



Promote Health and Safety

1015 15th Street NW • Suite 400 • Washington, DC 20005 • p (202) 906.8000 • f (202) 842.2885 • www.clasp.org

April 2010

About this Project

CLASP's *Charting Progress for Babies in Child Care* project highlights state policies that support the healthy growth and development of infants and toddlers in child care settings, and provides online resources to help states implement these policies. The foundation of the project is a policy framework comprised of four key principles describing what babies and toddlers in child care need and 15 recommendations for states to move forward. The project seeks to provide information that links research and policy to help states make the best decisions for infants and toddlers.

Acknowledgements

This work is supported by the Birth to Five Policy Alliance, the Irving Harris Foundation, the John D. & Catherine T. MacArthur Foundation, and an anonymous donor. We also wish to thank our reviewers for their comments and input. While we are grateful to the contributions of our reviewers, the authors are solely responsible for the content.



By Rachel Schumacher¹

As they develop from birth to age 3, young children rely on the adults who care for them to keep them clean, dry, fed, and safe from harm. All babies and toddlers in child care need healthy and safe environments in which to explore and learn. To support this goal, CLASP recommends that states ensure that state licensing rules require practices and training that protect the safety of infants and toddlers—by addressing physical environments, safe sleep practices, bathing, and accident prevention—and promote infant/toddler health and well-being (including areas such as hand-washing, holding, feeding, comforting, diapering, and providing responsive caregiving); make certain that all infant and toddler providers and caregivers have access to the training and technical assistance needed to care for this age group; and require training prior to child care subsidy receipt.

This document presents research supporting the recommendation to promote health and safety. Visit www.clasp.org/babiesinchildcare for materials related to this recommendation, including ideas for how state child care licensing, subsidy, and quality enhancement policies can move toward this recommendation; state examples; and online resources for state policymakers.

What does the research say about ensuring the health and safety of babies and toddlers in child care?

Babies and toddlers have immature immune systems and engage in behaviors that make them particularly vulnerable to illness. Babies and children new to group-based care are developing their immunities and have not yet completed the full schedule of

recommended immunizations. Very young children are also naturally more susceptible to communicable diseases because they often place objects in their mouths, spend much of their time crawling on the floor, and are still in diapers. Babies and toddlers rely on adult caregivers to clean toys and surfaces regularly, wash their hands, and prepare bottles and food using good hygienic practices. Young children entering group care are more likely to be exposed to illness compared to those cared for in the home, and infants and children in their first year of care are most at risk. Research seems to indicate that groups of six or more children are more likely to see an increase in infections compared to smaller groups.²

Although overall fatality rates are low for children in child care, babies may be more likely to experience fatalities than older children. A study of child fatalities in child care settings found children under age 1 to be much more vulnerable than older children, even excluding deaths attributed to Sudden Infant Death Syndrome (SIDS).³ This research, based on a combination of national media and legal records as well as reported incidences occurring in child care settings in seven states,⁴ found much higher fatality rates with family child care arrangements and unregulated care in a child's home than in child care centers. The reasons for these findings are not clear. The authors highlighted that the rate of fatal violence toward infants was almost non-existent in center care as compared to family child care (2.31 per 100,000 children) and unregulated in-home care (2.00 per 100,000 children). They suggest that supervision and staff support can be inherent in the organization of child care centers, while family child care providers and in-home license-exempt caregivers are more likely to provide care alone with less peer interaction or supervision.⁵ Other reasons could include differences in the rigor of licensing and monitoring between the various types of care and unequal access to training and supports.

