American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Testimony of Lee Savio Beers, MD, FAAP
President, American Academy of Pediatrics
On Behalf of the American Academy of Pediatrics

Before the U.S. Senate
Committee on Agriculture, Nutrition, & Forestry

"Child Nutrition Reauthorization: Healthy Meals and Healthy Futures"

March 25, 2021

Chairwoman Stabenow and Ranking Member Boozman, thank you for the opportunity to testify here today. I am Dr Lee Savio Beers, President of the American Academy of Pediatrics. I am a Professor of Pediatrics and the Medical Director for Community Health and Advocacy at Children's National Hospital. I am also the Founding Director of the DC Mental Health Access in Pediatrics program and Co-Director of the Early Childhood Innovation Network. In addition, I oversee our Child Health Advocacy Institute's Community Mental Health CORE, a public-private coalition that serves as a catalyst to elevate the standard of mental health care for every young person in Washington D.C. 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.

COVID-19 and Food Insecurity

As a practicing pediatrician, I regularly see the benefits of consistent access to nutritious foods on the health and development of children. In my practice, we have been screening for food insecurity for several years, and a significant percentage of families that I see experience food insecurity. Since the COVID-19 pandemic began sweeping through the country last March, food insecurity has remained persistently elevated at record levels. Early in the pandemic, my colleagues and I had to move quickly with innovative solutions when our patients were having a great deal of difficulty obtaining infant formula. This led to many families diluting formula, or feeding their babies regular milk, both things which can cause severe illness, or even be fatal. While those challenges improved after the first few months of the pandemic, we are still seeing too many families and children of all ages who consistently don't have enough food to make it through the week. Many of these parents cut back on their own meals and go hungry, so that they can make sure that their children have enough to eat.

Research from Northwestern University estimates that nationally, food insecurity has doubled overall and tripled among households with children.[i] Feeding America estimates that 45 million people (1 in 7), including 15 million children (1 in 5), may have experienced food insecurity in 2020 and that 42 million people (1 in 8), including 13 million children (1 in 6), may experience food insecurity in 2021.[ii] The rates of children not getting enough food are much higher than anything that's been recorded since the government began tracking food insecurity and five times higher than the rate in 2018.[iii] Further national research finds that more than one in three (37%) of adults report skipping meals or cutting back their portions to allow more food for their children during the public health emergency.[iv]

The District of Columbia's food insecurity trends reflect the national trends referenced above. Researchers at Northwestern University estimate that food insecurity rates in the District almost doubled between February and May 2020 from 10.6% to approximately 21.1%. In the first two weeks of collected data from April 23 to May 5, nearly half (44.5%) of households with children reported that they were not able to access or afford enough food that they wanted. Put simply, nearly one out of every three children and almost one in five residents in the District was food insecure in 2020.[v] I don't think I will ever forget -when I was a relatively young pediatrician practicing here in DC- a mother I knew well called me in panicked tears because her wallet had fallen out of her bag on the bus on her way to the grocery store. In her wallet was her last forty dollars for the month, which she needed to buy food to feed her triplets for the next ten days. She had no other money and didn't know how she was going to feed her children. As I scrambled with our social work team to find her resources for food, she called me back. She had been able to borrow $20 from a friend and found a large pack of frozen chicken on a really good sale at the store, which she thought would last them the week. She was again in tears, this time of

relief. I was so struck by the fact that she lived less than two miles from the US Capitol building and yet her ability to feed her family for the week was almost fully derailed by what to many of us would be an inconvenient but otherwise unremarkable mishap, and then restored by the generosity of a friend who also had little, and the luck of finding healthy food at a deep discount. And this was well before the pandemic.

Just this month, my colleague saw a family who newly screened positive for food insecurity. Prior to last year, both the mother and father had worked in low-wage jobs—it was tight but they were able to support their family. The mother was an office cleaner, and unfortunately lost her job several months into the pandemic. The family has young children who have been in full virtual learning, and no one else available to stay home to provide supervision - she has not been able to find another job that has hours which will allow her to supervise her children while her husband is at work. The family is eligible for school meals even during virtual learning, but they are not offered at a school within walking distance—the family does not have a car and are worried about their potential exposure to COVID on public transportation, particularly as the father is still working as a front-line essential worker and is at high risk himself for exposure. This is an all-too common patient story that I hear.

