that adds the father’s information to the birth certificate. While this does not fully give the picture of the status of the family structure for children in South Carolina, it is proxy data for single parent home at birth. According to a report from the Annie E. Casey Foundation, over 400,000 children under age 18 live in single parent families in South Carolina, about 40 percent of the total child population (17).

Research finds a link between birth to a teenage mother and negative child health and development outcomes. Teenage mothers are less likely to receive timely prenatal care, which is linked to negative pregnancy outcomes particularly birth weight (18). Teen pregnancy is linked to higher rates of mothers not completing school, which has negative impacts for their income stability in the future. Research also suggests that the children of teenage mother are likely to face a number of challenges, including higher rates that they will drop out of school and be unemployed during young adulthood (13).

Of course, not all children are raised by their own parents. About 6 percent of South Carolina’s children under age 18 are in the care of their grandparents, which can include householders where the parents are present or where they are not. This rate is slightly higher than the rate in Georgia and North Carolina (5 percent) (19). Another family composition to consider is “kinship care” which refers to the full-time care of a child by relatives, family friends, or other adults known to the family; this does not include foster care of a child otherwise unknown to the family. About 6 percent of South Carolina’s children live in such a household, higher than the prevalence of the arrangement in North Carolina and Georgia. It is important to keep in mind that some families could be included in both of these statistics.

## **Physical Health**

### *Prenatal Care*

According to the March of Dimes, a full-term baby from birth through his/her first-year costs \$5,085 in medical costs. In comparison, a preterm or low birth weight baby costs \$55,393 over the same duration. The brunt of these costs is covered by employers, \$4,389 and \$54,149 respectively (20). Thus, if prenatal care reduces preterm and low birthweight rates, it also reduces the economic impact of those births. In 2016, approximately one in five (18.0 percent) expectant mothers in South Carolina did not receive adequate prenatal care, compared to 17.5 percent of women in Georgia and 16.0 percent of women in North Carolina (21). Although not by a large margin, South Carolina has a higher percentage of inadequate prenatal care when compared to its neighboring states.

*Substance use during pregnancy.* South Carolina’s Department of Health and Environmental Control (DHEC) Pregnancy Risk Assessment Monitoring System (SC PRAMS) on prenatal and early infancy risk factors relating to birth outcomes reports 7.4 percent of South Carolina mothers (22) and 10 percent of North Carolina mothers (23) reported consuming alcohol during the last three months of pregnancy compared to a national average of 8.0percent (24). Georgia did not have available data

for a comparison. Although this statistic is less impactful than knowing what percentage of mothers report consuming alcohol during the critical first three months of pregnancy, it is still a useful for quantifying alcohol use by pregnant mothers which is ultimately recommended against.

In 2015, 10.8 percent of South Carolina mothers (25) and 9.2 percent of North Carolina mothers (26) reported smoking during the last three months of pregnancy, which represents a critical time for lung development. Both states percentages were higher than the national average of 8.8 percent (24). In contrast, nationally 9 percent of mothers reported smoking during the same period (24).

*Domestic abuse during pregnancy.* In 2015, 2.7 percent of South Carolina mothers reported being physically abused during pregnancy, higher than the North Carolina and the national average of 2.1 percent (24, 27). Furthermore, South Carolina consistently ranks near the top nationally in men killing women (28). Domestic violence statistics may not represent true numbers of physical abuse due to underreporting and does not reflect other forms of abuse, such as verbal or emotional abuse (29). The Department of Justice reports that approximately 580,000 cases of domestic violence are unreported nationally, due to factors including fear of retaliation and desire to protect the offender (29).

*Preterm births.* Preterm birth is the birth of an infant prior to 37 weeks gestation. Preterm births are the largest cause of long-term neurological disabilities and infant death. Infants born prematurely are more likely than those born full-term to suffer from cerebral palsy, respiratory problems, visual problems, hearing loss, intellectual disabilities, and feeding and digestive problems. These births are far costlier and are more likely to require costly neonatal intensive care and longer hospital stays (30, 31). The March of Dimes reports that preterm babies cost approximately \$50,000 more in their first year of life than babies born at full-term (20).

In 2017, 11.2 percent of all births in South Carolina were premature (32), which was slightly below the percentage of Georgia (11.4 percent) (33) but higher than North Carolina's (10.5 percent) (34) and the national average (9.9 percent) (35). Black mothers had a higher average of preterm births than

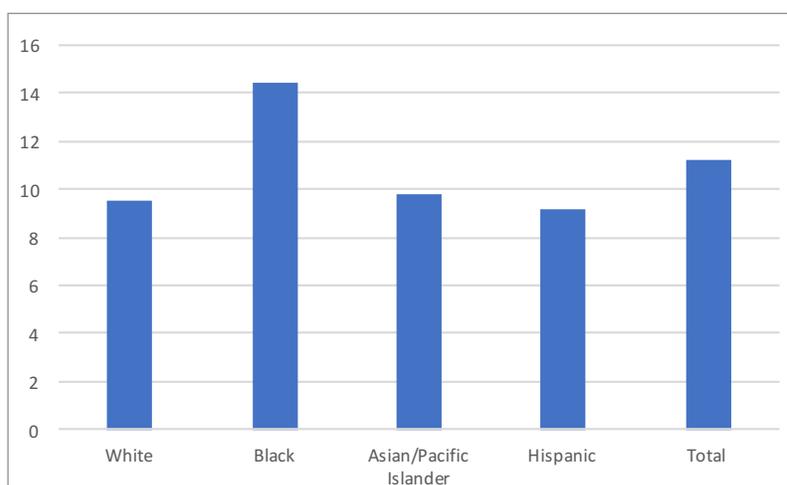


Figure 4. Preterm by race: South Carolina, percent of live births, 2014-2016 average (32)

either non-Hispanic White or Hispanic mothers from 2014-2016 in all states. South Carolina had the highest average preterm births among Black mothers at 14.4 percent while Georgia (13.7 percent) and North Carolina (13.6 percent) were closer to the national average of 13.4 percent. As far as preterm birth percentages Hispanic mothers, South Carolina and Georgia matched the national average of 9.2 percent while North Carolina was significantly lower at 8.6 percent. See Figure 4 for a graphic representation of South Carolina low weight births, and Figure 5 for a map of South Carolina's low weight births by county.

### Low Birth Weight

Low birth weight is defined as a weight of less than 5 pounds 8 ounces at birth (approximately 2,500 grams). In 2016, 9.6 percent of all live births in South Carolina were considered to be of low birth weight which was less than Georgia (9.8 percent) but higher than North Carolina (9.2 percent). All three states were above the national average of 8.2 percent (37). All states had a similar percentage of very low birth weight births with 1.8 percent of all live births in South Carolina and Georgia considered to be very low birth weight, while 1.6 percent of North Carolina's births were of the same classification. The national average is 1.4 percent (37). Very low birth weight is defined as weighing less than 3.3 pounds at birth (38). Infants of very low birth weight are at an even greater risk to suffer complications than those of low birth weight.

### Infant and Child Mortality

Many of the previous indicators can lead to higher rates of infant mortality, the death of an infant between birth and age 1 year. In 2017, South Carolina had 57,029 live births which was lower than North Carolina and Georgia who each had over 120,000 live births (39).

Of the 57,029 live births, 6.5 per 1,000 resulted in death before age 1 (40). South Carolina's rate of 6.5 deaths per 1,000 live births is higher than the national rate of 5.8 but lower than the rates of Georgia (7.2) and North Carolina (7.1) (40). African American families were disproportionately more likely to suffer the loss of a child in the first year of life in all three states (37). South Carolina had the lowest rate of African American infant mortality at 10.0, compared to North Carolina (13.4), Georgia (11.1), and even the national average (11.1) (37). In contrast, non-Hispanic White families in South Carolina had an infant mortality rate of 4.84 deaths per 1,000 births which matched the national average and was lower than North Carolina (5.0) and Georgia (5.3) (37).

### Breastfeeding

The number of South Carolina mothers breastfeeding declines over time in the first year of an infant's life (see Figure 6). In 2017, 76.4 percent of South Carolina mothers reported ever breastfeeding their infants, which was significantly lower than both peer states (Georgia 84.0 percent, North Carolina 84.9 percent) and the national average of 83.2 percent (41). The breastfeeding rate dropped to 45.1 percent non-exclusively at six months, which has an even greater margin of difference when compared to peer states and the national average. North Carolina has the highest rate of non-exclusive breast feeding at six months at 58.8 percent, then the national average at 57.6

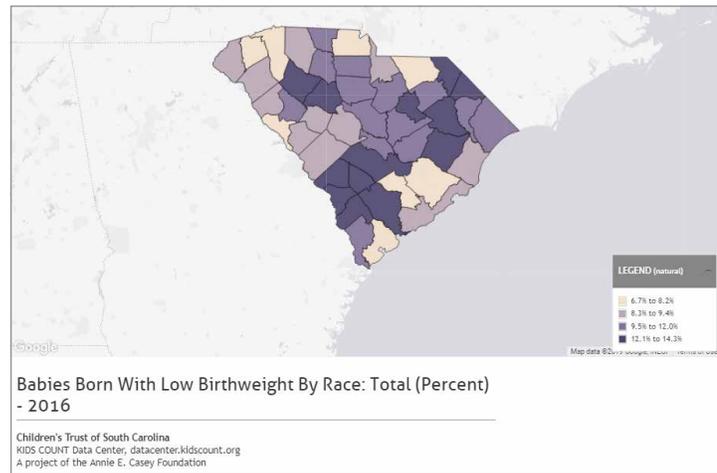


Figure 5. Babies born with low birthweight by race: Total (percent)- 2016 (36)

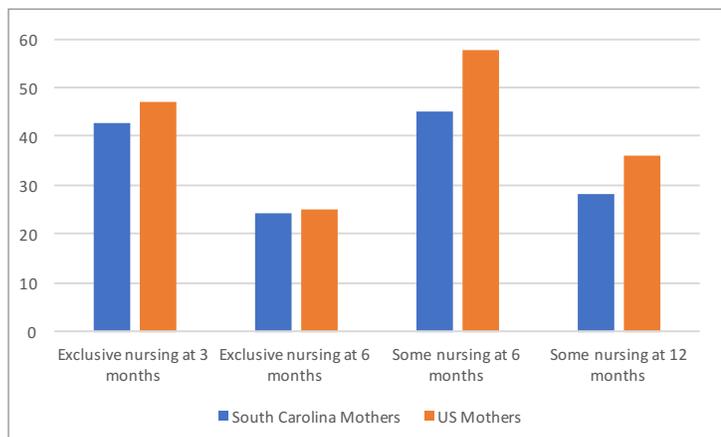


Figure 6. Percentage of nursing mothers, South Carolina compared to US, 2015 (41)

percent, and last but still significantly above South Carolina, Georgia at 55.6 percent (41). Fewer than 25 percent of South Carolina mothers continue to breastfeed exclusively for six months which is on par with the national average of 24.9 percent. Only North Carolina is above the 25 percent mark at 27 percent.

