

1                   **C2: CHILD HEALTH POLICY FOR THE UNITED STATES**

2    Purpose:

3    As a result of the scheduled review of child health policies in 2007 the American Public Health  
4    Association (APHA) archived five policies (#4902, 6604, 6913, 7227, and 7408). The six  
5    remaining policies address specific issues relating to child health. There is no policy that  
6    provides a comprehensive approach to children’s health. The purpose of this policy paper is to  
7    guide further debate and decision-making by the APHA on the health of children in the United  
8    States. This policy provides a set of principles along with the associated scientific support and  
9    identified problems. The policy statement will enable APHA to position itself as a leader in  
10   advocating for policies related to children’s health. Specifically, APHA will be positioned to:

- 11       • Provide guidance for Federal agencies providing services and programs for children and  
12       families.
- 13       • Improve public health education about comprehensive child health.
- 14       • Promote sufficient funding for children’s health.

15

16   The APHA recognizes meeting the developmental needs and promoting the well being of  
17   children is a primary role for any society. It is the joint responsibility of the parents, community,  
18   and society to assure that they are healthy in mind, body and spirit. “Healthy development is  
19   shaped by the dynamic and continuous interaction between biology and experience and is framed  
20   by the constantly changing developmental contexts over the lifetime. These nested contexts  
21   include child rearing, access to resources, employment and health care, the psychological  
22   environment that mediates behavior and stress responses to the trials and tribulations of daily

1 life". (1) Good health is essential to children's academic achievement, successful transition to  
2 adulthood, and lifelong contributions to society.

3 PRINCIPLES:

4 Meeting the basic needs of food, shelter and safety is fundamental to good health.

5 In 2007, 37.3 million people in the United States, 13,324 of them under 18 years old,  
6 lived with incomes below the poverty level. (2) Over just one year, the poverty rate  
7 increased for children under 18 years of age (18 percent in 2007, up from 17.4 percent in  
8 2006).(2)

9 In 2007, 13 million U.S. households were food insecure. That is, these households, at  
10 some time during the year, had difficulty providing enough food for all their members  
11 due to inadequate financial resources. 323,000 households with children experienced  
12 times of very low food security. This was an increase from the number (221,000) in 2006  
13 that lacked consistent access to enough food for active healthy lives for all household  
14 members. (3)

15 Low-income children are more likely to be exposed to structural hazards such as poor  
16 construction and maintenance that lead to water leakage, inadequate heating and lighting,  
17 and electrical hazards. Over time these structural problems also often result in  
18 overgrowth of mold, poor indoor air quality, infestation of rodents and insects, and  
19 hazardous materials such as lead and asbestos. (4)

20 In 2007, 37% of housing units in the United States had major structural defects which  
21 may have direct or indirect effect on the health of the occupants.(5)

1 Family violence accounted for 11% of all reported and unreported violence between  
2 1998-2002. 49% were a crime against a spouse or partner, 11% a parent attacking a  
3 child, and 41% an offense against another family member. Drugs or alcohol were  
4 involved 39% of the time. The average age of a child killed by a parent was 7 years old;  
5 80% were younger than 13. (6)

6 Children live and grow in the context of family and community. The physical, emotional and  
7 developmental well being of a child is influenced by the health of all the members of the family.  
8 Of particular importance is the health and well being of the mother before, during and after  
9 pregnancy.

10 Some of the most powerful influences on pregnancy outcome are related to influences on  
11 women's health that occur long before pregnancy begins. In particular, nutrition,  
12 infections, chronic disease, and exposure to environmental toxins are of ongoing and  
13 increasing concern. Given the prevalence of unintended pregnancy in the US, women's  
14 health is central to child health.(7, 8)

15 Less than two-thirds of mothers (59%) rate both their physical and emotional health as  
16 excellent or very good, although that drops for mothers living in households with  
17 incomes less than 200% of poverty.(9)

18 Approximately 12 % of all women experience depression in a given year. Low-income  
19 mothers of young children, pregnant and parenting teens report depressive symptoms in  
20 the 40-60% range. Maternal depression threatens two core parental functions: fostering  
21 healthy relationships and carrying out the management functions of parenting. Estimates

