

SPECIAL FEATURES

This section provides information on factors associated with child health and well-being which can impact children and adolescents across the life course. Topics include adverse childhood experiences, flourishing and resiliency among youth and adolescents, and mortality

and nonfatal injury. Additional information is provided on a wide range of federal policies and programs that support women's and children's health throughout the lifespan.



CHILD MORTALITY

The death of a child is a tragedy for family and friends and a loss to the community. Along with the direct impact of a child's death to a family, the child mortality rate in a community can be an important indicator for researchers or policymakers.¹ A high rate can point to underlying problems, such as poor access to health care, violent neighborhoods, high levels of risk-taking behaviors, or inadequate child supervision.² It can also point to inequities, for example, in access to behavioral health services, safe places to play, or exposure to environmental toxins.

Since 1999, the overall mortality rate for children aged 1–19 years declined by more than 25 percent to a low of 25.7 per 100,000 in 2011 (figure 1). The decline was fairly uniform, ranging from 23 to 30 percent across age groups.

According to 2011 data, racial and ethnic disparities persisted in mortality among children. Mortality rates were highest for non-Hispanic American Indian/Alaska Native (47.6 per 100,000) and non-Hispanic Black (37.3 per 100,000) children, while the rates for Hispanic (21.1 per 100,000) and non-Hispanic Asian/Pacific Islander (13.4 per 100,000) children were lowest (figure 2).

According to 2011 data, the “All Cause” mortality rate for children aged 1–9 years was 18.3 per 100,000. Most deaths to children in that age group (10.8 per 100,000) were classified as noninjury (i.e., natural causes) followed by unintentional injury (5.9 per 100,000), homicide (1.5 per 100,000), and deaths of undetermined nature (0.2 per 100,000). For adolescents aged 10–19 years, the “All Cause” mortality rate was 75 percent greater (32.0 per 100,000) than that of

children 1–9 years of age. Most of the difference could be attributed to the higher mortality rates among 15- to 19-year-old males (68.5 per 100,000) resulting from higher rates of unintentional injury (27.4 per 100,000), homicide (13.0 per 100,000), and suicide (12.9 per 100,000) relative to younger males. The mortality rates for females in all age groups were lower than the rates for males.

Leading causes of death due specifically to intentional and unintentional injury varied by age group. Drowning, homicide, and motor vehicle accidents were predominant in the 1- to 9-year-olds, though their rank order frequency was different for 1- to 4-year-olds (drowning, homicide, and motor vehicle traffic accident) compared to 5- to 9-year-olds (motor vehicle traffic accident, homicide, and drowning). Motor vehicle traffic accidents, suicide, and homicide were the highest ranked leading causes of deaths due to injury for adolescents aged 10–19 years; however, the rates were higher for 15- to 19-year-olds (12.9, 8.3, and 7.8 per 100,000, respectively) compared to 10- to 14-year-olds (2.1, 1.4, and 0.7 per 100,000, respectively).

General societal improvements, advances in medical care, and the introduction of Medicaid have been cited as factors in the long-term decline in child mortality.³ Despite these advances, many states have disproportionately high child and adolescent mortality, and rates among some racial and ethnic groups fall far short of the *Healthy People 2020* goals.⁴ Continued research on mechanisms underlying racial and ethnic disparities and expansion of child fatality review to inform state and local prevention strategies have been suggested.^{5,6}

Figure 1. Mortality Among Children Aged 1–19 Years, by Year and Age, 1999–2011

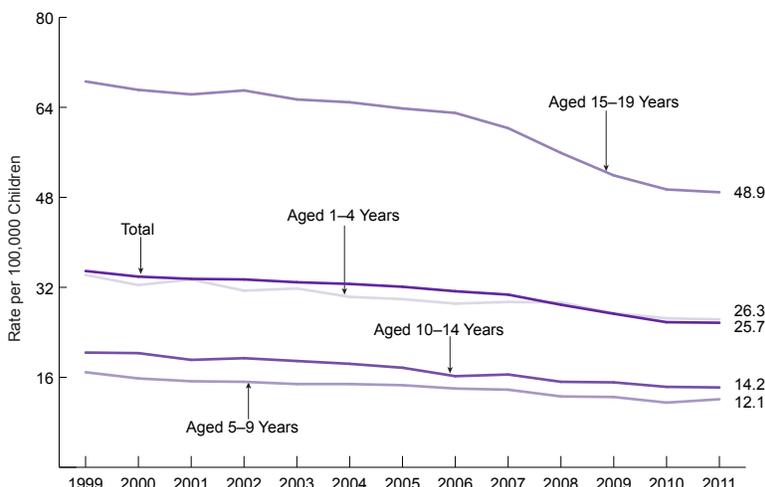
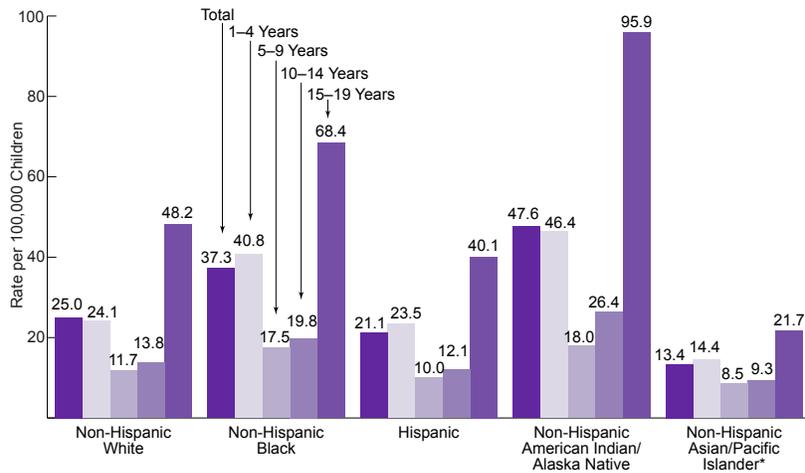