SIDS continues to be a concern in child care settings. A study of 2005 data found that a disproportionate number of SIDS deaths—17 percent—continue to occur in non-parental care arrangements, including licensed centers, family child care homes, and unregulated in-home care.⁶ Researchers believe this may be due in part to placing children on their stomachs to sleep when they are not

accustomed to that position, or the stress inherent in starting a new care arrangement; most SIDS deaths in child care occur in the first week of care.⁷

To prevent injuries and fatalities, babies and toddlers need physical environments in center- and home-based child care settings that are specifically prepared for their care and safety. Extra precautions are necessary to design a physical environment that anticipates the various stages of infant/toddler development, periods when children are at greater risk for injuries and death. For example, infants may not yet be able to hold up their heads or roll over, and toddlers may not yet understand the dangers of water, stairs, or pets. Toddlers are especially driven to develop their motor skills and explore their environments, which can lead to injury and fatalities without basic health and safety precautions.⁸ Child care settings in which infants and toddlers receive care may be more likely to fail to meet standards related to use of space and appropriate furnishings in good repair. For example, a review of environmental rating scale data relevant to health and safety gathered as part of the *Massachusetts Cost and Quality Study* found that over half of the infant/toddler center spaces and half of the family child care homes reviewed did not meet standards, compared to just 2 percent of preschool centers.⁹

From Albert Chang and Susan S. Aronson, Co-Chairs, Steering Committee, *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care.*

“Health involves more than the absence of illness and injury. To stay healthy, children depend on adults to make healthy choices for them and to teach them to make such choices for themselves over the course of a lifetime.”¹⁰

Different hazards are a concern depending on the setting for child care. A multi-state study of child fatalities in centers, licensed and unlicensed family child care, and in-home child care (not including relative care) from 1993-2003 found the most prevalent causes of death in home settings were drowning, suffocation, scalding, and fire, while death caused by being left in a vehicle was more common for center care. Overall, the researchers found much higher fatality rates for infants and toddlers in family child care and in-home care settings as compared to center-based child care.¹¹ Their analysis posited that systemic procedures typically required by licensing, such as dedicated spaces designed for children, clear sight lines in the classroom, and constant supervision serve as protective factors for young, curious children in centers.¹² Home settings, where care may occur in multiple rooms and additional physical dangers may present themselves (for example, kitchen stoves, pets, firearms, and cleaning supplies), demand heightened physical precautions and thoughtful regulation to protect the safety of babies and toddlers.

Research shows that provider and caregiver training specific to the health and safety needs of young children can be effective, particularly when paired with follow-up, supports, and monitoring.

Simple training and ongoing monitoring of diapering and handwashing practices have been shown to reduce the incidence of illness.¹³ Long-term changes in overall provider knowledge and practices may not be sustainable, however, if regular monitoring, such as observation visits and required regular reporting of child health issues and injuries, is absent.¹⁴ Training providers to prevent injuries and provide basic first aid has been found to be effective, but here, too, the effects can dissipate over time according to some studies. Training on how to identify signs of ill health may help prevent spread of disease in child care as well.¹⁵ Research has also shown that increased state regulation requiring safe sleep practices is important to begin to reduce the prevalence of SIDS.¹⁶

Understanding infant and toddler development can also help prepare providers and caregivers to prevent risks that arise more for children under age 3. The recommendations of the American Academy of Pediatrics, American Public Health Association, and

National Resource Center for Health and Safety in Child Care and Early Education in *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, state that providers should be prepared to work with infants and toddlers, possessing knowledge and competency in the areas of diapering, bathing, feeding, holding, comforting, SIDS prevention, developing responsive and continuous relationships with young children, and creating opportunities for child-initiated activities.¹⁷

Current state requirements are not adequate to protect the health and safety of all babies and toddlers in child care. As a condition of accepting federal Child Care and Development Block Grant (CCDBG) funds, states must certify that licensing requirements designed to protect the health and safety of children cared for by subsidized child care providers are in effect at the state or local level. These include the prevention and control of infectious diseases (including immunization requirements), building and physical premises safety, and minimum health and safety training appropriate to the provider setting.¹⁸ Federal law allows states flexibility to decide which providers and caregivers must be licensed and the specifics of what is required. Many programs are exempt from licensing. For example, 26 states¹⁹ exempt facilities with small numbers of children in care, 19 exempt part-day programs, and 12 exempt programs operated by religious institutions.²⁰ Only ten states require family child care homes to be licensed when just one child unrelated to the provider is in care.²¹ Similarly, a mere ten states require center providers to undergo a full roster of background checks using criminal, child abuse and neglect, sex offender, and state and federal fingerprint databanks.²²