Two common types of lactation consultants are Certified Lactation Counselors (CLCs) and International Board-Certified Lactation Consultant (IBCLC). Both are qualified professionals whose intervention can improve breastfeeding rates and consistency. In South Carolina, there are 3.87 CLCs and 3.32 IBCLCs per 1,000 live births. Nationally, the averages are 4.57 and 3.79 respectively. Georgia and North Carolina each favor either CLCs or IBCLCs more than the other. Georgia has 5.97 CLCs and 2.77 IBCLCs per live birth while North Carolina has 1.19 CLCs and 5.38 IBCLCs (41).

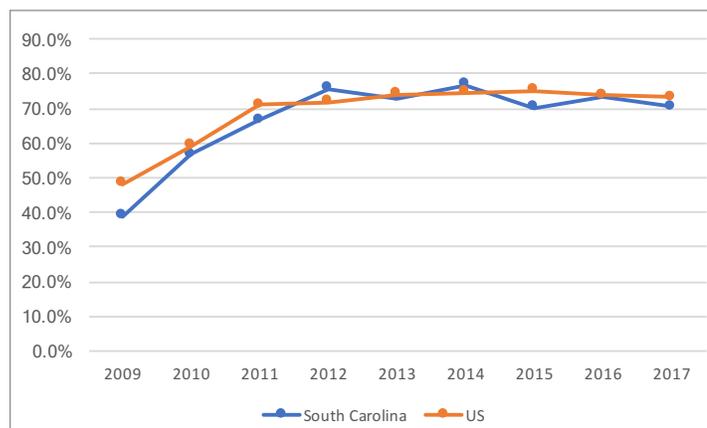
### *Health Care*

In 2017, 3.9 percent of children under age six in South Carolina had no health insurance, which is lower than the national average (4.5 percent), and a general improvement overall (13 percent in 2011). Georgia had the highest percentage of children under 6 without health insurance at 6.2 percent and North Carolina had the lowest at 3.6 percent (42).

Medicaid and CHIP (Children’s Health Insurance Program) are federally funded programs that states administer to insure low income and vulnerable populations, such as children, to improve their access to medical care.

South Carolina (59.28 percent), Georgia (64.01 percent), and North Carolina (66.19 percent) were all well above the national average of 43.22 percent for of Medicaid enrollees who are children (43).

*Immunizations.* By the time a child is 2-years-old, the Center for Disease Control and Prevention (CDC) recommends that they have received vaccines for fourteen diseases, including polio, chicken pox, whooping cough, hepatitis A and B, and measles. In 2017, 29.5 percent of 2-year-olds in South Carolina were not fully immunized, compared to 26.8 percent nationally (44, 45). South Carolina’s rate of nonimmunized children falls between Georgia at 30.9 percent and North Carolina at 26.4 percent. South Carolina has seen a significant decrease in the percentage of fully vaccinated 2-year-olds, as 2014 had the highest percentage at 76.9 percent. South Carolina’s slight decrease in vaccination rate mirrors a national trend but was still below the national average of 73.2 percent in 2017 (45) (see Figure 7).



**Figure 7.** Percent of 2-year-olds fully immunized, 2009-2017

### *Oral Health*

In 2017, 10.4 percent of South Carolina 1-5 year olds had at least one oral health problem within the past year (compared to 9.6 percent nationally) (see Figure 8). Both North Carolina and Georgia were well below the national average at 8.3 percent and 6.2 percent respectively (46). Furthermore, 5.9 percent of South Carolina children aged 1-5 had teeth in poor or fair condition, compared to

4.0 percent nationally, 2.3 percent in Georgia, and 1.60 percent in North Carolina (46). Overall, South Carolina performs significantly worse in oral health; early treatment of oral health issues is important to children’s long-term health (47) and discussed in greater detail in the Discussion section.

*Obesity and Activity*

In 2014, 12 percent of South Carolina children aged two to four enrolled in the Women, Infant, & Children (WIC) food program were obese which was lower than the national average (14.5 percent), and peer states (Georgia 13 percent, North Carolina 15 percent). Children enrolled in WIC may be more likely to be obese due to economic and environmental influences. While this data is not necessarily generalizable because it captures a specific population, it is a useful proxy for tracking the trend of under 5 obesity, as there are barriers to collecting reliable surveillance data for the under 5 population in terms of obesity.

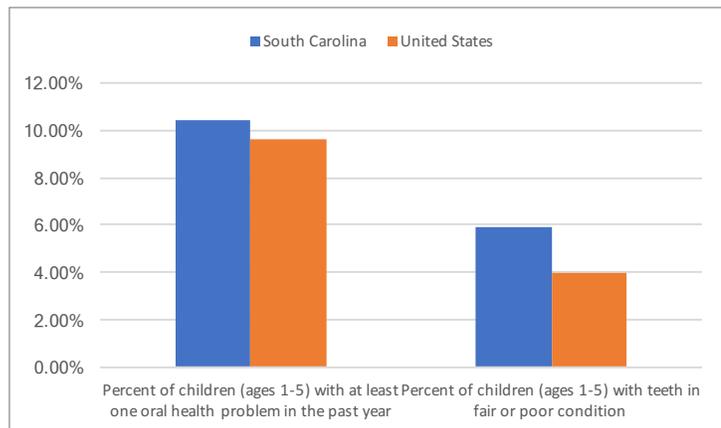


Figure 8. Oral health issues, 2017 (46, 47)

Physical activity data is limited, but several proxies for factors that influence physical activity exist. In South Carolina, 23.2 percent of children ages 0-5 lived in a neighborhood with “detracting elements” which can pose a barrier to safe outdoor play, such as litter or garbage on the street or sidewalk, poorly kept or rundown housing, or vandalism such as broken windows and graffiti (national average 26.9 percent) (48). While below the national average, South Carolina had a significantly higher percentage than Georgia (18.7 percent) and nearly double North Carolina’s percentage of 8.8 percent (48). Furthermore, 24.1 percent of South Carolina children ages 0-5 live in neighborhoods without physical activity amenities such as recreation centers or parks, well above the national average of 9.4 percent, further limiting their opportunities to be active. North Carolina and Georgia boasted similar percentages at 22.5 percent and 19.5 percent respectively (49).

In South Carolina, 5.9 percent of children aged 1-5 were engaged in more than four hours of screen time per day (national average 4.9 percent) (50). North Carolina had the lowest overall percentage at 3.1 percent and Georgia was above South Carolina and the national average at 6.2 percent (50).

**(emotional well-being)**

*Maternal Depression*

In 2010, 12.8 percent of all South Carolina mothers experienced postpartum depression (51). In 2015, the rate in reported postpartum depression was notably lower, with a cumulative percentage of 7.9 percent of mothers reported experiencing postpartum depression always or often (52). North Carolina mothers experienced a similar level of depression, always or often, at 8 percent (53). The national average of mother reporting postpartum depressive symptoms was 12.8 percent. Reliable comparison data for maternal depression not found for Georgia. It is not clear at this time whether the PRAMS reported methodology and sampling deficiency between these time points is a reason for this decrease.

### *Abuse and Neglect*

Data from 2016 reveals that 17,331 (15.8 per 1,000) South Carolina, 21,635 (8.6 per 1,000) Georgia, and 7,134 (3.1 per 1,000) North Carolina children have experienced some form of maltreatment (54). Compared to the national (United States) number of 671,622 (9.1 per 1,000) children (54), South Carolina's children are suffering maltreatment at a higher rate than our nation's children, while Georgia's children are close to the national rate, and North Carolina's children are experiencing maltreatment at less than the national rate.

Of the children who are experiencing maltreatment, a large percentage of those children are aged 5 and under, and an even higher proportion of children are 10 and under. Five and under rates alone for each state and the nation are South Carolina 39 percent, Georgia 37 percent, North Carolina 35 percent, and United States 41 percent. With the addition of the 5-10 year old population to the 5 and under population, the percentages of maltreatment victims for children 10 and under are South Carolina 74 percent, Georgia 72 percent, North Carolina 70 percent, and the United States 74 percent (54).

Children who are in foster care are also likely to be aged 6 and under. In South Carolina, 1,531 (39 percent) of the children served by foster care are aged 6 and under, compared to Georgia 5,316 (43 percent), North Carolina 4,219 (41 percent), and the United States 178,822 (41 percent) (55).

## **(cognitive development)**

### *Developmental Delays*

In 2017, 12.6 percent of South Carolina children under the age of five had been diagnosed with at least one functional difficulty, compared to 9.2 percent of Georgia's, 16.1 percent of North Carolina's and 11.8 percent of the United States' children (56). Functional difficulties were defined in the data source (The Child & Adolescent Health Measurement Child and Adolescent Health Measurement Initiative (56)) to include difficulty with one or more of the following areas: breathing or other respiratory problems; eating or swallowing; digesting food; repeated or chronic physical pain, including headaches; using hands, age 0-5 years; coordinating or moving around, age 0-5 years; concentrating, remembering, or making decisions, age 6-17 years; walking or climbing stairs, age 6-17 years; hearing problems; or vision problems.

Children who receive Medicaid benefits are eligible for developmental screenings through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. In 2017, of the total number of children aged between 0-9 years who were eligible for EPSDT (414,444), 9.3 percent of those children were less than one year of age, 21.1 percent were between the ages of 1-2 years, 30.1 percent were between 3-5 years, and 39.5 percent were between 6-9 years of age (57). In 2017, 92 percent under one year of age, 73 percent aged 1-2 years, 54 percent aged 3-5 years, and 68 percent of South Carolina's eligible children received at least one EPSDT screening. These numbers are comparable across states and nationally, as is demonstrated in Table 3.

### *Child Care*

The most up-to-date data from 2018 reveals that there were 335,723 working mothers in South Carolina, and of that number, 120,033 were single (58). Of those numbers, 85,810 were working mothers with children under the age of 6; the total number of reported children under the age of 6 who potentially need care is 226,195 (58).

North Carolina and Georgia, both larger states than South Carolina (in both population and area), are more similar to each other in numbers on these indicators. Data from 2018 reveals that there were 767,112 Georgia and 774,100 North Carolina working mothers. Of those numbers, 256,161 Georgia and 235,918 North Carolina were single (58). 181,673 Georgia and 182,424 North Carolina were working mothers with children under the age of 6; in total, the numbers of reported children under the age of 6 who potentially need care is 501,117 Georgians and 461,457 North Carolinians (58).

As of January 2019, there were 2,491 child care facilities that were licensed or registered in South Carolina (59). This facility count included religiously-affiliated, private, public, and home-based centers. The average annual cost for center-based care for infants was \$6,840, which is estimated to be 32 percent of the median family income for a single parent who is required to cover full-time care for an infant in a child care center, and 22 percent for home-based care (60).