Figure 2. Mortality Among Children Aged 1–19 Years, by Age and Race/Ethnicity, 2011



*Separate estimates for Asians, Native Hawaiians, and other Pacific Islanders were not available.

Data Sources

Figure 1 and 2. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying cause of death 1999–2011. CDC WONDER Online Database, released 2014. Data are from the Multiple Cause of Death Files, 1999–2011.

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NONFATAL INJURY

Each year, millions of children are injured and live with the consequences of those injuries. For some children, injury causes temporary pain and functional limitation; for others, injury can lead to permanent disability, traumatic stress, depression, chronic pain, and a decreased ability to perform age-appropriate activities.¹ In addition, family members must often care for the injured child, which can cause stress, time away from work, and lost income.² Communities, states, and the Nation feel the economic burden of child injuries, including medical care for the injured child and lost productivity for caregivers.³

The U.S. nonfatal injury rate among children aged 0–19 years was 11,548 per 100,000 children in 2012. While injuries were higher among children aged 0–4 years compared to 5- to 9-year-olds (12,280 and 9,087 per 100,000, respectively), those aged 15–19 years had the highest nonfatal injury rates (13,579 per 100,000; figure 1). In all age groups, rates of injuries were higher for males than for females.

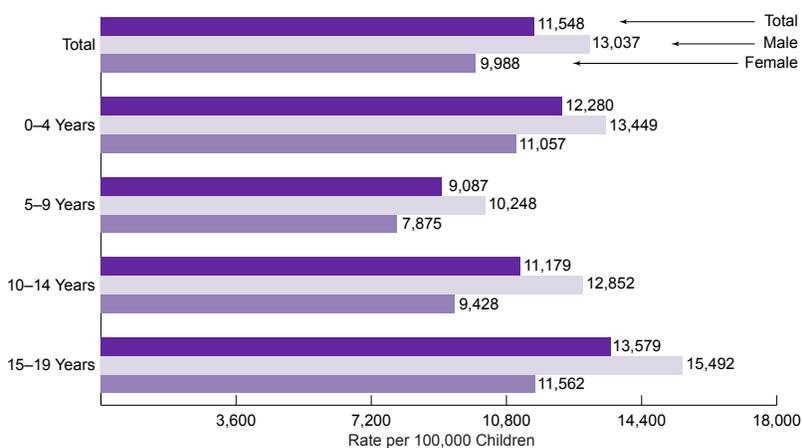
In general, nonfatal injuries trended downward for all age groups from approximately 2001 to 2007 (figure 2). After 2009, however, overall rates began trending upward. A particularly pronounced upward trend is noted for 0- to 4-year-olds beginning in 2007–2008. Although overall a 10 percent decrease in nonfatal injuries occurred between 2001 and 2012 for children: 3 percent for those aged 0–4 years, 14 percent for children aged 5–9, 13 percent for 10- to 14-year-olds, and 10 percent for 15- to 19-year-olds.

Falls were the leading cause of nonfatal injury among 0- to 4-year-

olds (43.7 percent) and 5- to 9-year-olds (36.7 percent), followed by being struck by or against an object (17.0 and 23.0 percent, respectively). For children aged 10–14 years, the most frequent causes of nonfatal injuries were also falls and being struck by or against an object (26.0 and 26.5 percent, respectively), followed by overexertion (13.8 percent). Among 15- to 19-year-olds, being struck by or against an object was ranked highest (20.8 percent), followed by falls (15.7 percent) and overexertion (13.3 percent).