Few states hold centers or family child care homes to standards which are linked to safer and healthier care, such as recommended provider-to-child ratios for babies and toddlers, small group sizes, and sufficient age-specific training prior to caring for children.²³ A review of data from a survey of 2007 state licensing policies demonstrates that states vary widely in the extent to which their regulations support specific practices that promote the health and safety of babies and toddlers in child care. Three states (California, Hawaii, and Montana)

have promulgated separate regulations specifically for infant/toddler center providers. Forty-nine states have at least one requirement specific to infants and toddlers in their general center care rules, and 36 have at least one requirement in their rules for family child care homes.²⁴

Limiting group size and assuring adequate adult supervision is critical to promoting safety in child care settings. Not many states meet recognized standards for **centers or family child care homes**. The 2007 study found that three states (Kansas, Maryland, and Massachusetts) require licensed child care center providers to meet the recommended 1:3 provider-to-child ratio for infants, and one (Maryland) also limits group size to six if three or more infants are in the group. Maryland also maintains a 1:3 ratio for 18-month-olds, with group size limited to nine. Eight other states (Connecticut, District of Columbia, Missouri, North Dakota, Oregon, Utah, Vermont, and Wisconsin) meet ratio guidelines of 1:4 with a maximum group size of eight for toddlers aged 18 months, but only two (Connecticut and the District of Columbia) continue this requirement for children aged 27 months.²⁵ Twelve states limit the number of children under age 2 to two per family child care provider. Thirteen states cap group size at six for small family child care homes regardless of the ages of children in care.²⁶

Not all states require some preventive measures that could protect the safety of babies and toddlers. While 42 states regulate the safety of swimming areas in child care centers, just 36 states do for family child care homes. Just 39 states require child care centers to enclose any outdoor space used for play, and only 15 states have a similar rule for family child care homes. A minority of states require center staff to be able to see (15 states) or hear (12 states) children in their care at all times. In terms of family child care home regulations, 17 states require providers to be able to see children at all times, and 15 require that the provider be able to hear children at all times. Most (40 states) have regulations governing supervision of children while they nap in a center, and 14 states have specific regulations for infants and toddlers. Only 17 states have requirements governing the supervision of children while they nap in a family child care home.²⁷

State requirements need strengthening in the areas of pre-service and continuing health and safety training and implementation supports for providers in centers and in-home caregivers. Many individuals who provide care to babies and toddlers are not likely to be required under state child care licensing rules to possess or be offered appropriate information about health and safety needs specific to babies and toddlers. In comparison, the federal Early Head Start program requires teachers to earn a Child Development Associate Credential within one year of hire date, as well as complete training that includes knowledge of safety issues in infant/toddler care.²⁸

States may not match safety practice licensing requirements to safety practice training for baby and toddler care providers. For example, 28 states require that infants cared for in licensed centers be placed on their backs to sleep to prevent SIDS, and 22 have a similar requirement for family child care providers. However, only seven states require center providers to ensure staff have training on SIDS prevention, and only nine require training for family child care providers. This is also true for health practices that benefit babies and toddlers. While 46 states require center providers to follow handwashing procedures, and 39 have a similar requirement for family child care providers, only eight states require providers to ensure center staff are trained in handwashing, and only one state requires handwashing training for licensed family child care providers.²⁹

In general, providers who work directly with children in child care settings are not likely to have had training prior to service. As of 2007, only 13 states required any specific training before caring for children in a child care center, although 48 states have ongoing annual training requirements.³⁰ For family child care homes, only nine states have pre-service training requirements and 12 more have requirements that must be met in the initial few months of licensure. Thirty-eight have ongoing training requirements for licensed providers.³¹ Seventeen states have more specific qualification requirements for those working with babies and toddlers in child care centers, including providers who lead center classrooms and center directors. Only five states specify pre-service training/education at the provider level, ranging from one

hour of training to a set number of higher education credit hours.³² A national study of the training offerings of child care resource and referral agencies, which many states fund to provide the bulk of training options to help providers meet annual state licensing requirements, found that only 4 percent of the content was targeted to specific age groups, such as infants/toddlers.³³