The 6,860 reported child care workers in centers in South Carolina are paid an average annual income of \$20,370 (58). Childcare workers were paid slightly higher in Georgia and North Carolina at \$22,380 and \$22,080, respectively (61, 62). Compared to the average United States child care worker, who makes \$22,290, Georgia is actually about \$100 above the national average (58, 61, 62).

The number of institutions providing courses for early childhood credentialing varies widely by state: South Carolina 16, Georgia 56, and North Carolina 112 (63-65).

#### *Head Start and Early Head Start*

Eligibility for federally-funded Head Start (HS) program is largely based on income, with families at or below 100 percent of the federal poverty level (FPL) qualifying. Children under age 3 and expecting mothers may be eligible for Early Head Start (EHS), a program which provides center-based programs for low-income families tailored to the needs of infants and toddlers (66).

Over the 2014-2015 enrollment year, 13,390 South Carolina children under age 4 were included in Head Start or Early Head Start. This number does not include pregnant women, who can receive services including home visiting, during their prenatal period. In Georgia, almost 25,000 children were served in this age range, and nearly 22,000 were served in North Carolina. Nationally, enrollment in these programs reached 916,612 children under age 4 (67).

Head Start has a focus on serving children from low-income families or with other qualifying risk factors. In South Carolina, 82 percent of children enrolled in HS/EHS come from a single parent family; this is higher than the rates in Georgia (76 percent), North Carolina (63 percent), and the national average (58 percent) (67). Sixty-one percent of children served in South Carolina have at least one parent who is employed, similar to the rates in Georgia and North Carolina though below the national average (65 percent) (67). Head Start also tracks the number of children enrolled in the program who have been diagnosed with a disability, specifically those who have an Individualized Education Program or Individualized Family Service Plan – two specific documents that are developed for children receiving special education or early intervention services under the federal Individuals with Disabilities Education Act (68). In South Carolina, just 8 percent of enrollees already have an IEP/IFSP, compared to 9 percent in Georgia, 11 percent in North Carolina, and 12 percent nationally (67). Head Start also aims to focus on the needs of families and children outside of the classroom – 67 percent of enrolled families in South Carolina and in Georgia access at least one family service through the program, compared to 70 percent in North Carolina and 72 percent nationally. These services can include parent education, housing and income assistance, and connections to physical and mental health care.

More than three-quarters of participants in South Carolina – 78 percent – identify as black/African American, compared to 68 percent in Georgia and 46 percent in North Carolina. Nationally, this figure is just 29 percent. On the other hand, the rate of Hispanic student enrollment is lower in the region than the national average – just 10 percent of South Carolina’s participating children identify as Hispanic, compared to 17 percent in Georgia, 29 percent in North Carolina, and 38 percent nationwide (67). See Figure 9 for a graphic of South Carolina versus the United States Head Start demographics.

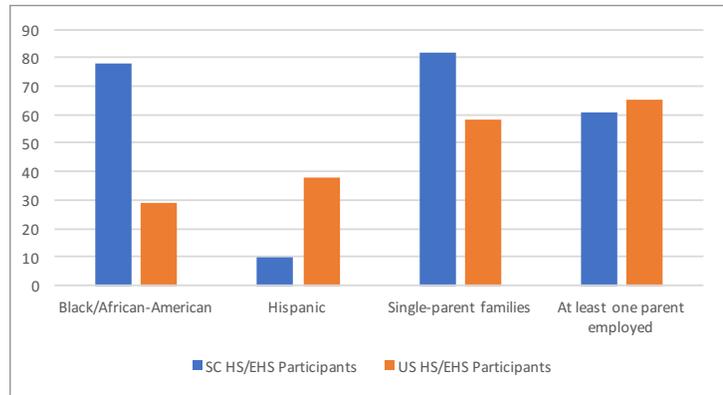


Figure 9. Demographics of families enrolled in Head Start in South Carolina, 2014-2015

### Enrollment in Pre-Kindergarten/ 4K Programs

When asked if their 3- and 4-year-old children were enrolled in school (as the parent defines it), 53 percent of South Carolina families reported their preschooler was not enrolled (69). In Georgia, 51 percent of parents reported their preschool-aged child was not enrolled, similar to the 52 percent of parents reporting this nationally (69). North Carolina had higher rates of non-enrollment at 57 percent (69).

The rates of 3- and 4-year olds not being enrolled in school also differed based on racial and ethnic background of the family (see Figure 10)(70). In South Carolina, 62 percent of Hispanic families reported their preschooler was not enrolled in school, compared to 53 percent of children in non-Hispanic white families and 51 percent in Black/African-American families (70).

In the 2016-2017 school year, 24,079 South Carolina children were enrolled in publicly funded 4K (71). The National Institute for Early Education Research estimated that 41 percent of all South Carolina 4-year-olds were enrolled in publicly-funded 4K in the 2016-2017 school year (71). Sixty percent of Georgia’s, 22 percent of North Carolina’s, and 33 of the nation’s 4-year-olds were enrolled in publicly-funded 4K in the same school year (71).

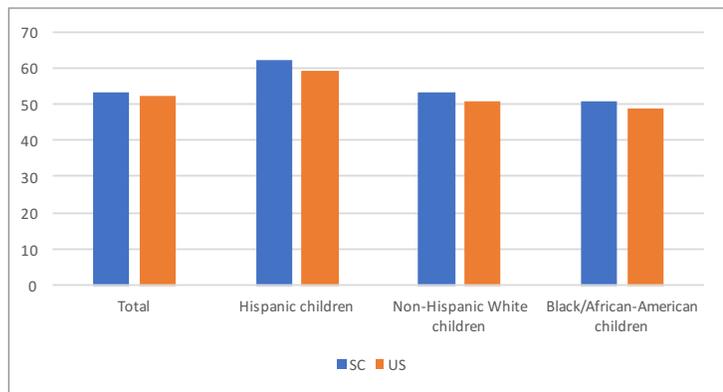


Figure 10. Percent of 3 to 4 year olds not enrolled in school (2012-2016 average) (69).

As of 2017, the South Carolina spends \$2,970 per child enrolled in 4K (71). By comparison per child spending is \$4,315 in Georgia, \$5,308 in North Carolina, and the United States on average spends \$5,008 per child enrolled in publicly-funded Pre-K (71). One hundred percent of all districts for South Carolina, Georgia, and North Carolina reported offering state-funded 4K (71). South Carolina spends less than Georgia (\$348,959,814) and North Carolina (\$143,419,198), in total on state Pre-K (4K): \$71,513,051 (71).

## **(discussion and policy implications)**

### **Family Environment**

Experiencing extended periods of poverty in childhood significantly decreases a child's likelihood of economic and social mobility, facilitating a multi-generational cycle of poverty from which it is difficult to escape. Families experiencing extended poverty or economic insecurity often experience other forms of instability, like hunger or inadequate nutrition, housing instability or insufficiency, or parental unemployment. Parental education levels are associated with parental involvement in education, academic expectations, academic achievement, and adult employment stability. Additionally, due to the increased earning potential associated with higher educational attainment, parental education levels are associated with children's socio-economic status in early childhood (72). Family structure impacts the economic well-being of children as well as parental access to resources. Children of unmarried mothers are more likely to live in poverty than children of married mothers and face a higher risk of adverse birth outcomes (73). These conditions can hinder young children's development and family functioning.

The building blocks of early language development are related to poverty and family environment. Young children develop language skills beginning at birth, building their knowledge from ongoing visual, vocal, and verbal exchanges between a very young child and his or her primary caregivers (74). These interactions are critical developmental building blocks that inform children's brains on how language works (75). When adults engage young children in rich conversations, children develop larger vocabularies, learn to read more easily, and develop emotionally (74). Quality of language interactions matter, with value coming from rich conversations between adults and children other than just giving commands and naming objects (76).

Children whose families have incomes below the poverty line face many challenges to well-being and academic success, including parental unemployment (77), housing instability or insufficiency (77, 78), hunger, inadequate nutrition, or "food insecurity," (79) and toxic stress (80). Children in families at or below 50 percent of the federal poverty level, children living in chronic poverty, and very young children living in poverty are particularly vulnerable. As the gap between median income and the cost of necessities has increased, family income has become nearly as strong a predictor of children's achievement as parents' education levels (81, 82).

This report does not paint a definitive picture of non-parent-caregiving, however, it is a step towards understanding the prevalence of families beyond the nuclear model. Families headed by someone other than a parent may face a range of challenges across early childhood systems related to accessing services, medical care provision, and housing and may be impacted differently by early childhood policies.

### *Social Determinants of Health*

Poverty is not the only environmental factor which impacts the experiences of children and families. “Social determinants of health” (SDOH) are defined by the World Health Organization as “factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family [which] all have considerable impacts on health, whereas the more commonly considered factors such as access and use of healthcare services often have less of an impact.” (18) SDOH are commonly categorized into several domains:

- Economic stability,
- Education,
- Social and community context,
- Health and health care, and
- Neighborhood and built environment.

Each of these determinants has an impact on child and family well-being, and often have a complicated interplay amongst themselves. Thus, it is important to consider the systems-level and environmental factors, positive and negative, which shape family outcomes and not only individual behaviors.

### *Adverse Childhood Experiences*

This report has focused largely on indicators of child well-being, measured during childhood. Another metric of exposure to risk factors is one’s “ACEs score.” An ACE – or Adverse Childhood Experience – is one of a number of risk factors or exposures which children may have that are linked to startling adult impacts on health and wellness – these include parental divorce, household substance abuse or mental illness, and incarceration, among others (83). Recent data indicate that 38 percent of South Carolina’s current adult population had exposure to more than two ACEs in their childhood. These data reflect the situation of adults – but serve as an important reminder now of the need for two-generation policies to help prevent ACEs exposure for today’s children as well as help adults build their capacity to address their own exposure (84). Research from the Children and Adolescent Health Measurement Initiative (CAHMI) reports that about a quarter of South Carolina’s current children have been exposed to two or more ACEs (85).

### *Poverty*

As highlighted in the results section, 23 percent of children under 18 live in poverty in South Carolina. Families with wages above the poverty level still face significant challenges; more than half of children under age 5 are considered low-income (living below double the poverty level). The poverty level is a standard set at the national level; local economic conditions, including cost of living, must be considered in gauging family economic well-being. While South Carolina has seen some progress in poverty rates due to improvements in economic conditions, wages have largely stagnated while the cost of living continues to rise. Without economic and social supports, housing and child-care costs alone could consume nearly all the earnings of a low-income family with two children (86).

Experiencing poverty in childhood has long been associated with many of the health, education, and development indicators discussed in this report, including wellness, birth outcomes, infant mortality, developmental delays, and maltreatment.