Significant racial disparities in food insecurity which existed before COVID-19 persist during the pandemic. Feeding America projects that 21% of Black individuals (1 in 5) may experience food insecurity in 2021, compared to 11% of white individuals (1 in 9).[vi] As with the food insecurity rates for the general population, the public health emergency disproportionately affected Black children and other children of color in the District. Among District households that reported some level of food insufficiency from April 23 to May 5, Black households were 13.5 times more likely to report that they sometimes did not have enough food to eat and nearly 11 times more likely to report that they often did not have enough food to eat compared to White households. Latinx households were 6.5 times more likely than White households to report that they sometimes did not have enough food to eat and more than four times more likely to report that they often did not have enough food to eat compared to White households. Asian households were 10.5 times more likely to report that they sometimes did not have enough food to eat compared to White households, although there were no differences for reporting that they often did not have enough food to eat.

These elevated rates of food insecurity will not vanish as soon as the COVID-19 vaccine is widely available and our lives begin to look a bit more normal. Food insecurity in the United States is a persistent issue with deep systemic roots. Critical federal child nutrition programs in the United States, including the Special Supplemental Nutrition Program for Women, Infants, and Children (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), are effective in reducing food insecurity and promoting access to healthy, nutritious foods among children and their families. **We are grateful for the investments Congress has made in WIC, the Supplemental Nutrition Assistance Program (SNAP), Pandemic EBT, and other programs in past COVID-19 relief packages. It is imperative for Congress to reauthorize and improve these programs through Child Nutrition Reauthorization.** We are excited that today's hearing is beginning that process and look forward to working with you to ensure all children in this country have access to the nutritious meals they need to thrive.

Health Effects of Food Insecurity

Before the pandemic, 1 in 6 children lived in poverty, and nearly half of all children lived in low-income households.[vii] Decades of research has documented the adverse impact 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.[viii,ix,x,xi,xii] Among school-aged children, food insecurity is associated with lower math and reading scores, hyperactivity and absenteeism and tardiness at school.[xiii,xiv,xv,xvi] Some longitudinal studies have found food insecurity increases the risk of obesity or being overweight among children.[xvii,xviii] 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.[xix]

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[xx]. I often reflect on how hard it would be to attend to other aspects of my and my family's life if I was constantly worrying about just being able to feed my children every day. Toxic stress, a result of prolonged and unmitigated exposure to adverse childhood experiences such as poverty, the inability to provide food for yourself or your children, or having a severely depressed parent, can affect the physical, mental, and economic well-being of children well into adulthood.[xxi] As families struggle with the impacts of the COVID-19 pandemic, both parents and children are reporting worsening mental or emotional health.[xxii] These challenges in turn affect a family's ability to ensure their child has optimal nutrition.

This past August, I saw a teenaged patient of mine, who has Down Syndrome and has long struggled with her weight—as is typical of many children with her condition—for a well child visit. In the six months since the pandemic began, she had reversed her trend of slow weight loss—which was a medical goal for her-- and had gained 15 pounds. In talking with her grandmother, who is her primary caregiver, I learned of the tremendous stress the family was under. The grandmother was still working, but worried about her own risk for exposure to COVID as well as needing to support additional family members who had lost their jobs. It was increasingly difficult for her to purchase and prepare healthy foods at home. Additionally, my patient had been in full virtual learning during the prior school year and in summer school, but the family did not have an appropriate device and she was participating in all her classes from her grandmother's phone—which for any child, but especially one who has special educational needs and a limited attention span, was entirely inadequate. Because of the increased need for supervision during the day while virtually learning from home, my patient was spending her days with another family member who was allowing her to eat large amounts of sugary and calorically dense foods. Working together with the family and our social worker, we were able to ensure that my patient was able to attain a more appropriate device for learning, enroll in the hybrid learning program at the school, and get access to school meals for the daytime, which were more nutritionally balanced. We also assisted the grandmother in reengaging with her own mental health care. By October, my patient's situation was stabilizing and she was beginning to lose weight again, and at her most recent visit last month has continued to do well with her goals with the increased support she and her family have been able to access.