1 are that 80% of low-income women who receive treatment for depression are helped. (10,  
2 11)

3 Women are more likely than men to have been diagnosed with a chronic disease such as  
4 diabetes (81.2 vs. 70.4 per 1,000 adults), asthma (89.3 vs. 55.7), arthritis (24.4 vs. 17.7),  
5 or hypertension (16.3 vs. 15.2). (12) While chronic diseases can be managed during  
6 pregnancy, a woman's health and fetal health remain compromised...certain treatments  
7 may be teratogenic; pregnancy may also exacerbate chronic diseases. (13) The burden of  
8 chronic disease falls disproportionately on two overlapping subpopulations of women at  
9 increased risk for adverse perinatal outcomes; poor women and minority women. (14)

10 In 1960-62, 24.5% of women were overweight and 15.7% were obese, compared to 27  
11 and 34% in 2001-2004. (12) Being overweight or obese increases the risk for  
12 hypertension, diabetes, heart disease, stroke, and perinatal morbidity. (8, 15, 16) Labor  
13 and delivery problems are also correlated with maternal body mass index, (17) (18-21)  
14 and some studies suggest that overweight and obesity may limit a woman's ability to  
15 successfully breastfeed. (22, 23) (24-26)

16 Infant's who are not breastfed for a period of months are at increased risk of acute otitis  
17 media, atopic dermatitis, gastrointestinal infections and asthma, as well as a lifetime risk  
18 of developing obesity, diabetes (type 1 and type2), hypertension, childhood leukemias  
19 and SIDS. (27, 28) Lack of breastfeeding also increases the mother's risk of type 2  
20 diabetes and breast and ovarian cancers. (27) However, initiation and duration of  
21 breastfeeding do not meet the Healthy People 2010 goals of 75% initiation 50% duration  
22 at 6 months, and 25% duration at 12 months.

1 The health and safety of a child is strongly influenced by the environment in which the child  
2 lives and grows. Chronic and acute conditions such as obesity, asthma, lead poisoning and  
3 injuries, are associated with risk factors within a child's built environment. (4)

4 Almost five percent of children missed 11 or more days of school over the past year due  
5 to illness or injury. (29)

6 In 2006 , there were 9.8 million children (14%) who had been diagnosed with asthma at  
7 some point in their lives and 6.8 million (9%) who were still affected.(29) Children in  
8 poor families were more likely to have been diagnosed or to still have asthma (18% and  
9 14%) than children in families that were not poor (13% and 8%). (29).

10 Obesity is a serious health concern for children and adolescents. Data from NHANES  
11 surveys (1976-1980 and 2003-2006) show that the prevalence of obesity has increased in  
12 all age groups. For the very young (2-6) from 5% to 12.4%; children (6-12) from 6.5%-  
13 17%; and adolescents (11 – 20) from 5% to 17.6%. The prevalence is highest among  
14 Non-Hispanic Black and Mexican American children. (30) There are physical and  
15 psycho-social consequences of childhood obesity including orthopedic complications,  
16 type 2 diabetes, poor immune functions, increased blood pressure and hypertension, low  
17 self esteem, discrimination and depression. (31) The causes of obesity include both  
18 excess food intake and inadequate physical activity. Community and neighborhood  
19 design can either promote or hinder physical activity. (4) Safe places to play (parks,  
20 bicycle paths, recreational facilities), regular opportunities for physical activities during  
21 the school day, formal physical education program all promote physical activity in  
22 children.