In the table of indicators, we reported a number of indicators highlighting family engagement, including frequency of reading with children and eating dinner as a family. Young children develop best through “serve and return” interactions which include focused time from a reliable caregiver (87). While these indicators begin to capture measurements of engagement, they certainly do not show the whole picture as families can engage meaningfully in a number of ways that suit their lifestyle, culture, and parenting styles. In 2017, South Carolina introduced the Palmetto Basics campaign, built from previous work in Boston. The Basics are “five fun, simple, and powerful ways to help all our children become the happiest and most successful they can be,” with a particular focus on children ages 0 to 3:

1. Maximize Love, Manage Stress
2. Talk, Sing, and Point
3. Count, Group, and Compare
4. Explore Through Movement and Play
5. Read and Discuss Stories

While these specific tasks are not the focus of data in this section, they provide a simple and wonderful framework to understand the everyday interactions that fuel a young child’s healthy development.

## **(physical health)**

Many indicators of young children’s health are linked to the health of their biological mothers before, during, and after pregnancy. Research shows that women who have access to appropriate health care have healthier pregnancies and babies. There is a link not only between prenatal care and fetal health but also to the mother’s pre-conception health. More and better health care pre-pregnancy may prevent risk factors during pregnancy, including maternal smoking or limited prenatal care. Shifting public policy from an exclusive focus on the period of pregnancy to a woman’s health status and health care access before a pregnancy occurs can help reduce low weight and preterm births (88).

The health and well-being of children is shaped not only by their direct experiences but by the families, homes, and communities in which they live. This report highlights data related to both child maltreatment and to domestic violence experienced by mothers during pregnancy. Children are also negatively impacted by witnessing violence within their families even when they are not the direct target. South Carolina has been within the top ten domestic violence states for over a decade (28). Experiencing domestic violence in childhood is one of the ten types of ACEs and is highly correlated with children’s learning difficulties, attention and memory problems due to chronic stress, school performance challenges, and long-term chronic health conditions (89). Continued efforts to reduce the prevalence of domestic violence in South Carolina will improve outcomes for children and for their families.

Since the previous edition of this report in 2014, the national health insurance landscape has changed significantly through the introduction of the Affordable Care Act. The ACA is credited with reducing child uninsured rates though families still report challenges in securing affordable care through employers and marketplace plans (90, 91). Policymakers should continue to work to ensure access across all demographics and geographies. Expanded access to insurance may have impacts on child health outcomes as a result of more reliable care, though this analysis does not attempt to quantify such relationships.

*Prenatal Care.* Women who receive prenatal care earlier in pregnancy are more likely to give birth to healthier infants (92). High-quality prenatal care provides education about health choices during pregnancy, such as dietary choices and physical activity recommendations, and opportunities to uncover fetal abnormalities and health problems that should be addressed as early as possible. Prenatal care is also crucial in managing pre-existing conditions, such as high blood pressure and diabetes, which can negatively impact pregnancy. As such, women who receive prenatal care are less likely to give birth to an infant weighing less than 5 pounds, 8 ounces (considered “low birthweight”), give birth to an infant who dies within the first year, smoke postpartum, more likely to attend well-baby visits, and more likely to breastfeed (93-96). Prenatal care appointments pose a significant benefit to society due to their large return on investment.

*Substance abuse.* Substance use during pregnancy is the largest preventable cause of cognitive and physical developmental delays and negative birth outcomes. The effects of substance use are most significant in the first trimester when the fetus is most vulnerable, with risk decreasing over time across trimesters (97). Alcohol use during pregnancy is linked to Fetal Alcohol Syndrome, an irreversible set of defects including physical deformities, mental developmental delays, learning disorders, vision difficulties, and behavioral problems. Smoking during pregnancy increases the likelihood of premature births, low weight at birth, infant death within the first year, and developmental problems (98-101).

The first trimester of pregnancy carries the highest risk of detrimental effects on fetal development from alcohol consumption, but no data is currently being collected in South Carolina concerning alcohol use during this time.

*Domestic abuse during pregnancy.* Domestic abuse during pregnancy is a risk factor for several adverse birth outcomes, including significantly greater odds of a preterm birth or low birthweight (102, 103). Other risks include miscarriage, placental abruption, and infant death. Women who are abused during pregnancy suffer mental and emotional stress, leading to increased use of substances in the form of smoking or alcohol abuse, and are more likely to suffer from postpartum depression, and attempt suicide (102).

#### *Low Birth Weight*

Low birth weight has two main causes – premature births which do not allow the infant time to grow sufficiently prior to birth and fetal growth restriction which cause a fetus to gain insufficient weight during pregnancy (104). Fetal growth restriction is defined as a fetal weight below the 10th percentile for gestational age, can be caused by maternal health conditions during pregnancy including diabetes and high blood pressure, placental problems, substance use during pregnancy, and infections. Fetal growth restriction can be classified as symmetric, when all internal organs are reduced in size, and asymmetric, signified a normal sized head and brained but small abdomen.

Infants born at a low birth weight have a greater risk of suffering from a variety of health problems, including respiratory difficulties, heart problems, gastrointestinal disorders, vision problems, and bleeding in the brain that will sometimes cause long-term damage including cognitive and motor development disability. As adults, these individuals are more likely to have heart problems, high blood pressure, and diabetes than individuals born at a normal birth weight (104).

#### *Infant and Child Mortality*

In the Results section, we reported on the rates of infant mortality, defined as children who die before reaching the age of 1. In Table 2, we highlight the top 10 causes of death for children and adolescents in the United State. These data cover all children and adolescents nationwide. These causes of death include unintentional injuries as well as homicides and suicides – all of which demand attention but may require different strategies to address. The factors contributing to these deaths vary significantly among age groups of children and adolescents. Our goal in sharing this information is not to make specific policy prescriptions for prevention but rather to call attention to the very real impacts of injury and illness on America’s children. Improving indicators discussed in this report can help reduce the rates of some child deaths but we must also have national, state, and local communities, informed by good data, to address the causes of death in our communities.

**Table 2: The 10 Leading Causes of Child and Adolescent Death in the United States in 2016, in Order of Frequency**

Cause of Death	No. of Deaths	Percent of Deaths
All Causes	20,360	
All injury-related causes <sup>a</sup>	12,336	60.6
Motor vehicle crash	4,074	20
Firearm-related injury	3,143	15.4
Homicide	1,865	
Suicide	1,102	
Unintentional	126	
Undetermined intent	50	
Malignant Neoplasm	1,853	9.1
Suffocation <sup>b</sup>	1,430	7
Suicide	1,110	
Unintentional	235	
Drowning	995	4.9
Drug overdose or poisoning	982	4.8
Suicide	123	
Unintentional	761	
Congenital anomalies	979	4.8
Heart disease	599	2.9
Fire or burns	340	1.7
Unintentional	272	
Chronic lower respiratory disease	274	1.3

Note. Adapted from “The Major Causes of Death in Children and Adolescents in the United States,” by R. M. Cunningham, M. A. Walton, and P.M. Carter, 2018, *The New England Journal of Medicine*, p. 2469 Copyright 2018 Massachusetts Medical Society (105). For more information about the table that is not provided below, please see the original article.

<sup>a</sup>The data in this table, from the original source, were drawn from CDC WONDER data (37, 105).

<sup>b</sup>The table elaborates upon the injury-related deaths, which add up to 53.8 percent of the stated 60 percent of injury-related child deaths. In this table, these injuries include motor vehicle crash, firearm-related, suffocation, drowning, drug overdose or poisoning, and fire or burns. Percentages on this table do not add up to 100 as this table only captures the top 10 causes of death.

### *Breastfeeding*

Given the well-documented dose-response benefits of breastfeeding, it is notable that the number of South Carolina mothers breastfeeding declines over time in the first year of an infant's life. The American Academy of Pediatrics, the World Health Organization, and the Institute of Medicine all recommend exclusive (non-formula supplemented) breastfeeding to six months of age and continued breastfeeding to 1 year of age or longer if mutually desired by both the mother and infant.

Breastfeeding for any length of time has been shown to improve infants' immune responses, decrease the number of gastrointestinal infections in infants by 64 percent, and decrease the rate of Sudden Infant Death Syndrome (SIDS) by 45 percent (106). Breastfeeding has a dose response effect, with the benefits increasing with duration. Children breastfed longer than three months have a reduction in ear infections, asthma, eczema, type 1 diabetes, hospitalizations for lower respiratory tract infections in the first year, and type 2 diabetes as adults. For children breastfed exclusively for longer than six months, there is a reduction in pneumonia, serious colds, throat infections, childhood leukemia, celiac disease, and adult obesity. For preterm infants, breastfeeding is essential to the development of their immune systems and allows them to adapt to full feedings quicker. Preterm infants who are exclusively breastfed have fewer hospital readmissions for three years.

Breastfeeding is mutually beneficial, promoting maternal health as well as infant health. For mothers, exclusively breastfeeding to six months reduces their likelihood of postpartum depression, hypertension, heart disease, diabetes, breast cancer, and ovarian cancer, and increases the likelihood that they will space their children appropriately and return to their pre-pregnancy weight more quickly (107, 108).

Lactation consultants are seen as an increasingly important resource in promoting breastfeeding. Lactation consultants have been shown to improve breastfeeding initiation and intensity (109).

### *Immunizations*

By the time a child is 2 years old, the Center for Disease Control and Prevention (CDC) recommends vaccines for fourteen disabling, often deadly, vaccine-preventable diseases, including polio, chicken pox, whooping cough, Hepatitis A and B, and measles. By following the recommended vaccination schedule, children are well-protected from these diseases before coming into contact with them. Additionally, a well-vaccinated population provides "herd immunity" for individuals who cannot be immunized for a variety of reasons, including allergies to ingredients of the vaccine and children that are immunocompromised due to diseases such as cancer.

Resistance to vaccines is a product of two factors: herd immunity reducing the prevalence and severity of diseases, leading people to think vaccines are not necessary and the "anti-vaccination movement (110)." Vaccine refusal has been associated with an increased risk of measles and pertussis for both vaccinated and unvaccinated populations (45, 111). Overall, the decrease in vaccination rate and increase in vaccine refusal are trends which threaten not only the health of individual children but herd immunity as a whole, increasing the recurrence of previously eradicated diseases (45).

For the majority of children, vaccines are a safe and effective choice to bolster their immune system. Unless a child is allergic to components of the vaccine or has a weakened immune system due to illness, vaccines pose no risk to health other than slight tenderness at the injection site. There has been no significant evidence of a link between vaccines and developmental delays with several studies disconfirming an association between vaccines and autism.

### *Access to Medical Care*

Access to medical care is unsurprisingly linked to better health outcomes. Two significant barriers to accessing medical care are a lack of health insurance and difficulty accessing primary care. Children without health insurance are less likely to have a consistent source of care, which can lead to missed immunization and developmental screenings. Furthermore, children without insurance are more likely to suffer from serious illnesses, suffer complications from asthma, and have more hospitalizations when compared to their counterparts with insurance. These conditions are exacerbated because they are often only treated when it is an emergency, rather than consistently managed. For children with special health needs, an absence of insurance often means they are unable to see specialists who can provide care for their unique needs (112).