Ongoing assistance and supports can also improve the health and safety of child care in centers and in homes. For example, centers and family child care providers participating in the federal **Child and Adult Care Food Program (CACFP)** receive reimbursement for the cost of healthy meals and snacks for low-income children and ongoing training in nutrition and food preparation safety. Family child care providers also have a minimum of three home visits a year during which they receive on-site technical assistance.³⁴ Participation in CACFP was associated with higher global quality ratings in the 1994 *Study of Children in Family Child Care and Relative Care*.³⁵

Providers and caregivers of babies and toddlers need health and safety information in their primary spoken languages, delivered in appropriate formats at effective literacy levels. The population of children under three is increasingly diverse, and there is some anecdotal evidence that their providers and caregivers are culturally and linguistically diverse as well. For example, one in four children under age 3 live in an immigrant family (i.e., one comprised of one or more foreign-born parents).³⁶ Although national data on the linguistic diversity of the child care workforce—including those who care for babies and toddlers—is not available, there are data that may indicate that this group may be more diverse than those who care for older children.³⁷ In general, some research suggests that in certain communities, one-fourth or more of the child care workforce may speak a language other than English.³⁸ In addition, babies and toddlers are more likely than older children to be in unregulated care with a family member, friend, or neighbor caregiver.³⁹ Some anecdotal evidence suggests that family, friend, and neighbor care may be more likely to reflect the culture and languages of the children in care, because parents are connected to

caregivers of the same backgrounds through common social networks.⁴⁰

How can state child care licensing, subsidy, and quality enhancement policies ensure the health and safety of babies and toddlers?

States can study current health and safety data and practices in infant and toddler child care settings to identify improvement needs. States can review their existing data, such as tracking of complaints, injuries, and fatalities in child care settings, to identify concerns and leading causes of injury and death for infants and toddlers. For example, **Michigan** has county-based child death review teams and a state advisory committee charged with making recommendations on state policy changes to prevent future injuries.

States can also develop a picture of the current health and safety practices in child care settings for babies and toddlers that can be used to identify different areas of need among types of care, regions of the state, or particular aspects of health and safety. For example:

- Massachusetts conducted a **health report** that found that 77 percent of observed child care centers in the sample did not meet minimal health standards, and 29 percent failed to meet minimal safety standards. Observers trained in the Infant Toddler Environmental Rating Scale (ITERS) found that over 70 percent of centers failed to meet minimal standards for personal care routines in the areas of feeding, napping, and diapering. Family child care homes were found to be below minimal standards for health (69 percent) and safety (65 percent). Observers trained in the Family Day Care Environmental Rating Scale (FDCRS) found high proportions of home providers failed to meet minimal standards for feeding and diapering practices, although most family child care providers (68 percent) were doing a good job on safe and appropriate naptime routines.⁴¹

- The **Kansas Infant-Toddler Project** also conducted baseline assessments of the quality of center and family child care providers using environmental rating scales, and rated physical space, furnishings, and basic care routines among the lowest. This helped inform project priorities for training and technical assistance.⁴²

As part of any study, states need to assess the extent to which child care providers have the capacity to provide culturally and linguistically appropriate information on injury prevention and health promotion to parents.