1 Unintentional injuries are the leading cause of death for children aged 1-24 years. In  
2 2005 unintentional injuries represented 43% of all deaths in this age group. As in the  
3 past, motor vehicle crashes, drowning, and fires and burns were the most common causes  
4 of unintentional injury death among children 1-4. Motor vehicle crashes were the most  
5 common cause for both children 5-14 and young adults. (32) Contributing to this is the  
6 lack of seatbelt use. The 2007 Youth Risk Behavior Survey found that 11.1% of student  
7 had rarely or never worn a seat belt, and even fewer, 33.9%, wore a motorcycle  
8 helmet.(33)

9 In 2001-2004 17% of children 4-17 are exposed to significant levels of environmental  
10 tobacco smoke (ETS). (34) Equally concerning, ten percent of women delivering a live  
11 birth report having used tobacco during pregnancy. Use varies by ethnic group, ranging  
12 from 2% among Asian mothers to 8% among American Indian/Alaskan mothers.(34)

13 In 2005, 60 percent of children under 6 years required at least one child care  
14 arrangement. (35) High-quality early education and child care for young children  
15 improves their health and promotes their development and learning. Research of high  
16 quality, intensive early childhood education programs for low-income children confirm  
17 lasting positive effects such as greater school success, higher graduation rates, lower  
18 juvenile crime, decreased rates for special education services later and lower adolescent  
19 pregnancy rates. Public funding for quality child care is inadequate. In many states the  
20 cost of early education and child care programs is about twice as expensive as paying for  
21 one year of tuition at a four year public college. (36)

1 All children, families and communities have assets and strengths that should be recognized and  
2 supported by building a fabric of social support that includes key relationships and community  
3 involvement. Children develop assets from constant exposure to interlocking systems of support,  
4 empowerment, boundaries and expectations, and structure. (37) Many children lack sufficient  
5 assets to protect them from risky behaviors.

6 In 2007, 50% of students surveyed had tried cigarette smoking, and 20% smoked  
7 cigarettes on at least one day in the past month. 75% had had at least one drink of  
8 alcohol and 44% reported drinking in the past month. 47% had ever had sexual  
9 intercourse, and 14.9% had had sexual intercourse with four or more persons during their  
10 lifetime. (33)

11 The age of onset of risky behaviors is also of concern: 14.2% of students surveyed had  
12 smoked a cigarette before the age of 13; 23.8% had drunk alcohol before age 13; and  
13 7.1% of students had had sexual intercourse for the first time before age 13. (33)

14 In 2007, 87% of 25-29 year olds had received a high school diploma or an equivalency  
15 certificate. There continues to be a gap between the completion rates for Blacks and  
16 Hispanics compared to White students. (38)

17 Children should have access to developmentally appropriate, integrated health care (physical,  
18 mental, developmental and oral) that is accessible, continuous, comprehensive, family centered,  
19 coordinated, compassionate, and culturally effective. It should include a uniform core of  
20 preventive and support services that are established in policy at the national, state and local level.  
21 (39)

1 In 2007, 8.1 million children (11%) did not have health insurance. (2) Children in poor  
2 households were more likely not to have coverage, and those without coverage were 4  
3 times more likely not to have seen a health professional in the past year. (29)

4 More than 4 million children between the ages of 2 and 17 had unmet dental needs  
5 because their families could not afford dental care. (29) Thirty-seven percent of  
6 uninsured children had no dental contact for more than 2 years.(29)

7 Some children are more vulnerable (children with special health care needs, children of  
8 immigrants or refugees, children in foster care or in the juvenile justice system) and special  
9 policies may be necessary to assure that these children thrive. Service systems should address  
10 the special needs of these children while promoting the inclusion of these children and their  
11 families in all aspect of community life.

12 14% of children have special health care needs. (40)

13 While most CSHCN receive the services they need, the National Survey of Children with  
14 Special Health Care Needs found that 16% of these children were reported to need at  
15 least on health care service that they did not receive, and 6 % needed more than one  
16 service. The service most likely to be not received was preventive dental care, followed  
17 by mental health services.(40)

18 Nearly 10 million US children take regular prescription medication for at least 3 months.  
19 (29)

1           The children with special needs are complex. Currently they are served by many systems  
2           of care that are not integrated (education, health, early intervention, social services, child  
3           welfare, juvenile justice, mental health services, etc.)

4   Assuring that all children are healthy requires a broad based national commitment to child  
5   health. This includes an infrastructure that supports public participation and education, research,  
6   professional education and training, and systems to assure equity in health care delivery.