Medicaid and the Children's Health Insurance Program (CHIP) are federally funded programs that states administer to insure low income and vulnerable populations, such as children, to improve their access to medical care. Under the Affordable Care Act, states could choose to expand Medicaid, to cover more low-income populations (113). None of the states observed in this report expanded Medicaid.

Referring back to the numbers seen in the results (also Table 3), while a high percentage of child coverage is good, too high of a number may indicate that the parents of these same children enrolled in Medicaid are not insured. As a result, they may be less likely to take their children to primary care, because they may be unfamiliar with the system. Uninsured parents are also less likely to be healthy and have positive health outcomes, which is likely to impact their children who rely on them.

### *Oral Health*

The dearth of updated oral health data found in this data review is unfortunate. The good news is that a public comment period is currently open as the Surgeon General has commissioned a 2020 Report on Oral Health (114), suggesting that more accurate and comprehensive information will be available in the future. Oral health is one of the most important and commonly overlooked determinants of physical health. Oral diseases are the most common form of pediatric disease and the least treated (115). Poor oral health is problematic in the both the short-term, because of the pain associated with oral diseases, and in the long-term, impeding physical, emotional, and cognitive development. Children with untreated tooth decay have worse overall health and academic achievement. Untreated oral disease can increase absence from school, speech difficulties, struggles with self-esteem, and difficulty sleeping (116). Children with untreated dental pain are also four times more likely to have a low grade point average and 3 times more likely to miss school (117). Overall, children with chronic dental pain report a lower quality of life. As these children become adults, periodontal disease is associated with heart disease, stroke, increased mortality, and premature and low birth weight births (118).

### *Obesity and Physical Activity*

Obesity is the product of several factors including environment, behavior, diet, and stress (119). Childhood obesity is a serious problem due to the short- and long-term health risks it poses. Similar to oral disease, obesity has implication beyond just physical health, as it impacts cognitive, emotional and social well-being. Short term physical risks of childhood obesity include increased risk for high cholesterol, high blood pressure, prediabetes, sleep apnea, bone and joint problems, metabolic syndrome, and asthma. Cumulatively these factors result in a lower reported quality of life in obese children and lower academic performance. Obese children were four times more likely to report

academic struggles and more likely to miss school than children deemed healthy weight (120). In the long term, obese children are likely to become obese adults, putting them at risk for heart disease, diabetes, multiple kinds of cancer, and premature death (121).

Physical activity levels are a significant determinant of obesity, as activity helps maintain a caloric deficit which is crucial for maintaining a healthy weight. Aside from obesity, physical activity is an important component of healthy growth and development in children, helping strengthen joints and bones and improving motor skills (122). Physical activity is also highly correlated with increased cognitive function, due to promoting angiogenesis (creation of new blood vessels) which in turn results in neurogenesis (creation of new nerve pathways) and increased brain plasticity. Cognitively, these factors result in improved academic achievement, executive functioning, and memory (123). These principles have been applied to early childhood development as physical activity has been shown to have a causal relationship in promoting motor and cognitive development, potentially with a dose-response effect (124). During early childhood, children should be active for at least 2 hours spread throughout the day (125). Physical activity also improves cardiorespiratory fitness, which is a strong predictor of mortality in adulthood (126, 127).

Similar to obesity, data that assesses the physical activity levels of preschool aged children is limited. Given the length of time many young children are in center-based care and education programs, activity levels are highly variable depending on the policies of each individual child care or preschool program. Sedentary behavior is the opposite of being physical activity and is a risk factor for obesity. For children, sedentary time is often spent watching television or playing video games. Overall, policies that promote physical activity such as statewide school recess policies should be incorporated to fill the gap in physical activity that children may have.

## **(emotional well-being)**

### *Maternal Depression*

Gains in neuroscience are helping to shed light on why children of depressed mothers are at higher risk for difficulties with school, social adjustment, and mental health than children of non-depressed mothers. Lasting effects of experiencing maternal depression in early childhood are the result of changes in brain architecture and stress response systems, with children of depressed mothers producing higher and more volatile levels of cortisol and other stress chemicals (128, 129). Studies have shown postpartum depression, an episode of major depression occurring within the first year after giving birth, to be associated with higher cortisol levels in children at age 3.

One recent report from the Brookings Institution indicates that maternal depression could be an economic mobility issue, as it can serve as a barrier to upward mobility due to lack of connection, energy, and other symptoms of depression (130). The researchers go on to describe the cyclical nature of a mother's depression affecting the bond between her and her child, which leads to poor performance in school and cognitive functioning, resulting over time in a depressed child who then not only struggles with getting out of poverty, but likely repeats the cycle with his/her own child (130).

While all families can be impacted by postpartum or maternal depression, research has found it is more prevalent among certain populations. One in two low-income mothers with young children may experience depression, presumably due to the additional stress caused by concern over meeting basic family needs (131). The American Committee for Obstetrics and Gynecology (ACOG)

recommends screening for depression at least once during the perinatal period, from pregnancy through the 12 months following delivery (132).

### *Abuse and Neglect*

Child neglect and abuse have immediate negative consequences for children in terms of psychological and physical impacts, with these outcomes often reinforcing each other (133). For example, physical consequences, such as damage to a child's brain during this sensitive period of growth, can be linked to cognitive delays or emotional difficulties. These negative experiences early in life also have long-term negative consequences, including links to high-risk behaviors later in life such as smoking, alcohol abuse, or drug use (134, 135). Exposure to ACEs, which include exposure to violence during childhood, is linked to chronic illness as an adult (136, 137).

Child neglect cases, rather than child abuse, account for about three-quarters of all substantiated cases involving child protective services nationwide. Neglect refers to children not receiving their basic needs of food, shelter, care, and adequate supervision (84). Given that 39 percent of South Carolina's children in foster care were under the age of 6, families can benefit from prevention services to avoid placement in the foster care system and ongoing support for both birth and foster families as they navigate these challenges, which is also something that has been highlighted in the South Carolina Early Childhood Common Agenda, supported by the United Way Association of South Carolina, Save the Children Action Network, the Children's Trust of South Carolina, and the Institute for Child Success (55, 138).

## **(cognitive development)**

### *Developmental Delays*

Developmental delay is defined broadly by the federal IDEA Part C program as a delay in one or more of the following five areas of early childhood growth and development relative to age-expected milestones: physical development including vision and hearing, cognitive development, communication, social or emotional development, and adaptive development. Because each developmental stage builds on prior development, it is critical that delays and difficulties are identified early, and proper interventions started.

Early identification of children with disabilities and delays who are eligible to receive special education services can reduce the intensity of duration of individual special education services (139-141); this early identification is increased by the greater availability of quality early childhood education programs and is thus beneficial for student, family, and taxpayers.

### *Child Care*

The availability, access to, and high cost of quality child care is an issue that affects American families of all socioeconomic groups; however, minority groups and families from lower socio-economic groups are disproportionately affected. As the results indicate above, the cost of child care is a large portion of any family's income, but particularly the single, working parent who needs full-time care. The median income of approximately \$23,000 for African American and Hispanic mothers severely limits choices for work and child care on the basis of cost alone (60). Improving access to quality child care is a complex question demanding national attention as well as solutions here in South Carolina. Provided here is an outline of how quality is currently measured in South Carolina, as well

as information on several programs in South Carolina which seek to ameliorate the child care access issue at the time of the writing of this report.

*Quality.* High quality child care is associated with improved school performance, academic attainment, higher cognitive test scores, fewer behavioral problems, and long-term well-being (142-145). It is difficult to quantify “quality” in early care and education settings and, to some degree, may be subject to the perceptions of administrators, teachers, and parents. Little universal data exists concerning the quality of care received in South Carolina child care centers. Since the research is clear that the benefits of early child care accrue only in high-quality settings, it is essential for South Carolina decision makers to have information about the quality of child care providers, instead of simply knowing the number of children who received out of home care.

The National Association for the Education of Young Children (NAEYC) and the National Institute for Early Education Research (NIEER) each provide their own set of research-backed indicators of quality in child care and preschool settings.<sup>1</sup> Though these criteria differ in their exact definitions, there is a focus on well-qualified staff; curriculum and alignment to early learning standards; family engagement and support services; appropriate use of continuous quality improvement strategies; and support for teachers, including appropriate class sizes and professional development (146, 147).

The ABC Child Care Program, administered by the Department of Social Services, provides the only statewide measure of quality child care. However, this program is an optional, voluntary quality improvement system for child care providers (148). The ABC system also includes a Child Care Program that ranks the quality of facilities and has a quality improvement component. Programs are rated on an A-B-C ranking based on evaluation and assessment criteria, and receive regular on-site reviews to measure performance on the program standards at that level (149). Programs that receive a B or higher rating are recognized as a quality program. As of February 2019, the SC Profile for Early Childhood (150) reports that of the 1,071 center-based and 1,173 home-based participating centers in South Carolina, 49.78 percent have received a “C” status, 45.37 percent a B+ or B, and only 4.85 percent an A+ or A.

*Resources to improve access.* South Carolina Child Care Resource and Referral (CCR&R), now administered by the Department of Social Services and the University of South Carolina, increases access to quality child care for families, improves knowledge of early childhood professionals, and facilitates community collaboration in support of children and families (151). Through this referral network, CCR&R is available to connect families searching for child care with facilities providing quality care.

The South Carolina Department of Social Services (SCDSS) administers the child care subsidy program, known as the SC Voucher Program. This program provides funding for child care for low income families, and has paid for 20,008 children in licensed/approved centers, 73 in licensed/registered homes, and 795 in legally exempt programs, as of February 4, 2019 (152). In order to be eligible for SC Vouchers, the first requirement is that parent income must be below 150 percent of the federal poverty level, based on family size; on the SC Voucher website, this annual income is indicated to be \$37,050 annually (153). Priority for child care services are given to parents participating in the TANF program, transitioning off of TANF, and families at risk of becoming

<sup>1</sup> Although there are now many organizations that offer quality standards and credentials for child care centers, we will mention only two of the most well-known and longest-serving programs here. It is difficult, and beyond the scope of the present project, to exhaustively examine and review each credentialing organization

dependent on TANF. Other priority populations include children who are in foster care, Child Protective Services, criminal domestic violence, families experiencing homelessness, wrap-around child care for Head Start recipients and families of children with special needs (154).

Another organization in South Carolina that currently helps families who need pecuniary assistance for child care is South Carolina First Steps to School Readiness (First Steps). Each county is responsible for executing the mission of First Steps; programs and implementation vary by county (155). However, one of the missions of First Steps is to “help parents access quality child care for their young children” (155). Some First Steps county partnerships choose to provide scholarships that support teen parents who are currently enrolled in school, participants in the Nurse Family Partnership program, and parents enrolled in approved workforce programs (156). The number of children currently being served by the South Carolina First Steps Partnership is 30,026 (157).