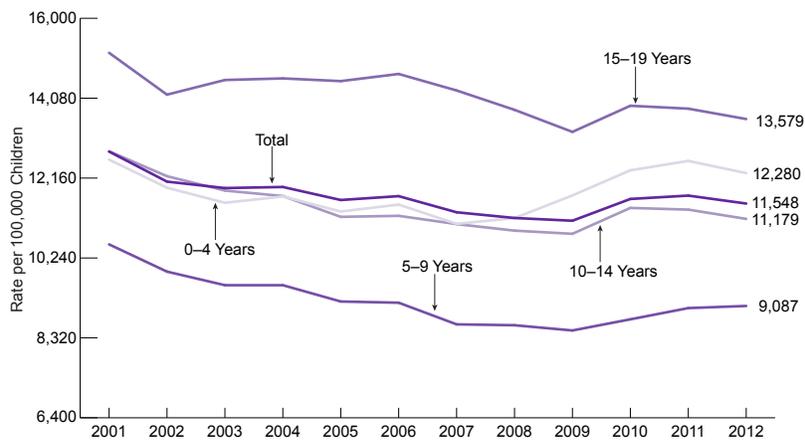
In 2012, more than 60 stakeholders and the Centers for Disease Control and Prevention collaborated to produce a National Action Plan for Child Injury Prevention. The focus of the group was to increase awareness of child injury, highlight prevention solutions through stakeholder action, and mobilize a coordinated national effort to reduce child injury. The plan is structured across six domains relevant to child injury prevention, each containing goals and specific actions: data and surveillance for planning, implementing, and evaluating injury prevention efforts; research on gaps and priorities in risk factor identification, interventions, program evaluation, and dissemination strategies; communications or messaging to promote prevention; education and training toward behavior change conducive to preventing injuries; health systems and health care for clinical and community preventive services; and policy that includes laws, regulations, incentives, administrative actions, and voluntary practices that enable safer environments and decisionmaking.⁴

Figure 1. Nonfatal Injury* Among Children Aged 0–19 Years, by Age and Sex, 2012



*Nonfatal injuries (all intents, all causes) resulting in an emergency department visit.

Figure 2. Rates of Nonfatal Injury* per 100,000 Among Children Aged 0–19 Years, by Year and Age, 2001–2012



*Nonfatal injuries (all intents, all causes) resulting in an emergency department visit.

Data Sources

Figure 1 and 2. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention & Control. National Electronic Injury Surveillance System—All Injury Program.

Endnotes

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ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs), such as living with someone who had problems with drugs or alcohol or witnessing violence in the home, can have significant effects on long-term health and well-being.¹ Early exposure to these types of life events has been linked to a wide range of chronic health conditions and health risk behaviors later in life.² The National Survey of Children's Health (NSCH) asks parents and caregivers about children's exposure to nine such experiences, including

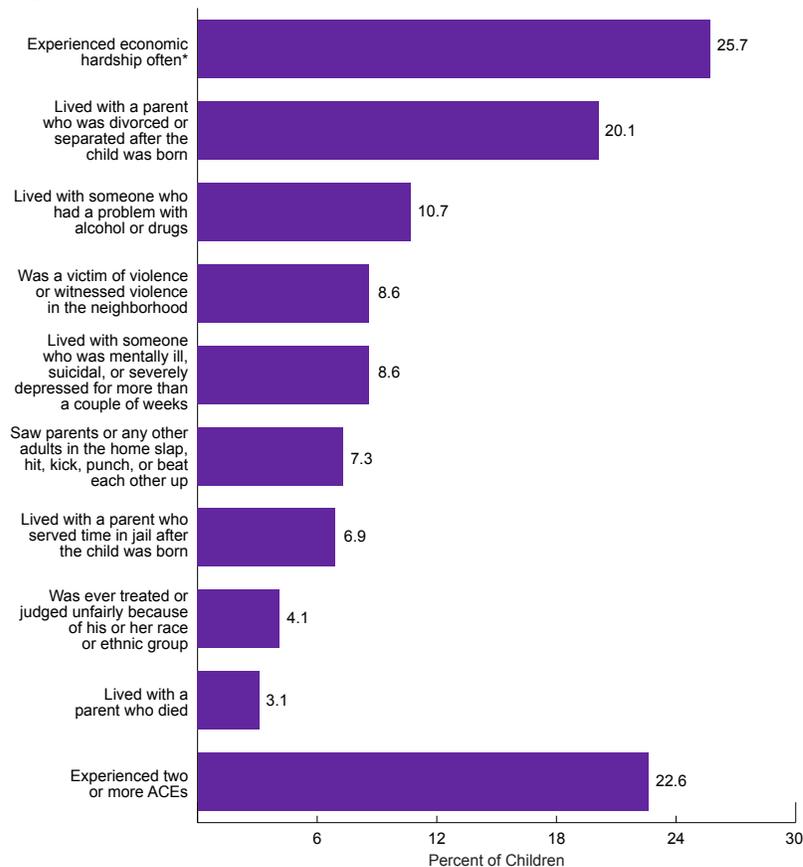
- Economic hardship (defined as living in a household that often had difficulty affording basics like housing or food);
- Living with a parent who was divorced or separated since the child's birth;
- Living with a parent who died;
- Living with a parent who served time in jail after the child was born;
- Witnessing intimate partner violence;
- Witnessing or was the victim of violence in their neighborhood;

- Living with someone who was mentally ill, suicidal, or severely depressed for more than a couple of weeks;
- Living with someone who had a problem with alcohol or drugs; and
- Having been discriminated against because of race/ethnicity.