Like poverty, food insecurity is a dynamic, intensely complex issue. For many families, like the family I told you about earlier who lost her wallet on the bus, 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. Pediatricians know the value of federal nutrition programs and routinely connect our patients to these programs. This has been true for me my entire career---I actually began my career as a pediatrician as a Naval officer in the Medical Corps—many of the young enlisted families I cared for were income eligible for WIC and other federal nutrition programs, though they weren't always aware of that. It was not uncommon for me to see families who were hungry or diluting their baby's formula to make it last longer, despite the dangers of that practice. As military pediatricians we played an important role in making sure families were educated about how to determine their eligibility and access these critical programs. Even with the other supports and benefits available to military families, the ability to access supplemental healthy foods was of critical importance for their children's health, and through reducing stress on the family I believe actually contributed to the servicemember's military readiness.

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[xxiii]. Child and adult health risks, including obesity, hypertension, and diabetes, may be programmed by nutritional status during this period[xxiv]. 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.[xxv]

Important primary structures and processes that support fundamental behaviors and provide scaffolds for later-developing structures form during the first 1,000 days[xxvi]. 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.[xxvii]

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.[xxviii] Restricted diets because of poverty or neglect may reduce infant intake of many key factors in normal neurodevelopment, including zinc, protein, and iron.[xxix]

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.[xxx] 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.[xxxi] Prenatal and early infancy iron deficiency is associated with long-term neurobehavioral damage that may not be reversible, even with iron treatment.[xxxii] 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.[xxxiii] 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.[xxxiv]

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.[xxxv]

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, and we again emphasize the importance of recognizing the developmental origins of adult health and disease.

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. As the COVID-19 pandemic thrust families into greater economic hardship, access to the nutrition support provided by WIC became even more critical.

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.[xxxvi] WIC is particularly effective at improving birth outcomes in moms with inadequate prenatal care and who are particularly high-risk cases.[xxxvii] One study found that WIC helps eliminate socioeconomic disparities in birth outcomes.[xxxviii]

Despite these proven public health successes, only 51% of eligible individuals were certified to receive WIC services before the COVID-19 pandemic. Pediatricians routinely report that families opt not to remain in the program after their child's first birthday. Many more have spent considerable time counseling immigrant families about the importance of WIC and clarifying that the program was not subject to the now defunct 2019 public charge rule only to be met with skepticism or reluctant interest. Pre-pandemic, families without reliable transportation often found it difficult to get to the WIC clinic to remain on the program. Others faced a lapse in benefits when their children turned 5 but had not yet started kindergarten where they could participate in the school meals program.

Physician Experience with WIC

As a pediatrician, I interact regularly with WIC and routinely refer my patients to the program knowing its many benefits. I am extremely fortunate to practice in a place where our WIC clinic is just across the hall from our medical clinic. Not only does this proximity allow me to better coordinate care and connect with the WIC nutritionists or enrollment specialists when there are questions or concerns, but it is significantly more convenient for patients—many of whom rely on public transportation--and reduces barriers to accessing healthy nutrition. There are also many other benefits to having WIC as a part of our medical home… I can't count the number of times I walked by the WIC waiting room and saw a patient of mine who was overdue for a check up or I was trying to reach for other types of follow up, or who saw me and was able to ask a question that was on their mind but that they were for a variety of reasons hesitant to call or come in for. This is particularly true for the young mothers I care for as a part of our hospital's program to support adolescent parents and their children—one time I even saw a patient of mine in the WIC waiting room who was trying to disguise herself with a wig and sunglasses because she knew my office was close by. We were able to connect and talk about a concern that needed treatment and that she was really worried about, but too embarrassed to call me back for.

The pediatricians I hear from are eager to find ways for physicians and WIC to work even more closely together to improve the patient experience and improve communication and collaboration between WIC and medical providers. Both primary care and WIC will be more effective at nutrition education and services when they align with each other and reinforce treatment plans together for families. Collaboration between WIC and pediatricians and other primary care providers needs to be a priority for the program.