State licensing policies can set a standard floor of basic health and safety knowledge and practices that licensed providers should obtain prior to caring for babies and toddlers. States should review their existing licensing requirements for practice and physical facility protections in center and family child care programs, as well as their provider training requirements, to assess the extent to which they address babies and toddlers in care. The health and safety standards articulated by the American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education in *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* can serve as a reference point and provide goals for states. For example, Michigan conducted a review of state licensing regulations that resulted in a number of changes important to the health and safety of babies and toddlers, including requiring safe sleep practices, posting of handwashing and diapering techniques, and mandatory training on safe sleep and shaken-baby syndrome.⁴³ A privately-funded study of Massachusetts health and safety standards and supports and current provider practices recommended more focus on staff training and hand hygiene.⁴⁴

States can move toward requiring basic training and practice for all providers and caregivers receiving child care subsidy funds. States should examine the types of child care settings used by their populations. It is possible that a significant portion of children under age 3 are cared for by providers who are exempt from current state licensing rules or by family,

friend, and neighbor caregivers who regularly provide child care, neither of which receive oversight or technical assistance. Some states are taking steps to bring information and assistance to more providers and caregivers. For example, Delaware requires that relatives who receive child care subsidies to care for low-income children participate in **45 hours of training** on topics such as safety (three hours), health (three hours), nutrition (three hours), child development (15 hours), and CPR/First Aid (six hours). The Insurance Commissioner of Delaware donates age-appropriate activity kits to caregivers at the completion of their training. Delaware's **Family & Workplace Connection** resource center offers relative caregivers on-site technical assistance and support if they choose to become licensed. Nine states require unlicensed, in-home caregivers who receive subsidy payments to have first aid and CPR training.⁴⁵

State policies can expand access to training specifically designed to promote health and safety for babies and toddlers, guide implementation of good practices in child care settings, and reduce isolation by building ongoing systems of support and consultation. All states report using the Infant/Toddler earmark of the CCDBG to support training and education for child care providers, although there is great variation in the intensity and reach of the training offered.⁴⁶ States should review the locations and types of training opportunities available to determine whether there is an adequate supply of trainers with infant/toddler-specific expertise across the state. States will also want to examine whether training opportunities are sufficient to reach all new providers on a pre-service basis, as well as to provide ongoing training that builds on entry-level training. For example, when North Carolina required licensed providers to complete training in infant/toddler safe sleep practices and SIDS within four months of becoming employed and working with infants and toddlers, the state used its CCDBG dollars to fund an Infant/Toddler Safe Sleep and SIDS Risk Reduction (ITS-SIDS) Project. The project facilitated an online train-the-trainer module to infant/toddler specialists, child care health consultants, and others, who then administered ITS-SIDS training to providers.⁴⁷

States can also create a consultation network staffed by experts in health and safety as well as infant/toddler issues to provide on-site assistance to providers and caregivers. At least twenty states reported using child health consultants or other health professionals to work with providers on improving health and safety practices in their 2008-2009 CCDBG state plans.⁴⁸ For example, the Infant Toddler Initiative of Healthy Child Care Washington (HCCW) reaches out to all child care settings in Washington State using child care health consultants who provide technical assistance, information, referrals, and child development knowledge to child care providers. An evaluation of HCCW found that child care providers increased their knowledge and use of practices promoting social and emotional health, physical health, cognitive development, and communication with parents.⁴⁹

States can provide financial resources directly or offer incentives to encourage child care providers and caregivers to implement health and safety measures and improve physical facilities and equipment. States may consider providing financial incentives for implementing higher health and safety standards such as through a state quality rating and improvement system (QRIS). [Iowa's quality rating system](#) provides additional points toward program ratings for completing injury prevention and health and safety assessments, as well as for participating in the Child and Adult Care Food Program. Higher-rated programs can win [achievement bonuses](#). Some states are using CCDBG dollars to provide grants or loans to child care providers to expand or improve their facilities, including those for babies and toddlers. A review of state CCDBG plans for 2008-2009 found 12 states and the District of Columbia offer grants to help providers meet health and safety standards.⁵⁰ South Dakota prioritized infant/toddler capacity-building in the award of its grants.

