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On Behalf of the American Academy of Pediatrics

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"Perspectives on Child Nutrition Reauthorization"

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Chairman Roberts and Ranking Member Stabenow, thank you for the opportunity to testify here today. I am Dr. Olanrewaju Falusi, a pediatrician at Children's National Health System here in D.C. and Past President of the DC Chapter of the American Academy of Pediatrics, or AAP. On behalf of the AAP, a non-profit professional organization of 67,000 primary care and subspecialty pediatricians, thank you for inviting me to be here today.

As a practicing pediatrician, I see the benefits of consistent access to nutritious foods on the health and development of children. In my practice, I have been screening for food insecurity in my clinic for several years, and a significant percentage of families that I see are experiencing food insecurity. I see children whose parents work 2 or 3 jobs and still struggle to put food on the table. I see families who live in neighborhoods that are food deserts, where they can get fast food on any block but have to take 2 buses to get to the nearest grocery store. And I recently met a mom who just the week before had left an abusive relationship, was staying on a friend's couch with her child, and did not have access to cook nutritious and balanced meals.

Here at Children's National Health System, we are very fortunate to have Special Supplemental Nutrition Program for Women, Infants, and Children – or WIC – clinics co-located with our medical clinics. I can walk a family down the hall to our WIC clinic rather than having them take another day off work to go to a separate site; co-location allows for collaboration and communication between our health care providers and WIC staff; we can be sure that we have consistent messaging around healthy food and beverage consumption; and particularly for new moms, the breastfeeding promotion and lactation support can help a mom reach her breastfeeding goals. The benefits of having a co-located WIC clinic cannot be overstated. In fact, I credit WIC for the health of my patient – who I'll call David – whose developmental delays at 3 years of age made it very difficult for him to chew solid foods. He was really struggling, underweight, with poor developmental skills, when I first met him. We got him connected into regular visits with our co-located WIC clinic to provide him with a special high-calorie milk and balanced diet with fresh fruits and vegetables, which took an enormous stress off his mother. She can now be sure that her son is not going to school hungry, and he is now able to focus on learning fine motor and cognitive skills. I am proud to say that now he is thriving and has reached a healthy weight.

On behalf of David and all of my patients, thank you for your support of critical federal child nutrition programs in the United States, including WIC, the National School Lunch Program (NSLP) and School Breakfast Program (SBP), the Child and Adult Care Food Program (CACFP), and the Summer Food Service Program (SFSP). All of these programs and others are effective in reducing food insecurity and promoting access to healthy, nutritious foods among children and their families.

Health Effects of Food Insecurity

Today, 1 in 6 children live in poverty, and nearly half of all children live in low-income households.[i] Households with children are nearly twice as likely to be food insecure as households without children. Decades of research has documented the adverse health effects of food insecurity on the health, growth, development, and educational outcomes of children from infancy through adolescence. Infants and toddlers living in food-insecure families are significantly more likely to be in fair or poor health, be hospitalized and have longer hospital stays, suffer from iron-deficiency anemia and common illnesses, and be at-risk for developmental delays compared to young children living in food-secure families.[ii,iii,iv,v,vi] Among school-aged children, food insecurity is associated with lower math and reading scores, hyperactivity and absenteeism and tardiness at school.[vii,viii,ix,x] Some longitudinal studies have found food insecurity increases the risk of obesity or being overweight among children.[xi,xii] Food insecurity in childhood not only affects children's short-term health, development and learning, but has also been associated with long-term health consequences including an increased risk of chronic conditions such as heart disease and obesity in adulthood.[xiii]

The inability to consistently provide food creates stress in families, contributing to depression, anxiety, and toxic stress, which make optimal parenting difficult regardless of social class[xiv]. Toxic stress, a result of prolonged exposure to adverse childhood experiences in the absence of caring, stable relationships with adults, can affect the physical, mental, and economic well-being of children well into adulthood.[xv] The inability to provide food for yourself or your children creates stress in families, and contributes to depression, anxiety, and other emotional impacts of poverty.

Like poverty, food insecurity is a dynamic, intensely complex issue. For many families, seemingly small changes to income, expenses, or access to federal or state assistance programs may instantly reduce the ability to purchase healthy food and result in increased vulnerability to food insecurity.

Federal nutrition programs are a critical protection against the adverse health effects of food insecurity in children.