In our conversations with physicians and WIC providers, we have heard repeatedly about the desire for WIC and primary care to more easily share data necessary to certify eligibility for WIC. The way WIC currently functions, it is often incumbent on a parent to share information from the WIC clinic with the doctor's office. In some states, WIC may not release information to physicians about patients' test results, making it difficult for medical providers to monitor health concerns. Even in my own clinical setting, where we have relatively close collaboration with our WIC colleagues, I routinely have patients who have laboratory testing done at WIC after they have had the same test done – sometimes within a month of each other– in our primary care clinic. Not

only is this unnecessary, it is painful for the child, increases the likelihood that there will be falsely abnormal results which then require even more lab tests to confirm, increases the risk of miscommunication and is burdensome to the family to have to be the go-between between the pediatrician and WIC.

As Congress begins to consider Child Nutrition Reauthorization, we urge you to authorize pilot projects to test the feasibility of systems and databases that permit WIC staff and medical providers to share limited health-related information necessary to certify eligibility for WIC in order to streamline and improve patient care and enhance the participant experience. This would help to avoid potentially duplicative medical procedures such as the drawing of blood for testing and ensure health information is communicated accurately.

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 and patients find it easier to access WIC services. 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.

As I mentioned, here at Children's National Hospital, we are very fortunate to have 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. We have even been able to partner with WIC in other ways—such as to deliver education about safe sleep, and conduct outreach to teen mothers. The benefits of having a co-located WIC clinic cannot be overstated.

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.[xxxix] Further, pediatric clinic staff had more positive views of coordination of WIC services and services in their practice after participating in the program.[xl] 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.[xli] **Because cost is a frequently cited barrier to co-location, AAP urges Congress to provide direct funding from USDA to physician practices to support their ability to have a co-located WIC clinic.**

In order to help WIC align even more closely with the medical provider community and promote the development of stronger relationships between WIC and primary care providers, Congress should support the formation of state-level WIC advisory councils. These councils could be comprised of WIC state agencies, the medical provider community for children and pregnant women including pediatricians, family practice physicians, and obstetricians-gynecologists, WIC clinic staff, participants, and others to identify opportunities

for collaboration and enhanced communication and to increase participation rates among eligible but unenrolled families.

Barriers to Accessing WIC

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. **The waivers provided by USDA to allow remote enrollment, services, and benefits issuance during the COVID-19 public health emergency have been crucial to helping families in need and should be made permanent in order to lessen the existing barriers to participation in WIC. WIC clinics can also 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.**[xlii] My colleagues and I have personally found this to be an incredibly important strategy in reducing barriers for families. This can also be accomplished by permanently co-locating a WIC clinic in a community health center or a hospital as previously discussed.[xliii]

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. Eligibility for postpartum women should be extended to two years in order to ensure that women have access to healthy foods between pregnancies, thus reducing the risk of negative birth outcomes for subsequent pregnancies.**

Further, Congress and USDA should look for ways to align WIC eligibility with other federal programs like Medicaid and SNAP in order to combat declining enrollment and reduce certification requirements. Adjunctive eligibility between WIC and Medicaid streamlines the WIC application process, reduces administrative burdens, increases coordination between these complementary programs, and should be maintained. Any linkage that reduces barriers to access for this critical program is a worthwhile investment for the health and well-being of children.

We want all families who would benefit from WIC services to access to them, but far too many eligible families are not participating in the program. **To ensure WIC reaches all eligible families, Congress should authorize and appropriate funding for USDA to issue grants to states for outreach for recruitment and retainment of women and children, with a priority on at-risk families.**

WIC Food Packages

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.[xliv] 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. Another recent study provides some of the first evidence that children of mothers who received the revised WIC food package during pregnancy had improved developmental outcomes in the first 2 years of life.[xlv] These findings underscore the importance of ensuring that the nutrition content of federal programs is determined by nutrition scientists and medical professionals.