In 2011–2012, nearly one-quarter (22.6 percent) of children aged 0–17 were reported to have experienced two or more of these nine ACEs. Economic hardship was the most commonly reported ACE (25.7 percent), followed by living with a parent who was divorced or separated after the child's birth (20.1 percent), living with someone who had a substance use or abuse problem (10.7 percent), and being a victim of or witness to neighborhood violence and living with someone who was mentally ill or suicidal for more than a couple of weeks (both 8.6 percent; figure 1).

Exposure to ACEs among children varied by sociodemographic characteristics, including race and ethnicity, parental education, and poverty. The proportion of children who had experienced two or more

Figure 1. Adverse Childhood Experiences (ACEs) Among Children Aged 0–17 Years, 2011–2012



*Reported that it was somewhat or very often hard to get by on the family's income; i.e., it was hard to cover the basics like food or housing.

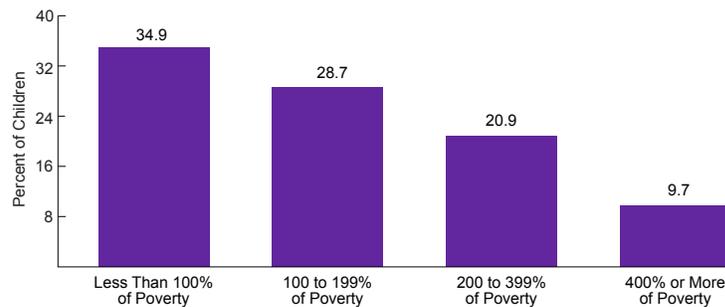
ACEs was highest among non-Hispanic American Indian/Alaska Native children, of whom two-fifths (40.3 percent) had experienced two or more of these nine life events; followed by non-Hispanic Black children and non-Hispanic children of multiple races, of whom approximately one-third had experienced such events (31.1 and 32.7 percent, respectively). About one-fifth of non-Hispanic Whites, Hispanics, and non-Hispanic Native Hawaiians/other Pacific Islanders reported experiencing two or more ACEs. Only 5.3 percent of non-Hispanic Asian children had experienced two or more ACEs since birth.

Exposure to two or more ACEs was more common among children living in poor and nearly poor families as well as those living in households where neither parent had completed college. More than

one-third of children living in households with incomes less than 100 percent of poverty (34.9 percent) had experienced two or more ACEs since birth, compared to 28.7 percent of those in households with incomes of 100–199 percent of poverty (figure 2). Less than 10 percent of children living in households with incomes of 400 percent or more of poverty had experienced two or more of these life events.

Similarly, while approximately 30 percent of children living in households where neither parent had completed college were reported to have experienced two or more ACEs, 13.1 percent of those living in households where at least one parent had completed college were reported to have done so.

Figure 2. Children Aged 0–17 Years Experiencing Two or More ACEs, by Poverty Status,* 2011–2012



*Based on the U.S. Department of Health and Human Services poverty guidelines, poverty was \$23,050 for a family of four in 2012.

Data Sources

Figure 1 and 2. Health Resources and Services Administration, Maternal and Child Health Bureau; and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health. Analyzed by the Health Resources and Services Administration's Maternal and Child Health Bureau.

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FLOURISHING AND RESILIENCE

In addition to traditional measures of health status and risk factors, positive health indicators can be used to help create a more complete picture of child health and well-being.¹ The 2011–2012 National Survey of Children’s Health (NSCH) included several such items to contribute to a better understanding of whether U.S. children were “flourishing” or “thriving.” The concept of flourishing is comprised of multiple dimensions of physical health, mental and emotional health, caring, empathy, and resilience.² Two sets of flourishing items were included in the NSCH: one for children aged 6 months to 5 years and a separate set for children aged 6–17 years based on developmentally relevant milestones and experiences. Four questions were included for younger children focused on curiosity, resilience, attachment to caregivers, and positive affect.² For parents and caregivers of school-aged children, three items were asked that focused on curiosity, resilience, and self-regulation.²

In 2011–2012, the proportion of children who were reported by their parents and caregivers to usually or always exhibit all age-specific behaviors associated with flourishing varied by age group. Among children aged 6 months to 5 years, 73.2 percent were reported to usually or always exhibit all four flourishing behaviors, while less than half (47.7 percent) of school-aged children were reported to usually or always exhibit the three flourishing behaviors (figure 1).