Early Nutrition as a Critical Factor in Childhood Development and Adult Health

Maternal prenatal nutrition and the child's nutrition in the first 2 years of life (1,000 days) are crucial factors in a child's neurodevelopment and lifelong mental health[xvi]. Child and adult health risks, including obesity, hypertension, and diabetes, may be programmed by nutritional status during this period[xvii]. Optimal overall brain development in the prenatal period and early years of life depends on providing sufficient quantities of key micronutrients (e.g. iron and folate) during specific sensitive time periods. These periods coincide with the times when

specific brain regions are developing most rapidly and have their highest nutrient requirements.[xviii]

Important primary structures and processes that support fundamental behaviors and provide scaffolds for later-developing structures form during the first 1,000 days[xix]. These structures and processes include the sensory systems (especially auditory and visual), the hippocampus (declarative learning and memory), myelination (speed of processing), and the monoamine neurotransmitter systems (affect and reward). Even the prefrontal cortex (planning, attention, inhibition, multitasking) and brain circuits involved in social development have the onset of rapid development in the first 1,000 days. Although neurodevelopment continues throughout the life of a healthy person, by age 2 years the brain has undergone tremendous restructuring. Many of the developmental changes expected to occur during this period will not be able to occur in later life. Failure to provide key nutrients during this critical period of brain development may result in lifelong deficits in brain function despite subsequent nutrient repletion.[xx]

Micronutrients such as iron and folate affect brain development and are commonly deficient in pregnant women and young children in the U.S. These deficiencies can lead to delays in attention and motor development, poor short-term memory, and lower IQ scores.[xxi] Restricted diets because of poverty or neglect may reduce infant intake of many key factors in normal neurodevelopment, including zinc, protein, and iron.[xxii]

Macronutrient (protein, fat, glucose) sufficiency is essential for normal brain development. Early macronutrient undernutrition is associated with lower IQ scores, reduced school success, and more behavioral dysregulation.[xxiii] Intervention in early nutritional deficiency can be effective, and the full effects may be felt for many years. In addition to generalized macronutrient undernutrition, deficiencies of individual nutrients may have a substantial effect on neurodevelopment.[xxiv] Prenatal and early infancy iron deficiency is associated with long-term neurobehavioral damage that may not be reversible, even with iron treatment.[xxv] Severe maternal iron deficiency, limited maternal-fetal iron transport (associated, for example, with cigarette smoking or maternal hypertension), or conditions that increase fetal iron demand (such as maternal diabetes) may lead to newborn iron deficiency and associated long-term cognitive deficits.[xxvi] The earlier the timing of the deficiency, the more likely long-term effects will occur, probably because structure and regulation of genes involved in neural plasticity have been significantly altered.[xxvii]

Data from animal and human studies indicate that two experiences relatively common in pregnancy – an unhealthy maternal diet and psychosocial distress – significantly affect children's future neurodevelopment. Prenatal exposure to maternal distress and poor nutrient status are associated with decrements in neurocognitive development, particularly in relation to memory and learning, and specifically with regard to variation in the structural, functional, and neurochemical aspects of the hippocampus.[xxviii]

Pregnancy through the first 2 years postpartum may be seen as a time of tremendous opportunity for neurodevelopment and a time of great vulnerability. This time period is one of rapid physical, cognitive, emotional and social development and because of this, it can set the stage for a lifetime of good health and success in learning and relationships, or it can be a time when physical, mental and social health and learning are compromised. In infants and children, toxic stress, emotional deprivation, and infection or inflammation have been shown to be associated with less optimal brain development, and a deficient diet for the child can worsen this. The effects of early adverse experiences, like food insecurity, may be a lifetime of medical and psychosocial problems, lost academic achievement and productivity, and possible effects on the next generation. These long-term issues are the true cost to society, a cost that exceeds that of preventing them, emphasizing the importance of recognizing the developmental origins of adult health and disease[xxix].

Effective Programs and Strategies

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

One of the most effective investments Congress can make during the prenatal to school-aged period is to support the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). I thank the committee for its strong, bipartisan support for WIC over the past 4 decades.

WIC provides nutritious foods, nutrition education, breastfeeding support, and referrals to health care and social services for millions of low-income women, their infants, and young children who are determined to be nutritionally at-risk. As such, it is the most important program providing nutritional support in the first 1,000 days. In providing this nutrition support and linkages with health care, WIC builds good health and promotes resilience in families at risk, helping to mitigate the effects of toxic stress.

WIC helps give children a healthy start at life, and children who receive WIC have improved birth outcomes, increased rates of immunization, better access to health care through a medical home, and participation may help reduce childhood obesity. It is now well-documented that WIC is effective in improving birth outcomes and the health of infants, including reducing low birth weight births below 2500g.[xxx] WIC is particularly effective at improving birth outcomes in moms with inadequate prenatal care and who are particularly high risk cases.[xxxi] One study found that WIC helps eliminate socioeconomic disparities in birth outcomes. WIC is a crucial program in providing food and education to support neurodevelopment.