As USDA begins the process of updating the WIC food packages, we urge both the agency and Congress to consider increasing the value of the WIC food packages. Though WIC is a supplemental program, the value of the benefit is not enough to ensure that families have regular access to nutritious foods, which are often higher-cost and out of reach for many low-income families. For example, children certified for WIC services receive only $2.25 per week for fruits and vegetables – hardly enough to ensure anywhere near the recommended daily nutrient intake. The average value of the food benefit per participant in fiscal year 2020 was only $38 per month, with an even lower value of $32 per month for children and $31 per month for postpartum, non-breastfeeding women. In the short term, Congress has recognized this need by including a short-term increase in the Cash Value Benefit for fruit and vegetable purchases in the American Rescue Plan, the most recent COVID relief package. We are grateful for this increase and know that this change will help our patients achieve a healthier diet. Many of my patients enjoy utilizing the WIC Farmers' Market Nutrition Program and use their benefits to buy fresh, nutritious, locally grown fruits and vegetables. For my patients, an increase in benefits will help them afford the healthy foods they need to thrive.

Breastfeeding and WIC

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.[xlvi] 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.** The breastfeeding peer counselors program both creates jobs and supports women to meet their breastfeeding goals. We have had such a program here in DC, and I can speak to how effective and helpful it is to both families and pediatricians.

Healthy School Foods

COVID-19 and the Impact on Healthy Eating

The ongoing COVID-19 pandemic has closed schools for in-person instruction throughout the country, led to record unemployment claims filed, limited opportunities for physical activity, and left families without adequate resources to feed their children. Families are struggling to sustain the healthy lifestyles necessary to build the foundations of health for their children and adolescents. In fact, a very recent Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report found that parents of children receiving virtual or combined instruction more frequently reported that their child's mental or emotional health worsened during the pandemic and that their time spent outside, in-person with friends, and engaged in physical activity decreased.[xlvii] Regular physical activity is associated with children's improved cardiorespiratory fitness, increased muscle and bone strength, and reduced risk for depression, anxiety, and chronic health conditions (e.g., diabetes); therefore, these differences in physical activity are concerning.[xlviii]

As a result of the economic hardships and inconsistent access to school breakfasts and lunches because of virtual, half-day, and/or hybrid learning, many children and adolescents may not have regular access to nutritious foods. Families may have had to shift to high-calorie snack foods and nonperishable processed foods, and there may have been significant increases in the consumption of unhealthy snacks and sugary sweetened beverages. Both food insecurity and food scarcity can negatively affect nutrition, lead to increased risk for disordered eating, and increase consumption of nonnutritive, calorie-dense foods that can lead to unhealthy weight gain and contribute to obesity.[xlix]

While few studies examining the impact of COVID on childhood obesity have been completed, preliminary data from the Children's Hospital of Philadelphia (CHOP) Care Network shows an increase in overall pediatric obesity prevalence, particularly in patients who are Hispanic/Latino, Non-Hispanic Black, publicly insured, or lower income.[l] This study suggests that during the pandemic, pre-existing disparities in obesity in terms of race/ethnicity, insurance, and neighborhood socioeconomic status widened.[li] The study authors note that COVID-19 mitigation efforts have likely contributed to worsening pediatric obesity. Families with children have faced the difficulties of managing virtual schooling, limited physical activity, and increased reliance on more heavily-processed and calorie dense foods.[lii] For disadvantaged families, many of the risk factors that have been shown to promote weight gain during the summer months are present in this pandemic.[liii] These include disrupted family routines, sleep dysregulation, reduced physical activity, increased screen time, increased access to unhealthy snacks, and less consistent access to appropriately portioned meals through school.[liv]

These findings mirror what I have seen in my own clinic and what pediatricians across the country are reporting; in fact, I have heard reports from many of my colleagues about seeing weight gain of 30-40 pounds in their patients, and increasing over many percentiles, over the course of the past year. These reports come from all areas of the country, in all types of settings—rural, urban, primary care, subspecialty. Additionally, mental health conditions such as depression or anxiety are also often associated with changes in eating patterns—such as emotional eating or decreases in appetite. Relatedly, we are also seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. My adolescent medicine and child psychiatry colleagues tell me that not only are they seeing many more cases of eating

disorders, but they are more severe and are starting at even younger ages, even down to the age of 8 or 9, and that because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients.

As more families are left unable to afford healthy, nutritious meals at home, the importance of healthy school meals has taken on new urgency. 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.