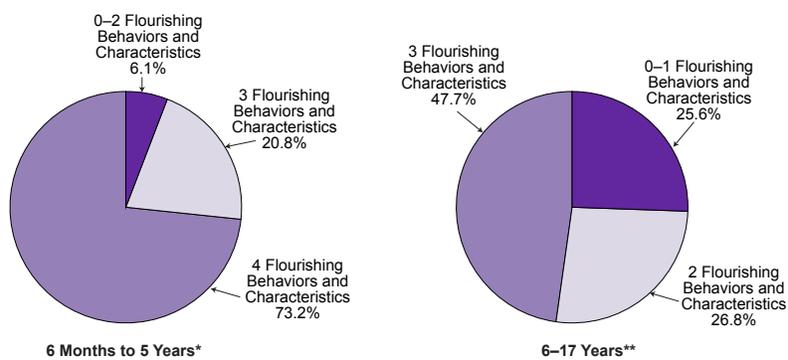
Among younger children, the most common behaviors reported were smiling and laughing a lot followed by showing interest and curiosity in new things; more than 80 percent of children aged 6 months to 5 years were reported to always exhibit these behaviors (figure 2).

About one-fifth of children in this age group were reported to never, rarely, or only sometimes bounce back quickly when things did not go their way.

Difficulties facing challenging situations were common among school-aged children, among whom more than one-third (35.3 percent) were reported to never, rarely, or only sometimes stay calm and in control when faced with a challenge. More than a third (34.8 percent) of this population also exhibited difficulties in finishing tasks and following through with what they said that they would do. The most commonly reported behavior among children in this age group was showing interest and curiosity in learning new things, with 85.0 percent reported to usually or always exhibit this characteristic.

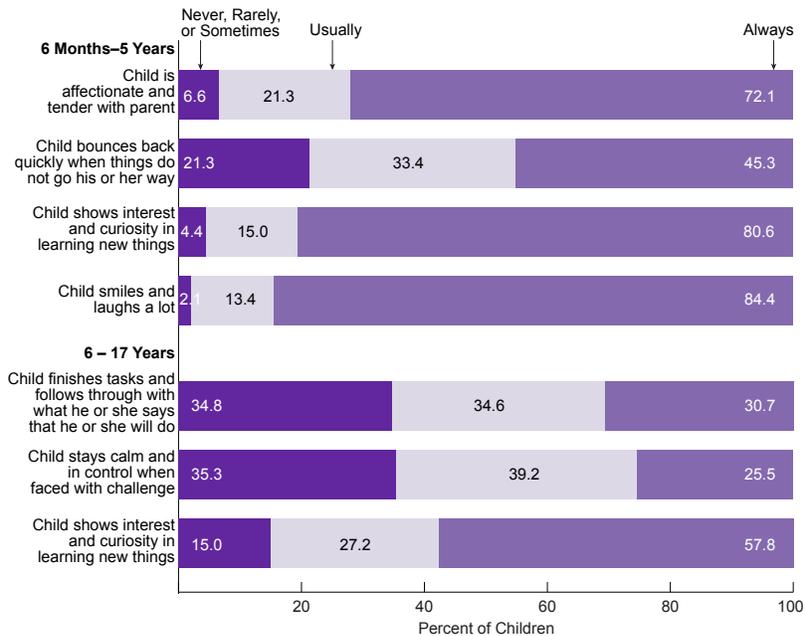
The prevalence of parent-reported flourishing behaviors and characteristics varied by both child and family characteristics. Greater proportions of children living in households with higher incomes and greater parental educational attainment were reported to usually or always exhibit all age-relevant behaviors and characteristics. For example, among children aged 6–17 years, 37.6 percent of those living in a household where neither parent had completed high school usually or always exhibited all three related behaviors compared to 54.9 percent among those living in a household where at least one parent or caregiver had completed college. Among children of all ages, girls were more likely than boys to be reported as meeting all age-specific measures of flourishing: 75.1 versus 71.3 percent, respectively, among younger children and 51.4 versus 44.1 percent, respectively, among school-aged children.

Figure 1. Overall Flourishing Behaviors and Characteristics Among Children Aged 6 months to 17 years, by Age, 2011–2012



*Parent or caregiver reported that the child usually or always exhibited: being affectionate and tender with the parent or caregiver, bouncing back quickly when things did not go their way, showing interest and curiosity in learning new things, and smiling and laughing a lot. **Parent or caregiver reported that the child usually or always exhibited: finishing tasks and following through, staying calm when faced with a challenge, and showing interest and curiosity in learning new things.