One of the hallmarks of any successful nutrition and health care intervention is its evidence and science base. WIC participants may not purchase just any foods. The WIC food packages are based on what nutrition science experts recommend are needed to meet the nutritional needs of pregnant and breastfeeding women and young children. Recent research found that science-

based changes made to the food package in 2009 may have helped to reverse the rapid increase in obesity prevalence among WIC participants observed before the food package change.[xxxiii] Participants purchased and consumed less fruit juice, refined grains, grain-based desserts, and sugar-sweetened beverages while increasing purchases and consumption of fruits, vegetables, and whole grains. This dietary pattern has been associated with less weight gain in both children and adults. These findings underscore the importance of ensuring that the nutrition content of federal programs is determined by nutrition scientists and medical professionals.

WIC has played an important role in promoting breastfeeding but more progress can be made. The AAP recommends exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant.[xxxiv] In addition to its nutritional benefits, breastfeeding protects against respiratory and gastrointestinal tract infections, ear infections, and may be linked to lower obesity rates in adolescence and adulthood. In order to support WIC participants to move closer to meeting AAP recommendations and national targets for breastfeeding, we recommend that the committee seek to find ways to promote breastfeeding in the WIC program including through an increase in the authorization for the successful breastfeeding peer counseling program within WIC to $180 million.

Despite the demonstrated positive impact of WIC, many eligible families fail to take advantage of the program. While reasons for this vary from family to family, barriers that families face to enroll and remain enrolled in the program should be eliminated. One such barrier that families cite is the need to travel to a WIC clinic to enroll in the program or receive nutrition education. WIC clinics can reach more eligible families if they are in locations where potential participants already go for other services or that are part of their normal routine.[xxxv] This can be accomplished by permanently co-locating a WIC clinic in a community health center or a hospital much like we have at Children's National Health System.

One study from a Vermont pilot project found that children who received services from a co-located clinic were more likely to be continuously enrolled in WIC during their first year of life and that parents were significantly more likely to receive advice about early nutrition practices from both their pediatrician and a WIC nutritionist.[xxxvii] Further, pediatric clinic staff had more positive views of coordination of WIC services and services in their practice after participating in the program. As coordination with WIC is often a concern of pediatricians, this result is quite positive. Another study found that compared with other infants, those who used co-located WIC sites either were closer to their age-appropriate weight or had higher immunization rates when recertified by WIC after their first birthday.

Co-location of WIC clinics with pediatric practices is a best practice. Pediatricians report that when WIC clinics are co-located with their practices, there is better coordination with the WIC program. This is important for bidirectional communication as well as reducing potentially duplicative tests. With co-location, physicians and WIC staff are better able to collaborate and

coordinate care and have found that physically integrating services allows them to serve WIC participants more effectively.

The AAP strongly supports giving states the option to reduce administrative barriers for families of infants and helping them stay connected to WIC by extending the recertification period from 12 months to 24 months. We believe this would have a meaningful impact on ensuring children continue to access the benefits of WIC after their first birthday. Additionally, we support extending WIC eligibility to age 6 in order to cover children who are neither age-eligible for school - and therefore school meals - nor eligible for WIC. We also strongly support maintaining or strengthening WIC eligibility through pregnant women and children's eligibility for other programs for low-income families such as Medicaid and SNAP. Any linkage that reduces barriers to access for this critical program is a worthwhile investment for the health and well-being of children.

Healthy School Foods

Good nutrition is essential to health, and good health is essential to effective learning. The National School Lunch program provides nutritionally-balanced, low-cost or free lunches to about 30 million children each school day. Roughly 14 million children receive breakfast in their school. Given the double burden of food insecurity and obesity facing our children, it is essential that the meals children receive in school are nutritionally sound and based on the best available nutrition science. Children typically consume up to half of their daily calories in school, and for some children, the only food they eat each day comes from the federal school meal programs.

Updated school lunch standards required under the 2010 *Healthy, Hunger-Free Kids Act (HHFKA)* ensure that children have access to healthy school meals with more servings of fruits, vegetables and whole grains and foods lower in sodium. Recent studies have found that children are now eating more fruits and vegetables and discarding less of their lunched under the healthier standards[xl][xli]. The U.S. Department of Agriculture, however, has recently made changes to the standards required under the HHFKA that could jeopardize this progress.

HHFKA provided for the first update to national standards for snack foods and beverages in schools since 1979. Through the updated Smart Snacks standards, we are setting up our children with the best possible chance at success by ensuring that they have healthy, nutritious food options. Ultimately, the HHFKA Smart Snacks standards improved children's nutrition and reduced intake of added sugars[xlii].