States can ensure that licensing and health and safety training and materials are available in appropriate languages and use effective literacy levels. States should review what information, orientations, and training they require for baby and toddler providers or programs to be licensed or subsidized and see that these are available in the languages spoken by caregivers in the state. For example, Minnesota has

translated the forms, checklists, and brochures available to family child care providers into multiple languages, consistent with the state's immigration patterns.⁵¹ The state child care agency plans to distribute videos in multiple languages, developed in conjunction with the Minnesota Early Childhood Comprehensive System grant, that provide information to child care providers and parents on seven early childhood health and safety issues. Many materials are available on the Minnesota Department of Human Service's [E-docs](#) service for public use.

Visit www.clasp.org/babiesinchildcare

for dynamically updated information related to this recommendation, including:

- **Policy Ideas** that states can use to move toward this recommendation
- **State Examples** profiling initiatives of policies under this recommendation
- **Online Resources** for state policymakers

¹ The author would like to thank Jacqueline Wood and Linda Smith for their comments on drafts of this resource.

² American Academy of Pediatrics, *Effects of Early Education and Child Care on Health and Safety*, <http://www.healthychildcare.org/>; Susan Aronson and Timothy R. Shope, "Improving the Health and Safety of Children in Nonparental Early Education and Child Care," *Pediatrics in Review* 26, no. 3 (2005): 86-95.

³ Julia Wrigley and Joanna Dreby, "Fatalities and the Organization of Child Care in the United States, 1985-2003," *American Sociological Review* 70, no. 5 (2005): 729-757.

⁴ The states were Colorado, Delaware, Georgia, Maryland, Michigan, Oklahoma, and Oregon. The researchers did not control for licensing differences between these states and the rest of the country.

⁵ Wrigley and Dreby, "Fatalities," 747-751.

⁶ Rachel Y. Moon, Bruce M. Sprague, and Kantilal M. Patel, "Stable prevalence but changing risk factors for sudden infant death syndrome in child care settings in 2001," *Pediatrics* 116, no. 4 (2005): 972-977.

⁷ Rachel Y. Moon, Lauren Kotch, and Laura Aird, "State child care regulations regarding infant sleep environment since the Healthy Child Care America-Back to Sleep campaign," *Pediatrics* 118, no. 1 (2006): 73-83; Moon et al., "Stable prevalence," 972-977.

⁸ ZERO TO THREE, *Caring for infants and toddlers in groups: developmentally appropriate practice*, 2nd edition, 2008, 25.

⁹ Valora Washington, Mary Reed, and Martha Cowden, *Cornerstones: Strengthening the Foundation of Health and Safety in Early Education and Care*, Schott Fellowship in Early Education and Care at Cambridge College, 2007, 12.

¹⁰ American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education, *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, 2nd edition, "Introduction," 2002.

¹¹ Wrigley and Dreby, "Fatalities," 736.

¹² Wrigley and Dreby, "Fatalities," 747-751.

¹³ Richard Fiene, *13 Indicators of Quality Child Care: Research Update*, presented to the Office of Assistant Secretary for Planning and Evaluation and Health Resources and Services Administration /Maternal and Child Health Bureau, U.S. Department of Health and Human Services, 2002, <http://aspe.hhs.gov/hsp/ccquality-ind02/>;

Helene Carabin, Theresa W. Gyorkos, Julio C. Soto, Lawrence Joseph, Pierre Payment, and Jean-Paul Collet, "Effectiveness of a Training Program in Reducing Infections in Toddlers Attending Day Care Centers," *Epidemiology* 10, no. 3 (1999): 219-227.

¹⁴ Carabin et al., "Effectiveness of a Training Program," 219-227.

¹⁵ Fiene, *13 Indicators of Quality*, 31.

¹⁶ Moon et al., "State child care regulations," 73-83.

¹⁷ American Academy of Pediatrics et al., *Caring for Our Children*, Standard 1.010.

¹⁸ Child Care and Development Block Grant Act of 1990, Sec. 685E(c)(2)(F),

<http://www.acf.hhs.gov/programs/ccb/law/ccdbgact/ccdbgact.pdf>.

¹⁹ Throughout this document the District of Columbia is counted as a state.