*Child Care Providers.* As this report’s data indicates, child care teachers make an annual salary that is less than what is a median income to be able to afford full-time child care. Their income level is also less than 150 percent of the federal poverty level (as detailed above). The systems that surround child care are complex, which is often the reason cited for low pay for child care workers; however, the pay and lack of benefits provided for many child care workers in South Carolina, as well as nationally, is deeply problematic. Child care workers provide an integral service for our nation and state’s children and families.

#### *Head Start and Early Head Start*

Head Start continues the work it has done over the last five decades: providing comprehensive health and education services to some of the neediest families in America. Recently, Head Start has experienced a renewed focus on ensuring quality through “recompetition” and ongoing quality monitoring (158). The revised Head Start Performance Standards, released in 2016, provide an opportunity for all those who work for families and children to recommit themselves to the needs of those served (159). Included in these Standards is an increased focus on full-day, full-week operating schedules, influenced heavily by parents’ work schedules and the likelihood of greater academic gains (160, 161). The South provides a model in this area, as the rate of children enrolled in this schedule is significantly higher than the national figure (162). However, no Southern states currently enroll 100 percent of children on this schedule; moving programs consistently towards this goal while seeking to maintain the number of children served will require innovative thinking.

#### *Enrollment in Pre-Kindergarten*

High-quality 4K programs positively impact the academic achievement and social-emotional development of their participating students. While all children certainly benefit from these types of programs, the effects are greatest for children who are considered at-risk for school failure due to factors like low family income, low parental education level, living in a home where English is not the primary language, and special needs considerations (163-166). Children are served in a range of early childhood care and education settings, including private child care centers, Head Start/Early Head Start programs, and public preschool/4K. Participation rates in early childhood vary based on a number of factors including cost, available slots, perception of quality, and location (167).

#### *School Readiness*

Children who begin school academically behind their peers are more likely to struggle academically in later grades as well. In fact, half of the educational achievement gap between poor children and their non-poor peers exists at kindergarten entry. Instead of these children catching up once they

are in school, the gap continues to grow larger, meaning that academic struggles in early grades are associated with higher grade retention and high school dropout rates in later schooling (168). Conversely, children who start ahead typically stay ahead in school and experience more positive school and life outcomes. Many early childhood services exist in South Carolina to ensure children are ready to learn when they begin school, including CDEPP, Head Start/Early Head Start, child care centers, and other community- and home-based interventions.

South Carolina recently began measuring Kindergarten Readiness using a tool called the Kindergarten Readiness Assessment (KRA). The tool was first developed between 2012 and 2015 through a partnership between the states of Ohio and Maryland, supported by a federal Race to the Top grant. The SC Department of Education adopted this tool in 2017, and it has now been deployed twice – in the falls of 2017 and 2018 – and results are now published from the 2017 school year.

The state first began measuring kindergarten readiness in a systemic fashion in the fall of 2015, in response to legislation requiring the schools to do so. The state then chose different assessment tools for each of 2015, 2016, and 2017, limiting the ability to observe trends in the data.

In August of 2018, South Carolina’s Education Oversight Committee (EOC) published the results from the first administration of the KRA from the fall of 2017 (169). It states that the 36 percent of children demonstrate readiness. Regarding the subdomains of readiness, it states that 45 percent demonstrate readiness for “Social Foundations,” 34 percent for “Language and Literacy,” 31 percent for “Mathematics,” and 48 percent for “Physical Development and Well-Being.” Information on school readiness is not provided in Table 3 as each state approaches measurement of this concept differently; it would be difficult to draw meaningful conclusions from cross-state comparisons, particularly as South Carolina has only completed one year of the use of this instrument.

## **Conclusion**

The indicators in this report make it clear that too many young children continue to struggle every day in South Carolina. By providing a snapshot of how young children are faring in the state, we strive to inform statewide efforts to intervene early and effectively in the lives of children. We recognize, however, that this report can only be as informative as the data available for us in the state. To be fully informed about the needs of young children and the outcomes of systemic reforms effecting changes in the lives of these children, we must ensure the availability of reliable, valid, and appropriate data statewide. To this end, the Institute for Child Success recommends continued efforts toward high-quality and timely data collection concerning early childhood well-being.

**Table 3  
State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
Total Population (5)	5,024,369	10,429,379	10,273,419	325,719,178	2017
Children under 18	1,105,362 (22.0% of total pop.)	2,513,481 (24.1% of total pop.)	2,301,246 (22.4% of total pop.)	73,612,535 (22.6% of total pop.)	
Children under 5	291,414 (5.8% of total pop.)	657,051 (6.3% of total pop.)	606,132 (5.9% of total pop.)	19,868,870 (6.1% of total pop.)	
<b>Vulnerable Children</b>					
Experiencing at least 1 risk factor (9) <sup>a</sup>	42%	43%	42%	44%	2016
Experiencing at least 3 risk factors (9)	21%	21%	20%	15%	
<b>Family Income</b>					
Median family income (with children) (170) <sup>a</sup>	\$58,000	\$64,700	\$63,800	\$71,400	2017
Children under age 18 in poverty (100% of federal poverty level) (171)	23%	21%	21%	18%	
Young children in low-income families (children under age 6, 200% of federal poverty level) (9) <sup>a</sup>	185,286 54% of young children	416,062 53% of young children	379,519 53% of young children	9,959,605 43% of young children	2016
<b>Government Assistance</b>					
Average number of families receiving TANF (172) <sup>b</sup>	8,654	11,673	16,189	1,075,183	2017
Average number of children receiving TANF (173) <sup>b</sup>	15,825	12,936	70,392	1,927,726	
Average number of women participating in WIC (174) <sup>c</sup>	24,917	57,414	55,792	1,737,991	
Average number of individuals participating in WIC (174) <sup>c</sup>	99,332	237,224	230,660	7,286,161	2018
Number of children receiving Free/Reduced Lunch (175)	472,193	1,190,227	850,455	22,000,000	
<b>Parental Education (12)</b>					
Less than high school degree <sup>d</sup>	129,000 12%	335,000 13%	305,000 13%	9,989,000 14%	2016
High school or GED	525,000 48%	1,147,000 46%	996,000 43%	32,279,000 44%	
Beyond high school	442,000 40%	1,023,000 41%	989,000 43%	31,163,000 42%	

<sup>a</sup> These data came from the 2012-2016 American Community Survey.

<sup>b</sup> Temporary Aid for Needy Families

<sup>c</sup> Women, Infants, & Children Program

<sup>d</sup> These data came from the 2005-2016 American Community Survey

**Table 3**  
**State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Parental Employment</b>					
Unemployment rate of parents (176) <sup>e</sup>	25,000 3%	58,000 4%	66,000 4%	1,841,000 4%	2017
Children under 6 with no parents in the labor force (177) <sup>f</sup>	32,000 10%	65,000 9%	60,000 9%	1,912,000 8%	
Parents of young children reporting work life impacted by child care issues (178)	12.8%	4.9%	10.4%	8.7%	
<b>Teenage Motherhood</b>					
Teen Pregnancy Rate per 1,000 girls (ages 15-19) (179)	21.7	21.9	20.6	18.8	2017
Percent of births to teen mother who had already given birth at least once (39) <sup>g</sup>	15%	17%	16%	16%	2016
<b>Family Engagement</b>					
Percent of families eating meals together four or more days per week (ages 0-5) (15)	70.6%	79.8%	86.4%	80.5%	2017
Percent of parents who sing songs or tell stories to their children every day (ages 0-5) (180)	40.7%	46.9%	48.3%	47.8%	
Percent of parents who read aloud to children everyday (ages to 0-5) (181)	34.8%	32.3%	41.0%	38.0%	
Percent of parents who read to less than 3 times per week (ages 0-5) (181)	45.3%	55.0%	38.1%	41.8%	
<b>Family Structure</b>					
Children in single parent families (under 18) (17) <sup>h</sup>	417,000 40%	899,000 38%	799,000 37%	24,001,000 34%	2017
Children under 5 living in a single parent household (182)	82,383	180,161	162,402	4,883,722	
Children living with neither parent (under 18) (183) <sup>i</sup>	74,000 7%	138,000 5%	132,000 6%	3,692,000 5%	2016
Grandchildren in the care of their grandparents (under 18) (19) <sup>j</sup>	61,000 6%	116,000 5%	113,000 5%	2,734,000 4%	2017
Children in kinship care (under 18) (184)	64,000 6%	85,000 3%	89,000 4%	2,632,000 4%	2015-2017

<sup>e</sup> These data came from the Population Reference Bureau analysis of Current Population Survey (CPS) Basic Monthly data 2007–2017.

<sup>f</sup> These data came from the Census Bureau, 2008–2017 American Community Survey.

<sup>g</sup> These data came from an analysis of 1990–2016 Natality MicroData files from Centers for Disease Control and Prevention, National Center for Health Statistics.

<sup>h</sup> These Data came from the 2002–2017 American Community Survey (ACS).

<sup>i</sup> These data came from the 2002–2016 American Community Survey.

<sup>j</sup> These data came from the 2005–2017 American Community Survey.

<b>Table 3 State Indicators and Statistics</b>					
<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Prenatal Care</b>					
Mothers receiving late or no prenatal care (185) <sup>k</sup>	4,120	10,175	7,214	236,065	2016
Mothers receiving late or no prenatal care	7%	8%	6%	6%	
Mothers reporting alcohol during last 3 months of pregnancy (22-24)	7.40% In third trimester	n/a	10% In third trimester	8.00% In third trimester	2015
Mothers reporting physical abuse in pregnancy (24, 27)	2.70%	n/a	2.10%	2.10%	
Preterm Birth Rate, all mothers (32-35) <sup>l</sup>	11.20%	11.40%	10.50%	9.90%	2018
Black <sup>m</sup>	14.40%	13.50%	13.60%	13.40%	
White	9.50%	9.50%	9.10%	8.90%	
Hispanic	9.20%	9.20%	8.60%	9.20%	
Percent of low birth weight births (36) <sup>n</sup>	9.60%	9.80%	9.20%	8.20%	2016
Percent of very low birth weight births (186)	1.80%	1.80%	1.60%	1.40%	
<b>Infant and Child Mortality</b>					
Number of live births (187)	57,029	129,243	120,125	3,855,500	2017
Infant Mortality Rate (infant deaths in first year of life per 1,000 live births) (40) <sup>o</sup>	6.5	7.2	7.1	5.8	
Black (188-190)	10	11.1	13.4	11.1	2017 SC  2016 GA, NC, USA
White (188-190)	4.8	5.3	5	4.8	
Hispanic (188-190)	5.1	6.3	6	5.2	
Asian or Pacific Islander (188-190)	Not available	3.6	4.5	3.4	
American Indian/ Alaska Native (188-190)	Not available	Not available	7.6	8	

<sup>k</sup> These data came from the 2007–2016 Population Reference Bureau analysis of Centers for Disease Control and Prevention (CDC).

<sup>l</sup> 2017 rate

<sup>m</sup> These data came from 2014–2016 averages (Black, White, Hispanic).