With one in five children living in a household where food is scarce, and nearly one in three children and adolescents overweight or obese, we must redouble our efforts to replace unhealthy, nutrient-poor foods in schools with healthy, nutritious options. That is a commitment we can and should take on: to continue offering nutritious school foods for

children. Anything less would jeopardize the tremendous progress made to date and would be a step back for child nutrition.

At the same time, we need to redouble our efforts to ensure that eligible but unenrolled children are participating in the program and not dissuaded by paperwork requirements, fear, or stigma. Innovative programs like breakfast in the classroom help reduce stigma and improve academic performance but funding for the School Breakfast Program has not kept pace with the need.

The Community Eligibility Provision (CEP), created by the HHFKA, allows schools in low income communities to serve free breakfast and lunch to all students without requiring their families to complete individual applications, thereby reducing stigma and making participation in the school meals programs easier for families. Importantly, it has reached more than 9.7 million children in more than 20,700 schools in the 2016-2017 school year, over half of all eligible schools. CEP has been absolutely critical to lessening the administrative burden on schools, increasing participation, and facilitating implementation of alternative breakfast service models. We urge Congress to protect and preserve CEP and the progress it has made in reducing burdens on schools, families, and child food insecurity.

Beyond the School Setting

Children need optimal nutrition year-round. Countless children go without access to food during out of school or child care time including mornings, evenings, weekends and especially the summer months. Pediatricians can tell almost immediately which children had adequate nutrition during the summer and which children did not when conducting back-to-school physical exams. Existing summer feeding programs are not able to meet the needs of food insecure children. In fact, only one in seven children who ate a free or reduced-price school lunch during the 2016-2017 school year participated in Summer Nutrition Programs in July 2017. Summer breakfast reaches even fewer children, despite its critical importance. In July 2017, summer breakfast reached just over half of children participating in summer lunch.

USDA's summer EBT pilots have proven successful in reducing food insecurity and improving nutrition among participating children during the summer. Evaluations of the pilot found that these projects reduced very low food security among children by one-third, and also improved the quality of their diets, relative to those that did not have access to it. Access to the summer EBT program and Summer Nutrition Programs should be expanded to allow for greater participation in these programs.

As noted previously, nutrition in early childhood is an essential foundation for healthy child growth and development; thus ensuring that young children have healthy, nutritious food where they live, learn, and play is critically important. More than 3 million children are served

by the Child and Adult Care Food Program (CACFP), which provides cash assistance to states to provide healthful food to children and adults in child and adult care institutions. Congress has a vital role to play in ensuring adequate funding to support high quality nutrition through CACFP, adding the provision of additional food to meet the nutrition needs of children in care for longer hours, increasing participation of family child care providers, and reducing administrative burdens and costs to participating in the program.

Consumption of Added Sugars by Children and Adolescents

Excess consumption of added sugars, especially from sugary drinks, contributes to the high prevalence of childhood and adolescent obesity, especially among children and adolescents who are socioeconomically vulnerable[xliii]. It also increases the risk for dental decay, cardiovascular disease, hypertension, dyslipidemia, insulin resistance, type 2 diabetes mellitus, fatty liver disease, and all-cause mortality. The 2015–2020 Dietary Guidelines for Americans recommend that added sugars contribute less than 10% of total calories consumed, yet U.S. children and adolescents report consuming 17% of their calories from added sugars, nearly half of which are from sugary drinks. Decreasing sugary drink consumption is of particular importance because sugary drinks are the leading source of added sugars in the U.S. diet, provide little to no nutritional value, are high in energy density, and do little to increase feelings of satiety. To protect child and adolescent health, federal nutrition assistance programs should aim to ensure access to healthful food and beverages and discourage consumption of sugary drinks.

Role of the Pediatrician

The pediatrician's office serves an important setting for conversations about food and health. Pediatricians see children and their families for 31 well-child visits during the first 21 years of life. Twenty of these visits occur in the first five years of a child's life, providing an opportunity to partner with families to establish healthy living habits. Pediatricians can play a crucial role in screening and identifying children at risk for food insecurity and connecting families with needed community resources.[xliv]

Good nutrition in pregnancy and childhood is a foundation for lifelong health. Just like we vaccinate to protect against illness, so too can we provide pregnant women and children with nutritional assistance and breastfeeding support to promote healthy development and protect against food insecurity and chronic disease. I urge the committee to put the nutritional needs of children first, from the prenatal months and onward. Our children's health simply cannot wait.

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