7           Children grow up in an environment of relationships which have enormous influence on  
8           their health outcomes. Many of these environments are shaped by public policies – from  
9           the foods served in schools to the health providers children get to see. There is a lack of  
10          public understanding about these critical aspects of child health and development which  
11          has resulted in the lack of political and public will to make children a priority.

12          It is estimated that by 2020 there will be a need for 57,900 pediatricians and 47,200  
13          obstetricians/gynecologists. Given the current medical school enrollment, age of current  
14          practicing physicians, and other factors, it is estimated that in 2020 there will be 54,560  
15          pediatricians and 44,630 OB/GYNs in clinical practice. (41) Of particular additional  
16          concern to maternal and child health practitioners is the great difficulty experienced in  
17          local and state child health programs in recruiting nurses with public health training and  
18          experience and advanced degrees. (42).

19          Moreover, a national survey of state MCH and CYSHCN Programs conducted in 2008,  
20          documents public health programs with a broad scope of responsibilities (many states  
21          oversee as many as 15-20 program areas spanning from chronic illness, medically fragile  
22          children, adolescent health, infant mortality reduction, newborn screening and follow-up,

1 injury prevention, oral health, family planning, etc.) but with staff levels as few as 7, and  
2 average staffing vacancy rates nationally of 13% of all positions. (42) Federal funding for  
3 public health infrastructure for maternal and child health in the states has declined  
4 substantially recently, leaving these programs greatly challenged to keep pace with needs  
5 for prevention programs and services, surveilling population needs and vulnerabilities,  
6 and assuring supportive and specialized services and systems of care for high risk groups  
7 of children, mothers, and families.

8 Recent reviews of child health and health promotion point to a number of major gaps,  
9 particularly with respect to understanding the mechanisms of gene-environment  
10 interactions that shape lifelong health, and intervention research (43) (44)

11 The White House Conference on Children and Youth was a series of meetings hosted  
12 over 70 years, 1909-1980, by the President of the United States. The Conferences were  
13 devoted to improving the lives of children. President Reagan was the first president not  
14 to convene a Conference dedicated to children. In 2008, legislation calling for a White  
15 House Conference on Children and Youth in 2010 was filed in both the House and  
16 Senate. However, the current plans for the 2010 Conference do not include a focus on  
17 child health.

#### 18 RECOMMENDATIONS:

19 APHA should be a leader in explaining critical issues affecting child health to the broader public  
20 and to connect this understanding to society's long-term interests in healthy outcomes for  
21 children.

1 APHA should support the development of a national plan for children’s health and development  
2 that

3 Is based on research in the neurobiological, behavioral and social sciences such as the  
4 National Children Study(44, 45)

5 Includes a core set of preventive and support services

6 Provides a public health and clinical workforce that is sufficient and proficient in caring  
7 for children and families. (APHA Policy 9511)

8 Through public statements and legislative advocacy, APHA should support public health  
9 programs and interventions that focus on building environments that support health and thriving  
10 communities, and policies that support community health and the improvement of social  
11 conditions for families including:

12 Continuing support for programs that address food security, livable wage, affordable and  
13 safe housing. (APHA Policies 20072, 200319, 200712, 200618)

14 Continuing support for the inclusion of children in all environmental policy, legislation,  
15 and regulation. (APHA Policy 9511)

16 Assuring adequate funding for and quality of out of home care and early childhood  
17 education.

18 Through public statements and legislative advocacy, APHA should support efforts that improve  
19 personal health throughout the lifespan by:

1 Promoting awareness of the impact of maternal depression, and support policies that  
2 promote screening and services.

3 Supporting breastfeeding as an expected health behavior choice, especially for poor  
4 women and their children, including employer policies.

5 Supporting the development and implementation of programs that develop assets in  
6 children and prevent risk taking behaviors.

7 APHA should promote legislation that will enhance and expand insurance coverage that includes  
8 physical, mental and oral health benefits and promotes prevention. (APHA Policy #20007)

9 Through public statements and legislative advocacy, APHA should support and promote the  
10 need for a strong infrastructure for children, youth and families that include:

11 Increased investments in basic and intervention research in child health and development.

12 Resources, authority and accountability for integration of services and information for  
13 children and their families at the local, state, and federal levels.

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