Importance of Science-based Nutrition Standards

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 conducted by the Pew Charitable Trusts show that under the HHFKA standards, children's eating habits improved. Students of all ages are choosing lunches with higher nutritional quality and lower calories per gram and consuming more fruits and larger shares of their entrees and vegetables. Other studies have found that plate waste stayed the same or even declined after the transition to the HHFKA standards. Nutrition education in schools is crucial to encouraging students to eat healthier foods and instilling life-long healthy eating habits.

HHFKA provided for the first update to national standards for snack foods and beverages in schools since 1979. Through the updated school meal and 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[lv]. Especially as the country recovers from the COVID-19 pandemic, 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.

The current nutrition standards for the school meals program are not aligned with the Dietary Guidelines for Americans (DGAs). The recently released 2020-2025 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. 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[lvi]. 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. 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 added sugars. **To better align with the current DGAs, USDA should restore the 100 percent whole-grain-rich requirement; and restore the limit on flavored 1 percent (low-fat) milk or implement a calorie limit consist with expert recommendations. USDA must also establish an added sugars standard for school meals and replace the total sugar standard with an added sugars standard for competitive foods consistent with the Dietary Guidelines for Americans.**

Ensuring Access to School Meals

While we work to ensure school meals are healthy, we need to redouble our efforts to ensure that children are participating in the program and not dissuaded by paperwork requirements, fear, stigma, or financial constraints should they not qualify for free- or reduced-price meals. 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 nationwide waivers put in place during the COVID-19 pandemic have allowed every student to access healthy school meals. Offering free meals to all students eliminates the cost barrier for children whose families' income is near the cutoff line to receive free school meals. Further, having meals available to every student for free eliminates the stigma of being singled out for receiving school meal assistance. Many struggling families do not qualify for free school meals, and school meal fees create a barrier to participation. **For these reasons, AAP supports healthy school meals for all students, regardless of income eligibility.**

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. CEP has been absolutely critical to lessening the administrative burden on schools, increasing participation, and facilitating implementation of alternative breakfast service models. **Short of making healthy meals for all students universal, Congress should expand CEP to reach more low-income students.**

Beyond the School Setting

Children need optimal nutrition year-round. Countless children go without access to food during out of school or childcare 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 2018-2019 school year participated in Summer Nutrition Programs in July 2019. Summer breakfast reaches even fewer children, despite its critical importance. **We appreciate the Committee's focus on summer meals and hope that Congress will expand access to summer feeding programs. Additional resources for summer feeding are essential as we get closer to the summer months.**

The Pandemic-EBT program has been greatly effective in providing families with resources to purchase food to replace meals that children would have received in schools but for the pandemic. After the pandemic, when schools fully reopen in person, this model should be used to ensure students have access to healthy meals

during summer vacation, on weekends, or during school holidays. 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 streamlining access to the program for parents and providers.**

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 which is why AAP partnered with the Food Research and Action Center. FRAC. on a toolkit for pediatricians to address food insecurity called, "Screen and Intervene".[lvii] [lviii]

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. As the country recovers from the COVID-19 pandemic, our children's health simply cannot wait.

---

[i] Food Access & Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency. September 2020. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-security-report-9-24-20.pdf.
[ii] Feeding America. The Impact of the Coronavirus on Food Insecurity in 2020 & 2021. March 2021. https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf
[iii] Bauer L. The COVID-19 Crisis Has Already Left Too Many Children Hungry in America. [(accessed on 7 May 2020)];2020 May 6; Available online: https://www.brookings.edu/blog/up-front/2020/05/06/the-covid-19-crisis-has-already-left-too-many-children-hungry-in-america/.
[iv] Food Access & Food Security in the District of Columbia: Responding to the COVID-19 Public Health Emergency. September 2020. https://dcfoodpolicycouncilorg.files.wordpress.com/2020/09/food-security-report-9-24-20.pdf.
[v] Id.