Figure 2. Detailed Flourishing Behaviors and Characteristics Among Children Aged 6 Months to 17 Years, by Age, 2011–2012



Data Sources

Figure 1 and 2. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children’s Health, 2011–2012.

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AFFORDABLE CARE ACT

The Affordable Care Act, enacted on March 23, 2010, contains provisions to expand access to health insurance coverage, control health care costs, and improve health care quality for U.S. citizens and legal residents.¹ These comprehensive insurance reforms were implemented with the goal of all Americans having access to affordable health insurance options.

For children, a key provision of the Affordable Care Act is the extension of dependent coverage, allowing them to remain on their parents' insurance through age 26.² In 2011, an estimated 3.1 million young adults gained health insurance coverage as a result of this law.³ The Affordable Care Act also prevents health insurance plans from denying coverage for children aged 19 years and younger with preexisting medical conditions. In 2008, approximately 24 percent of children had a preexisting health condition that would prevent them from receiving coverage without the health reform law.⁴

The Affordable Care Act includes coverage without family co-pays for preventive health services for children (table 1).⁵ For example, preventive services for infants include screening for hearing, development, sickle cell disease, phenylketonuria, and several other health

conditions. These services are particularly important, as early detection of medical conditions during infancy can help prevent long-term disability and improve children's health and well-being. In 2007, before the enactment of the Affordable Care Act, an estimated 80 percent of children aged 10–47 months were not administered a screening test for developmental delays.⁷ In addition, 50 percent of newborns who did not pass hearing screenings did not receive further testing for the diagnosis of hearing loss between 2009 and 2010.⁸

Preventive services that are covered for adolescents include screening for sexually transmitted infections, obesity screening and counseling, immunizations, and alcohol and drug use assessments. These services are especially important for lessening the potential for adverse consequences from risky behaviors during adolescence. Before the enactment of the Affordable Care Act, more than half of sexually active females aged 15–21 years had not been screened for chlamydia between 2006 and 2010.⁸ In addition, tobacco use was not documented for 31 percent of outpatient visits among young adults aged 11–21 years during the 6-year period from 2004 to 2010.⁸

Table 1. Covered Preventive Services for Children Under the Affordable Care Act

Alcohol and drug use assessments for adolescents
Autism screening for children at 18 and 24 months
Behavioral assessments for children of all ages
Blood pressure screening for children
Cervical dysplasia screening for sexually active females
Congenital hypothyroidism screening for newborns
Depression screening for adolescents
Developmental screening for children under age 3 and surveillance throughout childhood
Dyslipidemia screening for children at higher risk of lipid disorders
Fluoride chemoprevention supplements for children without fluoride in their water source
Gonorrhea preventive medication for the eyes of all newborns
Hearing screening for all newborns
Height, weight, and body mass index measurements for children
Hematocrit or hemoglobin screening for children
Hemoglobinopathies or sickle cell screening for newborns
HIV screening for adolescents at higher risk
Immunization vaccines for children from birth to age 18
Iron supplements for children aged 6–12 months at risk for anemia
Lead screening for children at risk of exposure
Medical history for all children throughout development
Obesity screening and counseling
Oral health risk assessment for young children
Phenylketonuria screening for this genetic disorder in newborns
Sexually transmitted infection prevention counseling and screening for adolescents at higher risk
Tuberculin testing for children at higher risk of tuberculosis
Vision screening for all children

Data Sources

Table 1. U.S. Department of Health and Human Services. Preventive Services Covered Under the Affordable Care Act. Available at: <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>. Accessed October 6, 2014.

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FEDERAL PROGRAMS TO PROMOTE CHILD HEALTH

The U.S. Department of Health and Human Services' (HHS) **Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB)** works to improve the physical and mental health, safety, and well-being of the maternal and child population, which includes all of the nation's women, infants, children, adolescents, and their families through a variety of programs.¹

Enacted in 1935, the **Title V Maternal and Child Health Block Grant Program** is the Nation's oldest federal-state partnership. State maternal and child health agencies apply for and receive formula grants each year that support programs designed to improve the health of women, infants, children and youth through population-based public health and preventive health care services. Some goals of the Title V program include ensuring access to quality care, especially for those households with limited incomes or limited care availability; increasing the number of children receiving health assessments and follow-up diagnostic and treatment services; providing and ensuring access to preventive and child care services and rehabilitative services for certain children; and implementing family-centered, community-based systems of coordinated care for children with special health care needs. A total of 59 states and jurisdictions receive Title V Maternal and Child Health Block Grant funding administered by MCHB. In fiscal year 2013, Title V programs served nearly 42 million individuals, including 2.3 million pregnant women, 4.0 million infants, 27.6 million children, and 2.7 million children with special health care needs.^{2,3}