<sup>n</sup> These data came from the 1990–2016 state-level estimates are from the National Center for Health Statistics (NCHS).

<sup>o</sup> 2016 Data

**Table 3  
State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Breastfeeding</b>					
Percent ever breastfed (41) <sup>p</sup>	76.40%	84.00%	84.90%	83.20%	2017
Percent breastfed beyond one month (at 6 months but not exclusively) (41)	45.10%	55.60%	58.80%	57.60%	
Percent breastfed exclusively for six months (41)	24.40%	22.10%	27.00%	24.90%	
Number of lactation consultants: Certified Lactation Counselors (CLCs) or International Board of Lactation Consultants (IBCLCs) per 1,000 live births (41)	3.87 CLCs 3.32 IBCLCs	5.97 CLCs 2.77 IBCLCs	1.19 CLCs 5.16 IBCLCs	4.57 CLCs 3.79 IBCLCs	2016
Number of designated "Baby Friendly" birthing facilities (191)	14	14	16	538	2018
<b>Health Care</b>					
Number of children without health insurance (42)	61,394	191,483	126,126	4,333,068	2016
Percent of children without health insurance (42)	5.20%	7.80%	5.30%	5.70%	2017
Percent of children under 6 without health insurance (42)	3.90%	6.20%	3.60%	4.50%	
Percent of Children under 6 who have no usual source of health care (primary care provider) (192-194)					2017
Insured	8.90%	Not available	Not available	2.60%	
Private Insurance	Not available	Not available	13.90%	1.90%	
Medicaid	Not available	Not available	20.4% <sup>q</sup>	3.60%	
Uninsured	9.40%	Not available	Not available	22.60%	
Number of children enrolled in Children's Health Insurance Program (CHIP) (43)	87,007	206,684	252,126	6,571,605	2018 (October Numbers)
Number of children enrolled in Medicaid (64)	554,028	1,003,869	1,186,265	28,673,230	
Total children enrolled in CHIP or Medicaid (64)	641,035	1,210,553	1,438,391	35,244,835	
Percent of Medicaid enrollees who are children (64)	59.30%	64.00%	66.20%	43.20%	

<sup>p</sup> CDC National Immunization Survey (NIS) 2016–2017, among 2015 births.

<sup>q</sup> In the NC CHAMPS dataset, this indicator is classified as "Public," which includes Medicaid, Carolina ACCESS, Health Check, or NC Health Choice.

<sup>r</sup> The US data is based upon a 2015–2016 survey, released in 2017 report by CDC. The SC data is based upon a compilation of data from 2012–2017, pulled upon request by Chelsea Richard of SC DHEC, from the South Carolina Children's Health Assessment Survey February 4, 2019. NC Data based upon 2016–2017 CHAMP Survey Results.

**Table 3**  
**State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Health Care (continued)</b>					
Percent of 2-year-olds fully immunized (45)	70.50%	69.10%	73.60%	73.20%	2017
Total number eligible to receive EPSDT services (under 21) (57)	767,838	1,428,926	1,329,341	42,995,500	
Number of children under 6 eligible to receive EPSDT services (57)	250,563	482,467	450,429	13,878,173	
Percent of children (ages 0-5) with special needs receiving care from a medical home (195)	54.40%	53.90%	59.80%	50.90%	
<b>Oral Health</b>					
Percent of children (ages 1-5) with at least one oral health problem in the past year (46) <sup>e</sup>	10.40%	8.30%	6.20%	9.60%	2017
Percent of children (ages 1-5) with teeth in fair or poor condition (47)	5.90%	2.30%	1.60%	4.00%	
<b>Obesity and Activity</b>					
Percent of children (ages 2-4) enrolled in WIC who are obese (196)	12.00%	13.00%	15.00%	14.50%	2014
Percent of children (ages 1-5) engaged in four or more hours of screen time per day (50)	5.90%	6.20%	3.10%	4.90%	2017
Children (ages 0-5) living in neighborhoods with 1 or more detracting elements (48) <sup>f</sup>	23.20%	18.70%	8.80%	26.90%	
Children (ages 0-5) living in a neighborhood without access to parks, recreation centers, sidewalks or libraries (48)	24.10%	19.50%	22.50%	9.40%	
<b>Maternal Depression</b>					
Percent of mothers always experiencing postpartum depression (53, 197)	2.00%	n/a	8.00%	n/a	SC 2015 NC 2016
Percent of mothers often experiencing postpartum depression (53, 197)	5.90%	n/a		n/a	

<sup>e</sup> These data are from 2014.

<sup>f</sup> Detracting elements were defined by the source as litter or garbage on the street or sidewalk, poorly kept or rundown housing, or vandalism.

**Table 3**  
**State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Abuse and Neglect</b>					
Number of children who have experienced maltreatment (54)	17,331	21,635	7,134	671,622	2016
Child maltreatment rate per 1000 children (54)	15.8	8.6	3.1	9.1	
Percent of maltreatment victims under 5 (54)	39%	37%	35%	41%	
Percent of maltreatment victims (ages 5-10) (54)	35%	35%	35%	33%	
Number of children under 6 served in foster care (55)	1,531	5,316	4,219	178,822	
Percent of children served in foster care who are under 6 (55) <sup>u</sup>	39%	43%	41%	41%	
<b>Developmental Delays</b>					
Percent of children under 5 with at least one functional difficulty (56)	12.60%	9.20%	16.10%	11.80%	2017 <sup>v</sup>
Percent of children (ages 6-11) with at least one functional difficulty (56)	17.50%	18.20%	19.20%	17.30%	
Total children (ages 0-9) eligible for EPSDT (57) <sup>w</sup>	414,444	789,289	729,701	22,704,781	2017
Children under age 1	38,337	84,056	73,136	2,339,249	
Percent of eligible children under 1	9.30%	10.60%	10.00%	10.30%	
Children (ages 1-2)	87,550	170,059	154,329	4,831,094	
Percent of eligible children (ages 1-2)	21.10%	21.50%	21.10%	21.30%	
Children (ages 3-5)	124,676	228,352	222,964	6,707,830	
Percent of eligible children (ages 3-5)	30.10%	28.90%	30.60%	29.50%	
Children ages (6-9)	163,881	306,822	279,273	8,826,608	
Percent of eligible children (ages 6-9)	39.50%	38.90%	38.30%	38.90%	
Eligible children (ages 0-9) who SHOULD receive at least one initial or periodic screening (57)	302,395	690,749	653,972	18,807,670	
Percent of eligible children (0-9) who SHOULD receive at least one screening	73.00%	87.50%	89.60%	82.80%	

<sup>u</sup> Child Trends analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), made available through the National Data Archive on Child Abuse and Neglect.

<sup>v</sup> These data were collected 2016–2017.

<sup>w</sup> Early and Periodic Screening, Diagnostic, and Treatment

**Table 3**  
**State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Developmental Delays (continued)</b>					
Children under 1	30,870	61,756	57,083	1,784,368	2017
Percent of eligible children under 1 who SHOULD receive at least one screening	80.50%	73.50%	78.10%	76.30%	
Children (ages 1-2)	83,197	162,651	141,297	4,594,601	
Percent of eligible children (ages 1-2) who SHOULD receive at least one screening	95.00%	95.60%	91.60%	95.10%	
Children ages (3-5)	112,532	197,719	206,385	5,777,029	
Percent of children (ages 3-5) who SHOULD receive at least one screening	90.30%	86.60%	92.60%	86.10%	
Children (ages 6-9)	75,796	268,623	249,207	6,651,672	
Percent of children (ages 6-9) who SHOULD receive at least one screening	46.30%	87.60%	89.20%	75.40%	
Eligible children (ages 0-9) who DID receive at least one initial or periodic screen of those who SHOULD (57)	204,501	456,757	454,921	12,866,452	
Percent of eligible children (ages 0-9) who received at least one EPSDT screening (57)	67.60%	66.10%	69.60%	68.40%	
Children under 1 <sup>x</sup>	28,512	58,783	55,027	1,578,479	
Percent of children under 1 who received a screening	92.40%	95.20%	96.40%	88.50%	
Children (ages 1-2)	60,689	131,250	126,766	3,595,722	
Percent of children (ages 1-2) who received a screening	72.90%	80.70%	89.70%	78.30%	
Children (ages 3-5)	60,507	136,740	151,522	3,929,859	
Percent of children (ages 3-5) who received a screening	53.80%	69.20%	60.80%	59.10%	
Children (ages 6-9)	54,793	129,984	121,469	3,535,230	
Percent of children (ages 6-9) who received a screening	72.30%	48.40%	48.70%	53.10%	

<sup>x</sup> These percentages represent the percentage of children who were screened of those who SHOULD be screened. We are assessing if children are having their needs met through the screening system. A lower percentage indicates the in-need population is not being reached. These numbers are calculated with the number of children screened for each age group as the numerator and the number of children who SHOULD receive screening as the denominator.

**Table 3  
State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Child Care</b>					
Number of working mothers (58, 61, 62) <sup>y</sup>	335,723	767,112	744,100	22,526,638 <sup>z</sup>	2018
Number of single working mothers (58, 61, 62)	120,033	256,161	235,918	6,757,924	
Number of working mothers with children under 6	85,810	181,673	182,424	5,559,717	
Number of children under 6 potentially needing care (58, 61, 62)	226,195	501,117	461,457	14,968,587	
Number of licensed child care facilities (all types) (59, 198, 199)	2,491	11,277	6,006	216,929 <sup>aa</sup>	SC 2019 GA 2017 NC 2019 US 2018
Number of child care spaces available (59, 198, 199)	189,659	385,056	433,008	9,347,351 <sup>bb</sup>	SC 2019 GA 2018 NC 2018
Average annual cost for family child care home (infant) (200)	\$4,797	\$6,454	\$7,412	\$9,321	2018
Average annual cost for family child care home (4 years old) (60)	\$4,531	\$5,853	\$6,548	\$8,617	
Average annual cost center-based care (infant) (60)	\$6,840	\$8,327	\$9,254	\$11,959	
Average annual cost for center- based care (4 years old) (60)	\$5,863	\$7,132	\$7,920	\$9,170	
Percent of median family income for a single parent required to cover full-time care for an infant in a child care center (60)	32%	36%	40%	37%	
Total number of childcare workers in centers (58, 61, 62)	6,860	15,320	18,210	562,420	
Average annual income for a childcare provider (58, 61, 62)	\$20,370	\$22,380	\$22,080	\$22,290	
Number of institutions providing courses for early childhood credentialing (63-65) <sup>cc</sup>	16	56	112	n/a	

<sup>y</sup> Statistics in the Child Care Need sections are from the American Community Survey, U.S. Census Bureau, 2012–2016 five-year estimates.

<sup>z</sup> This number was calculated by adding the number of married and single working mothers provided in the Fact Sheet.