²⁰ National Association for Regulatory Administration (NARA) and the National Child Care Information and Technical Assistance Center (NCCIC), *2007 Child Care Licensing Study*, 2009, 40-41,

<http://naralicensing.org/displaycommon.cfm?an=1&subarticlenbr=160>.

²¹ NARA and the NCCIC, *2007 Child Care Licensing*, 119.

²² National Association of Child Care Resource and Referral Agencies, *How Does Your State Stack Up: Criminal Background Check Requirements for Child Care Providers in Centers*, 2009, http://www.naccrra.org/policy/background_issues/background-checks/requirements-for-centers.php.

²³ National Association of Child Care Resource and Referral Agencies, *We Can Do Better: NACCRRRA's Ranking of State Child Care Center Standards and Oversight*, 2009,

<http://www.naccrra.org/publications/naccrra-publications/we-can-do-better>; National Association of Child Care Resource and Referral Agencies, *Leaving Children to Chance: NACCRRRA's Ranking of State Standards and Oversight of Small Family Child Care Homes*, 2008, http://www.naccrra.org/policy/recent_reports/fcc_report.php.

²⁴ NARA and NCCIC, *2007 Child Care Licensing*, 38.

²⁵ National Child Care Information and Technical Assistance Center, *State Requirements for Child-Staff Ratios and Maximum Group Sizes for Child Care Centers in 2007*, 2008, <http://nccic.acf.hhs.gov/pubs/cclicensingreq/ratios.html>.

²⁶ National Child Care Information and Technical Assistance Center, *Definition of Licensed FCC Homes in 2007*, 2008,

<http://nccic.acf.hhs.gov/pubs/cclicensingreq/definition-fcc.html>.

²⁷ NARA and NCCIC, *2007 Child Care Licensing*, 139.

²⁸ Head Start Regulations, 45 C.F.R. 1304.52(f).

²⁹ NARA and NCCIC, *2007 Child Care Licensing*, 173.

³⁰ National Child Care Information and Technical Assistance Center, *State Requirements for Minimum Preservice Qualifications and Annual Ongoing Training Hours for Child Care Center Teachers and Master Teachers in 2007*, 2008,

<http://nccic.acf.hhs.gov/pubs/cclicensingreq/cclr-teachers.html>.

³¹ National Child Care Information and Technical Assistance Center, *State Requirements for Minimum Preservice Qualifications, and Annual Ongoing Training Hours for FCC Home Providers in 2007*, 2008, <http://nccic.acf.hhs.gov/pubs/cclicensingreq/cclr-famcare.html>.

³² CLASP analysis of NARA and NCCIC, *2007 Child Care Licensing*, Table 34: Qualifications for Center Staff Working with Infants and Toddlers in 2007, 2009,

http://www.naralicensing.org/associations/4734/files/Table_34_ITQuals_Center_2007.pdf.

³³ Linda K. Smith, Mousumi Sarkar, Susan Perry-Manning, and Beverly Schmalzreid, *NACCRRRA's National Survey of Child Care Resource and Referral Training: Building a Training System for the Child Care Workforce*, National Association of Child Care Resource and Referral Agencies, 2007, 44,

http://www.naccrra.org/publications/naccrra-publications/publications/Training_FINAL_010407.pdf.

³⁴ Food Research and Action Center, *The Child and Adult Care Food Program: A Building Block for the Future*,

http://www.frac.org/html/federal_food_programs/programs/cacfp_bblock.html.

³⁵ Ellen Galinsky, Carollee Howes, Susan Kontos, and Marybeth Shinn, *The Study of Children in Family Child Care and Relative Care*, Families and Work Institute, 1994, 129.

³⁶ Calculated from U.S. Census Bureau, *America's Families and Living Arrangements: 2007, Nativity Status of Children Under 18 Years and Presence of Parents by Race, and Hispanic Origin for Selected Characteristics: 2007*,

<http://www.census.gov/population/www/socdemo/hh-fam/cps2007.html>.