[vi] Id.
[vii] National Academies of Sciences, Engineering, and Medicine. 2019. A Roadmap to Reducing Child Poverty. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25246.
[viii] Ettinger de Cuba S, Casey PH, Cutts DB, Heeren T, Coleman S, Bovell-Ammon A, et al. Household food insecurity positively associated with increased hospital charges for infants. *J Applied Research on Children*. 2018;9(1). Available at: http://childrenshealthwatch.org/wp-content/uploads/Food-Insecurity-Positively-Associated-with-Hospital-Charges-for-Infants.pdf.
[ix] Cook JT, Frank DA, Berkowitz C., Black MM, Casey PH, Cutts DB, et al. Food insecurity is associated with adverse health outcomes among human infants and toddlers. *The Journal of Nutrition*, 2004;134(6), 1432-1438.
[x] Alaimo, K., Olson, C. M., Frongillo Jr, E. A., & Briefel, R. R.Food insufficiency, family income, and health in US preschool and school-aged children. *American Journal of Public Health*, 2001;91(5), 781.
[xi] Rose-Jacobs, R., Black, M. M., Casey, P. H., Cook, J. T., Cutts, D. B., Chilton, M., et al. Household food insecurity: associations with at-risk infant and toddler development. *Pediatrics*, 2008;121(1), 65-72.
[xii] Skalicky, A., Meyers, A. F., Adams, W. G., Yang, Z., & Frank, D. A. Child food insecurity and iron deficiency anemia in low-income infants and toddlers in the United States. *Maternal and Child Health Journal*, 2006;10(2), 177-185.
[xiii] Ashiabi, G. Household food insecurity and children's school engagement. *Journal of Children and Poverty*, 11(1), 2005;3-17
[xiv] Jyoti, D. F., Frongillo, E. A., & Jones, S. J. Food insecurity affects school children's academic performance, weight gain, and social skills. *Journal of Nutrition*, 2005;135(12), 2831-2839.
[xv] Murphy, J. M., Wehler, C. A., Pagano, M. E., Little, M., Kleinman, R. E., & Jellinek, M. S. Relationship between hunger and psychosocial functioning in low-income American children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 1998; 37(2), 163-170.
[xvi] Alaimo, K., Olson, C. M., & Frongillo, E. A. Food insufficiency and American school-aged children's cognitive, academic, and psychosocial development. *Pediatrics*, 2001;108(1), 44-53.
[xvii] Bronte-Tinkew, J., Zaslow, M., Capps, R., Horowitz, A., & McNamara, M. Food insecurity works through depression, parenting, and infant feeding to influence overweight and health in toddlers. Journal of Nutrition, 2007;137(9), 2160-2165.
[xviii] Metallinos-Katsaras, E., Must, A., & Gorman, K. A longitudinal study of food insecurity on obesity in preschool children. Journal of the Academy of Nutrition and Dietetics, 2012;112(12), 1949-1958.
[xix] Case, A., Fertig, A., & Paxson, C. The lasting impact of childhood health and circumstance. *Journal of Health Economics*, 2005;24(2), 365-389.
[xx] AAP Council on Community Pediatrics and Committee on Nutrition. "Promoting Food Security for All Children." Pediatrics 136.5 (2015): Web.
[xxi] Shonkoff J, Garner A, AAP Committee on Psychosocial Aspects of Child and Family Health, et al. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 2012; 129(1): e232-246.
[xxii] Verlenden JV, Pampati S, Rasberry CN, et al. Association of Children's Mode of School Instruction with Child and Parent Experiences and Well-Being During the COVID-19 Pandemic — COVID Experiences Survey, United States, October 8–November 13, 2020. MMWR Morb Mortal Wkly Rep 2021;70:369–376. DOI: http://dx.doi.org/10.15585/mmwr.mm7011a1.
[xxiii] AAP Committee on Nutrition. Advocacy for Improving Nutrition in the First 1000 Days To Support Childhood Development and Adult Health. *Pediatrics*. 2018;141(2).
[xxiv] Id.
[xxv] Wachs et al. Issues in the timing of integrated early interventions: contributions from nutrition, neuroscience, and psychological research. *Ann. N.Y. Acad. Sci.* 1308 (2014) 89-106.
[xxvi] Id.
[xxvii] Id.
[xxviii] Monk et al. (2013).
[xxix] AAP Committee on Nutrition. Advocacy for Improving Nutrition in the First 1000 Days To Support Childhood Development and Adult Health. *Pediatrics*. 2018;141(2).
[xxx] Schwarzenberg SJ, Georgieff MK, AAP COMMITTEE ON NUTRITION. Advocacy for Improving Nutrition in the First 1000 Days To Support Childhood Development and Adult Health. *Pediatrics*. 2018;141(2).
[xxxi] Id.
[xxxii] Id.
[xxxiii] Id.