The **Healthy Start Program**, also administered by MCHB, works to reduce the rate of infant mortality and improve perinatal outcomes through grants to communities with high infant mortality rates. In 2013, 105 Healthy Start projects were providing services in 39 states, the District of Columbia, and Puerto Rico, serving 196 different communities. These projects provide core services: direct outreach and client recruitment, health education, case management, depression screening and referral, and services between pregnancies.⁴ The life course perspective posits that birth outcomes can have long-term impacts on a child's health. Healthy Start aims to improve birth outcomes and thereby reduce the likelihood of adverse childhood health outcomes. Adverse consequences of being born preterm or with low birth weight include developmental problems, poorer health and social/emotional functioning throughout young adulthood, poorer educational achievement, lower college attendance, and higher incidence of health issues in adulthood such as high blood pressure and respiratory disorders.⁵⁻⁸

HRSA's **Maternal, Infant, and Early Childhood Home Visiting Program** facilitates collaboration and partnership at the federal, state, and community levels to improve health and developmental outcomes for at-risk children through evidence-based home visiting programs. The program provides grants to support programs to improve maternal and newborn health, promote school readiness and achievement, prevent family violence and child injury, and develop family economic self-sufficiency. In 2013, HRSA awarded \$109.5 million to the 52 eligible states and territories. In addition, approximately \$69.6 million was awarded to 13 states to expand existing programs.⁹ There is also a **Tribal Maternal, Infant, and Early Childhood Home Visiting program** for American Indian and Alaska Native communities.¹⁰

The **Maternal, Infant, and Early Childhood Home Visiting Program** is part of a portfolio of early learning initiatives that work together to support access to high-quality early education for all children. These initiatives focus on the early years in a child's life, since research has shown that the early years are a window of opportunity to develop a child's potential and shape academic, social, and cognitive skills that determine a child's success in school and life. This agenda includes the **Preschool for All** initiative to improve quality and expand access to preschool; the **Child Care Development Fund** initiative to subsidize the cost of child care for low-income households and increase the availability and quality of that care; **Race to the Top: Early Learning Challenge**, which challenges states to compete and deliver better training and education for early educators; and the reformation and expansion of **Head Start**. Through the American Recovery and Reinvestment Act, \$2.1 billion is invested in Head Start and Early Head Start. Efforts are underway to raise Head Start standards, promote accountability, focus on school readiness, and utilize a process to ensure only the highest quality programs receive Head Start grants.¹¹

Text messaging is a means of improving health knowledge, behaviors, and clinical outcomes, especially among hard-to-reach populations. **Text4Baby** is a free mobile health education service that provides evidence-based health messages regarding issues such as breastfeeding, immunizations, safe sleep, and nutrition. These text messages are intended for pregnant mothers and parents and caregivers of infants less than 1 year of age. Text4baby is a campaign of the National Healthy Mothers, Healthy Babies Coalition. **TXT4Tots** distributes short, evidence-based messages regarding nutrition and physical activity. These text messages are intended for parents and caregivers of children aged 1-5 years. Content for messages is derived from the American Academy of Pediatrics (AAP) Bright Futures recommendations. A 2012 environmental scan found that research has shown that health text messaging programs can bring about behavior change and improve treatment compliance to improve outcomes.¹²

Injuries are the leading public health threat facing those aged 1-44 years. More children die from injuries and violence than all diseases combined. Injuries are also the leading cause of disability and medical spending for children. Funded by MCHB, the **Children's Safety Network** aids states in planning, implementing, strengthening, and evaluating injury and violence prevention programs. The **National Center for the Review and Prevention of Child Death** strengthens state capacity to perform Child Death Reviews (CDR), develops prevention-oriented recommendations, and translates those recommendations into local policies and programs. CDR is a community-based action process intended to guide communities in identifying and solving problems that contribute to poor child and adolescent health outcomes.¹³ The CDC supports the **Essentials for Childhood Framework**, with evidence-based strategies for communities to promote relationships and environments that help children grow up to be healthy and productive, as well as the national **Striving To Reduce Youth Violence Everywhere** (STRIVE) initiative which focuses on preventing youth violence before it starts.^{14,15}

HRSA's **Adolescent and Young Adult Health Program** provides information and resources to assist health professionals, program ad-

ministrators, and policymakers in the development of programs and policies at the community, state, and national levels that will help adolescents and young adults thrive. This program supports the **National Adolescent Health Information and Innovation Center**, which collects and disseminates relevant information on the health, safety, development, and social and economic well-being of school-aged children in transition to adolescence.¹⁶

HRSA's **Stop Bullying Now! (SBN!)** campaign serves children and adolescents. Bullying is intentionally aggressive behavior that involves an imbalance of power. It can take many forms, and studies show that 15–25 percent of U.S. students are bullied. Bullying can affect educational success and have social and emotional consequences. The SBN! campaign connects with its audience through the Web at <http://www.stopbullying.gov>. When SBN! began in 2001, only nine states had legislation regarding bullying; today 45 states have such legislation. The SBN! campaign has more than 80 active partners, and six federal departments are working together to coordinate bullying prevention activities.¹⁷