³⁷ Hedy Chang, *Getting Ready for Quality: The Critical Importance of Developing and Supporting a Skilled, Ethnically and Linguistically Diverse Early Childhood Workforce*, California Tomorrow, 2006,

<http://www.californiatomorrow.org/media/gettingready.pdf>; Dan Bellm and Marcy Whitebook, *Roots of Decline: How Government Policy Has De-Educated Teachers of Young Children*, Center for the Study of Child Care Employment, 2006,

http://www.iir.berkeley.edu/cscce/pdf/roots_decline06.pdf.

³⁸ Marcy Whitebook, Laura Sakai, Fran Kipnis, et al., *California Early Care and Education Workforce Study: Licensed Child Care Centers and Family Child Care Providers*, Center for the Study of Child Care Employment and California Child Care Resource and Referral Network, 2006,

http://www.iir.berkeley.edu/cscce/pdf/statewide_highlights.pdf; Hannah Matthews and Deeana Jang, *The Challenges of Change: Learning from the Child Care and Early Education Experiences of*

Immigrant Families, Center for Law and Social Policy, 2007,
http://clasp.org/publications/challenges_change.htm.

³⁹ Jeffrey Capizzano, Gina Adams, and Freya Sonenstein, *Child Care Arrangements for Children Under 5*, Urban Institute, 2000,
<http://www.urban.org/url.cfm?ID=309438>; National Center for Education Statistics, *National Household Education Surveys Program of 2005: Initial Results from the 2005 NHES Early Childhood Program Participation Survey*, 2006, <http://nces.ed.gov>.

⁴⁰ Chang, *Getting Ready for Quality*.

⁴¹ Nancy L. Marshall, *Massachusetts Early Care and Education Health Report*, Wellesley Centers for Women, 2006,
<http://www.wcwonline.org>.

⁴² Kansas Association of Child Care Resource and Referral Agencies, *Child Care Quality Study: Infant/Toddler Project*, 2003,
<http://www.kaccrra.org/PDFs/RESpdfs/CCQualityStudy.pdf>.

⁴³ Michigan's new center regulations may be seen at: Michigan Department of Human Services, *Licensing Rules for Child Care Centers*, http://www.michigan.gov/documents/dhs/BCAL-PUB-0008_241660_7.pdf.

⁴⁴ Washington et al., *Cornerstones*, 19-21.

⁴⁵ National Child Care Information and Technical Assistance Center, *Health and Safety Requirements for In-Home Providers Paid with CCDF Funds*, 2008,
http://nccic.acf.hhs.gov/poptopics/inhomeprovider_reqs.html.

⁴⁶ Teresa Lim and Rachel Schumacher, *State CCDBG Plans to Promote Opportunities for Babies and Toddlers in Child Care*, Center for Law and Social Policy, 2009, 3-8,
<http://www.clasp.org/admin/site/publications/files/Infants-Toddlers-in-CCDBG-Plans-Report.pdf>.

⁴⁷ Lim and Schumacher, *State CCDBG Plans*, 7-8.

⁴⁸ National Child Care Information and Technical Assistance Center, *CCDF Quality Activities for FY 2008-2009: Early Childhood Health Consultants*, 2008, <http://nccic.acf.hhs.gov/poptopics/consultants.html>.

⁴⁹ Organizational Research Services and Geo Education & Research, *Healthy Child Care Washington: Evaluation Report, April 2006 – March 2007*, prepared for the Washington State Department of Health, 2007, 29, <http://www.healthychildcare-wa.org/DOH%20HCCW%202007%20EOY%20Report%20FINAL%2008-30-07.pdf>.

⁵⁰ National Child Care Information and Technical Assistance Center, *Child Care and Development Fund Report of State and Territory Plans 2008-2009: Part 5, Activities and Services to Promote the Quality and Availability of Child Care*, 2008, 113,
<http://nccic.acf.hhs.gov/pubs/stateplan2008-09/part5.pdf>.

⁵¹ Minnesota Department of Human Services, *Minnesota Child Care and Development Fund Plan: FFY 2010-2011*, 2009,
http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_147439.pdf.