[xxxiv] Id.
[xxxv] Monk et al. Research Review: Maternal prenatal distress and poor nutrition – mutually influencing risk factors affecting infant neurocognitive development. *Journal of Child Psychology and Psychiatry*. 54:2 (2013), pp 115-130.
[xxxvi] Bitler MP & Currie J. Does WIC work? The effects of WIC on pregnancy and birth outcomes. J Policy Anal Manage. 2005 Winter; 24(1):73-91.
[xxxvii] El-Bastawissi AY, et al. Effect of the Washington Special Supplemental Nutrition Program for Women, Infants and Children (WIC) on Pregnancy Outcomes. Matern Child Health J.2007 Nov; 11(6): 611-21.
[xxxviii] Finch BK. Socioeconomic Gradients and Low Birth-Weight: Empirical and Policy Considerations. Health Serv Res.2003 Dec; 38(6 Pt 2): 1819–1842.
[xxxix] U.S. Department of Agriculture. WIC Services in the Medical Home: Improving Early Feeding Practices. https://fns-prod.azureedge.net/sites/default/files/VT_report.pdf. Published June 2007. Accessed February 21, 2019.
[xl] U.S. Department of Agriculture. WIC Services in the Medical Home: Improving Early Feeding Practices. https://fns-prod.azureedge.net/sites/default/files/VT_report.pdf. Published June 2007. Accessed February 21, 2019.
[xli] Kendal AP, Peterson A, Manning C, Xu F, Neville LJ, Hogue C. Improving the health of infants on Medicaid by collocating special supplemental nutrition clinics with managed care provider sites. Am J Public Health. 2002;92(3):399-403.
[xlii] Neuberger Z. Modernizing and Streamlining WIC Eligibility Determination and Enrollment Processes. Center on Budget and Policy Priorities. 2017. Available at https://www.cbpp.org/research/modernizing-and-streamlining-wic-eligibility-determination-and-enrollment-processes.
[xliii] Id.
[xliv] Daepp et al. WIC Food Package Changes: Trends in Childhood Obesity Prevalence. *Pediatrics*. 2019; 143(5): e20182841.
[xlv] Guan A, Hamad R, Batra A, et al. The Revised WIC Food Package and Child Development: A QuasiExperimental Study. Pediatrics. 2021;147(2):e20201853https://pediatrics.aappublications.org/content/147/2/e20201853.
[xlvi] AAP Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics*, 2012; 129; e827.
[xlvii] Verlenden JV, Pampati S, Rasberry CN, et al. Association of Children's Mode of School Instruction with Child and Parent Experiences and Well-Being During the COVID-19 Pandemic — COVID Experiences Survey, United States, October 8–November 13, 2020. MMWR Morb Mortal Wkly Rep 2021;70:369–376. DOI: http://dx.doi.org/10.15585/mmwr.mm7011a1.
[xlviii] Id.
[xlix] American Academy of Pediatrics. Supporting Healthy Nutrition and Physical Activity During the COVID-19 Pandemic. COVID-19 Interim Guidance. Dec 2020. https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/supporting-healthy-nutrition-and-physical-activity-during-the-covid-19-pandemic/.
[l] Jenssen BP, Kelly MK, Powell M, Bouchelle Z, Mayne SL, Fiks AG. COVID-19 and changes in child obesity. Pediatrics. 2021; doi: 10.1542/peds.2021-050123.
[li] Id.
[lii] Id.
[liii] Id.
[liv] Id.
[lv] AAP Section on Obesity, Committee on Nutrition, American Heart Association. Policy Statement: Public Policies to Reduce Sugary Drink Consumption in Children and Adolescents. *Pediatrics*, 2019; 143 (4) e20190282.
[lvi] Id.
[lvii] AAP Council on Community Pediatrics and Committee on Nutrition. "Promoting Food Security for All Children." Pediatrics 136.5 (2015): Web.
[lviii] American Academy of Pediatrics and the Food Research and Action Center. Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity. https://frac.org/wp-content/uploads/FRAC_AAP_Toolkit_2021.pdf.