<sup>aa</sup> This number is calculated based upon adding all available 50 states' facilities for childcare until school age, from the Child Care Aware State Fact Sheets. 12 states did not report data for this item. Added # center-based child care + family child care; NA other; regulated NA; did not add school-aged care programs

<sup>bb</sup> This number is calculated based upon adding all available 50 states' reported slot numbers for childcare until school age, from the Child Care Aware State Fact Sheets. 12 states did not report data for this item.

<sup>cc</sup> SC focuses on community colleges in their reporting here, while NC and GA include all public Universities and sources in the respective state.

**Table 3**  
**State Indicators and Statistics**

<b>Indicator</b> <i>Source reference number is provided in parentheses</i>	<b>SC</b>	<b>GA</b>	<b>NC</b>	<b>United States</b>	<b>Year</b>
<b>Head Start &amp; Early Head Start (67)</b>					
Number of children served in Head Start & Early Head Start <sup>dd</sup>	13,390	24,966	21,695	916,612	2016
Percent of participants that identify as African American	78%	68%	46%	29%	
Percent of participants that identify as Hispanic	10%	17%	29%	38%	
Percent of participants that identify as White (non-Hispanic)	12%	21%	27%	43%	
Percent of participants from single parent families	82%	76%	63%	58%	
Percent of families with at least one employed parent	61%	60%	62%	65%	
Percent of enrolled children with an IEP/IFSP <sup>ee</sup>	8%	9%	11%	12%	
Percent of enrolled families accessing at least one family service through Head Start	67%	67%	70%	72%	
<b>Pre Kindergarten (Pre-K)/4K Programs<sup>ff</sup></b>					
Percent of children (ages 3-4) not enrolled in school (69) <sup>gg</sup>	53%	51%	57%	52%	2016
Percent of children (ages 3-4) not enrolled in school (Hispanic) (70) <sup>hh</sup>	62%	65%	68%	59%	
Percent of children (ages 3-4) not enrolled in school (Non-Hispanic White) (70)	53%	49%	53%	51%	
Percent of children (ages 3-4) not enrolled in school (African-American) (70)	51%	46%	58%	49%	2012-2016
Total children enrolled in state-funded Pre-K (71) <sup>ii</sup>	24,079	80,874	27,019	1,523,410 <sup>jj</sup>	2017
Percent of 4-year-olds enrolled in publicly funded 4K (71) <sup>kk</sup>	41%	60%	22%	33%	
School districts offering the state-funded Pre-K (71)	100%	100%	100%	n/a	
State spending per child enrolled in publicly-funded Pre-K (71)	\$2,970	\$4,315	\$5,308	\$5,008	
Total State Pre-K Spending (71)	\$71,513,051	\$348,959,814	\$143,419,198	\$7,616,675,173	

<sup>dd</sup> These data came from Head Start Year 2014–2015

<sup>ee</sup> Percent of children enrolled with an Individualized Education Program/Individualized Family Service Program, which relates to special education services.

<sup>ff</sup> These data refer to state-funded Pre-Kindergarten/4K programs. In South Carolina, this includes both the Education Improvement Act Child Development Program (EIA 4K) and the public-private Child Early Reading Development and Education Program, presented here with combined totals.

<sup>gg</sup> These data came from the 2007–2009 to 2015–2017 one-year American Community Survey.

<sup>hh</sup> These data came from the 2005-09, 2010-14, 2011-15, and 2012–16 five-year American Community Survey.

<sup>ii</sup> These data are from the 2016–2017 academic year. For SC, GA, and NC, the numbers only reflect 4-year-olds, as 3-year-olds are not served by public Pre-K in these states.

<sup>jj</sup> This number includes all Pre-K students (based on NIEER's definition - see glossary) for all US states. iiThis percentage reflects the percentage of each state's/the nation's total population of 4-year-olds enrolled in publicly-funded 4K.

<sup>kk</sup> This percentage reflects the percentage of each state's/the nation's total population of 4-year-olds enrolled in publicly-funded 4K.

## (glossary of terms)

**Certified Lactation Counselor (CLC)** provide clinical breastfeeding counseling and management support to families who would like to, have questions, or are having difficulty breastfeeding. They are certified by the Academy of Lactation Policy and Practice, Inc. (202).

**Child Maltreatment:** The Child Abuse Prevention and Treatment Act (CAPTA) definition of child abuse and neglect is, at a minimum: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (54).

**Developmental delay** is defined broadly by the federal IDEA Part C program as a delay in one or more of the following five areas of early childhood growth and development relative to age-expected milestones: physical development including vision and hearing, cognitive development, communication, social or emotional development, and adaptive development (203, 204). Each state has its own legal definition of developmental delay.

**Developmental disability** is an instance in which a child under the age of 3 needs early intervention services because the child is experiencing a development delay as defined above, or who has a diagnosed physical or mental condition, which may include genetic abnormalities, severe attachment or nervous system disorders, congenital infections, and secondary impacts from toxic substance exposure, including fetal alcohol syndrome (204).

**Developmental monitoring**, or developmental surveillance, involves medical professionals examining children as part of well-child visits to identify signs of developmental delay or problems (205).

**Developmental screening** involves health care or other professionals engaging with a child to determine if he or she is learning basic skills as expected for his or her age. This screening often occurs during regularly scheduled well-child visits with a pediatrician. The American Academy of Pediatrics recommends that all children be screened at 9 months, 18 months, and 24 or 30 months in addition to recommended developmental surveillance at every well-child check. If a child is at high risk of developmental challenges, additional screening or monitoring may be needed (205).

**Early Intervention** is the process of providing services, education and support to infants and toddlers who have been evaluated as having a physical or mental delay, disability or special need, or whose risk factors place the child at high risk of delay. These services are offered to parents regardless of income level as part of the federal IDEA Part C program for infants and toddlers with developmental delays or disabilities. State eligibility requirements vary, but each of the following services must be available:

- Physical and motor skills such as reaching, rolling, crawling, and walking
- Cognitive skills such thinking, learning, and solving problems
- Communication skills such as talking, listening, and understanding
- Social-emotional development and skills such as playing and feeling secure and happy
- Self-help skills such as eating and dressing

**EPSDT** is the Early Periodic Screening, Diagnostic, and Treatment program for children in low-income families funded through the federal Medicaid program. This program provides funding for well-child visits and needed screenings and treatments for diagnosed conditions for children living with income-eligible families.

**Head Start** is operated through the federal Department of Health and Human Services, Head Start focuses not only on improving academic outcomes for children through center-based programming, but also on providing comprehensive services and opportunities for family engagement. Federal funding for Head Start flows to community-based grantees who implement the program, rather than state agencies, allowing for significant diversity in implementation (162). Eligibility for the program is largely based on income, with families at or below 100 percent of the federal poverty level (FPL) qualifying. Other factors can contribute to eligibility, including homelessness or having a child who is in foster care. Children under age 3 and expecting members may be eligible for Early Head Start, a program which provides center-based programs for low-income families tailored to the needs of infants and toddlers (66).

**IDEA** is the federal Individuals with Disabilities Education Act. Under this federal law, all states must provide children with a free and appropriate public education. Part C defines the services that must be available for very young children, ages birth to age 3, diagnosed with atypical development. Services must be provided by qualified personnel and delivered in natural contexts at no cost to families (unless a state has established a sliding fee payment arrangement). Parents, caregivers, or a professional may refer a child for Early Intervention/IDEA Part C evaluation (206). The definition of conditions warranting IDEA Part C intervention and the allocation of funding for the delivery of these services is determined by each state. See “special education,” below, for a description of IDEA Part B, for school-aged children.

**Individual Family Service Plan (IFSP)** is an IDEA plan for services to address developmental delays of young children. The IFSP may become an Individualized Education Plan (IEP) if the child continues to need services beyond the age of 3 (207).

**Infant mental health** refers to how well a child’s social-emotional skills are developing during the period from birth to age 3 (208).

**International Board-Certified Lactation Consultant (IBCLC)** serve as members of the child and maternal health care team to encourage breastfeeding practices. They can provide referrals to other appropriate healthcare professionals and community support resources, and are certified by the International Board of Consultant Examiners (209).

**Low birthweight** is defined as less than 2,500 grams or 5 pounds, 8 ounces. In the United States, one in 12 babies are born at low birth weight. While some low birth weight babies are born healthy, others at low birth weights experience serious health problems (104).

**SC Voucher** is a program administered by The South Carolina Department of Social Services (SCDSS). To qualify, a family would meet basic eligibility criteria according to the category of care. Additionally, a family’s income must be at or below 55 percent State Median Income (SMI) to be eligible for a child care voucher. Once enrolled in the program, parents may earn up to 85 percent of the SMI and remain eligible. For example, a family of three whose income is \$32,450 per year or less may qualify for the SC Voucher program (154).

**Social and emotional development** is the process through which children develop skills necessary to build strong attachments with adults; maintain positive relationships with peers and adults; construct a healthy personal identity; express, recognize, and manage their own emotions and behaviors through self-regulation, as well as the ability to recognize emotions in others (210).

Social-emotional development is often described in terms of a child's temperament, attachment, social skills or social competence, and emotional regulation (211).

**Special education** is a program of instructional services designed to meet the specific educational needs of children with delays or disabilities. Services for preschool children (ages 3 through 5) and school-aged children (K-12) are provided free of charge through the public education system. These services are available through IDEA Part B (212).

**State Preschool**, as defined by NIEER's State Preschool Yearbook series, focuses on state-funded preschool education programs which meet a number of criteria (available in full in their publication). The program must be funded, controlled, and directed by the state and serve children of preschool age, usually 3 and/or 4 years old. Although programs in some states serve broader age ranges, programs that serve only infants and toddlers are excluded. The program must reach at least one percent of the 3- or 4-year-old population in the state to be included. Early childhood education is the primary focus of the program. This does not exclude programs that offer parent education but does exclude programs that mainly focus on parent education (71).

**Substantiated maltreatment** includes a type of investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy (213).

**Temporary Aid for Needy Families (TANF)**, defined by the U.S. Department of Health and Human Services, is a program designed to help needy families achieve self-sufficiency. States receive block grants to design and operate programs that accomplish one of the purposes of the TANF program (214).

**Transition services** assist a toddler with a continued delay or disability (and his or her family) to move from a Part C early intervention program or service to Part B of the IDEA program or some other appropriate continuing service. The IDEA program specifies a formal process for transferring from Part C to Part B (215).

**Women, Infants, and Children Program (WIC)** is a Special Supplemental Nutrition Program for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, as well as infants and children up to age 5 who are found to be at nutritional risk. Federal grants are provided to states for supplemental foods, health care referrals, and nutrition education for this specific population (216).

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## Acknowledgements

The authors wish to acknowledge the assistance of researchers and data analysts who contributed to the information needed for this report: Katheryn Peterson at the Institute for the Advancement of Community Health, Furman University; Noelle McInerney at the South Carolina Department of Social Services; and Dr. Chelsea Richard at South Carolina Department of Health and Environmental Control. We also express our gratitude to the Priester Foundation for their support of this project. Any errors or omissions are solely those of the authors.

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