Part of **HHS, the Administration for Children & Families (ACF)** promotes the economic and social well-being of families, children, individuals, and communities.¹⁸ Programs for children include adolescent pregnancy prevention, adoption, child abuse and neglect prevention and intervention, child care, child and family services reviews, child support, child welfare, early childhood development, foster care, Head Start, and runaway and homeless youth and unaccompanied children's services.¹⁹ The **ACF Office of Head Start** administers the Head Start program, which aims to improve school readiness of young children from low-income households through local community agencies. Head Start and **Early Head Start** programs provide comprehensive services to support emotional, social, and mental development for children aged 0–5 years. The program provides education, health, nutrition, social, and other services. Programs also support positive parent-child relationships and family well-being. Head Start services are delivered by 1,700 public and private nonprofit and for-profit agencies. More than 80 percent of the children served by Head Start in 2013 were 3–4 years old. Early Head Start serves pregnant women, infants, and toddlers and is available to families until their child turns 3 years old. More than 1 million children are served by Head Start programs annually. In 2013, with a budget of \$7.6 billion, Head Start programs served 932,164 children and their families, and Early Head Start served 150,100 children.^{20,21}

The **HHS Centers for Medicare and Medicaid Services' (CMS) Children's Health Insurance Program (CHIP)** was enacted in 1997. This program provides health care coverage to children in households whose incomes are too high to qualify for Medicaid but who cannot afford private coverage. CHIP is administered by the states and funded by both the federal government and states.²² From 1997 to 2012, the rate of uninsured children was halved, from 14 to 7 percent.²³ For 2013, \$19.1 billion was set aside for CHIP allotments, and 8.5 million children received insurance through CHIP at some time during the year.²⁴ The Affordable Care Act of 2010 extends CHIP and enhances federal funding for the program by maintaining CHIP eligibility standards through 2019 and extending funding through October 1, 2015. The CHIP federal matching rate will be increased by 23 percent,

resulting in an average federal matching rate for CHIP of 93 percent. The Affordable Care Act provided \$40 million to continue efforts to promote Medicaid and CHIP enrollment.²²

Launched by the First Lady, the **Let's Move!** program is a comprehensive initiative intended to address the challenge of childhood obesity within a generation. The program involves parents, elected officials, schools, health care professionals, community-based organizations, and private-sector companies. Components of the program include providing information for parents to foster environments that support healthy choices; providing healthier foods in schools; ensuring that all families have access to healthy, affordable food; and helping kids become more physically active.²⁵ As part of this effort, the President established the first-ever White House Task Force on Childhood Obesity to develop and implement an interagency plan to end childhood obesity.²⁵ The Let's Move! program is supported by the U.S. Department of Education, the U.S. Department of the Interior, the U.S. Department of Agriculture (USDA), HHS, the White House, and numerous other organizations.^{26,27}

The **USDA Food and Nutrition Service** administers the **Supplemental Nutrition Assistance Program (SNAP)**, which helped more than 47 million low-income Americans put food on the table in 2013. SNAP primarily serves vulnerable populations, especially households with children, elders, and disabled members. About 44 percent of all SNAP participants are children.^{28,29} Nutrition educators teach SNAP participants the importance of a healthy diet and how to prepare healthy foods and make healthy choices.³⁰ In 2013, the SNAP budget was \$79.9 billion, resulting in an average monthly benefit of \$133.07 per person.²⁹

The **USDA Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age 5 who are at risk for poor nutrition. Foods provided through the WIC program are designed to supplement recipients' diets with specific nutrients. Some WIC foods include iron-fortified adult cereal, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, and peanut butter. WIC served approximately 4.6 million children, 2 million infants, and 2 million women in 2013.³¹

The Food and Nutrition Service administers other programs that provide healthy food to children, including the **National School Lunch Program**, the **School Breakfast Program**, the **Child and Adult Care Food Program**, the **Summer Food Service Program**, the **Fresh Fruit and Vegetable Program**, and the **Special Milk Program**. These programs are administered by state agencies and help fight hunger and obesity by reimbursing organizations such as schools, child care centers, and afterschool programs for providing healthy meals to children.³² The National School Lunch Program operates in about 100,000 schools and child care institutions. It provided nutritionally balanced low-cost or free lunches to about 30 million children each school day in 2012.³³ The School Breakfast Program also operates in schools and child care institutions. Breakfasts served meet federal requirements, and eligible children are offered free or reduced-price breakfasts. In 2012, nearly 13 million children participated daily; of those, more than 10 million received their meals at a reduced price or for free.³⁴

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