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Testimony of
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On behalf of the
American Academy of Pediatrics

Before the
National Commission on Hunger

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Co-Chair Mariana Chilton, Co-Chair Robert Doar and distinguished members of the National Commission on Hunger, I am Sandra Hassink, and I am President of the American Academy of Pediatrics (AAP), a non-profit professional organization of 64,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

It is a privilege to be invited to provide written testimony to the National Commission on Hunger. The work of the Commission is incredibly important for the lives of millions of children.

In addition to serving as President of the AAP, I have spent my clinical career caring for children with obesity in the Nemours/A I duPont Hospital for Children weight management clinic which I founded in 1988 in Wilmington, DE. I current serve as Medical Director of the AAP Institute for Healthy Childhood Weight and have written and lectured widely on childhood obesity, nutrition and food insecurity.

I'd like to start by addressing what I see as the three basic needs of every child:

- Sound, appropriate nutrition;
- Stable, responsive and nurturing relationships; and
- Safe, healthy environments and communities.

Meeting these needs for every child is fundamental to achieving and sustaining optimal child health and well-being into adulthood. These foundational needs are often intertwined and failure to meet these fundamental needs means that children are put at increased risk for chronic disease, poorer mental and emotional health and compromised well-being as adults. Ensuring that the nutritional needs of all children are met is key to ensuring a healthy population. Communities with high rates of food insecurity and/or high rates of childhood obesity are communities at-risk. Addressing the baseline health of our communities, means ensuring that the nutritional needs of food insecure families are being met. That will take resources, it will take willing partners, and it will take a persistent and comprehensive commitment to improve the nutritional quality of the foods our children eat. And, the federal government has an important role to play in it all.

Before providing several specific recommendations for policies that will help attain these goals, I want to highlight for the Commission's consideration the impact of early nutrition on early childhood development and its implications for lifelong health.

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

Exciting new data shows the short- and long-term impacts of investments in nutrition and health care during the prenatal and early childhood years. The time period from pregnancy through early childhood is one of rapid physical, cognitive, emotional and social development

and because of this, this time period in a child's life 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.

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.[i]

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.[ii]

Micronutrients such as iron and folate demonstrated effects on 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.[iii]

It is important to note that lack of adequate access to food is itself a contributor to toxic stress. Toxic stress, a result of prolonged exposure to adverse childhood experience in the absence of caring, stable relationships with adults, can affect the physical, mental, and economic well-being of children well into adulthood. The more adverse childhood experiences adults reported, the more likely they were to have cardiovascular disease, diabetes, poorer mental health and social functioning. [iv] The inability to provide food for yourself or your children creates stress in families, and contributes to depression, anxiety, and other behavioral 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.

The Double Burden of Obesity and Food Insecurity

Today our children are experiencing an unprecedented nutritional crisis resulting in the double burden of obesity and food insecurity. The picture of food insecurity is increasingly a child with overweight or obesity consuming a poor-quality diet. Families with children are more likely to be food insecure than families without children. Additional risk factors associated with poverty including lack of access to healthy, affordable foods, fewer opportunities for physical exercise,

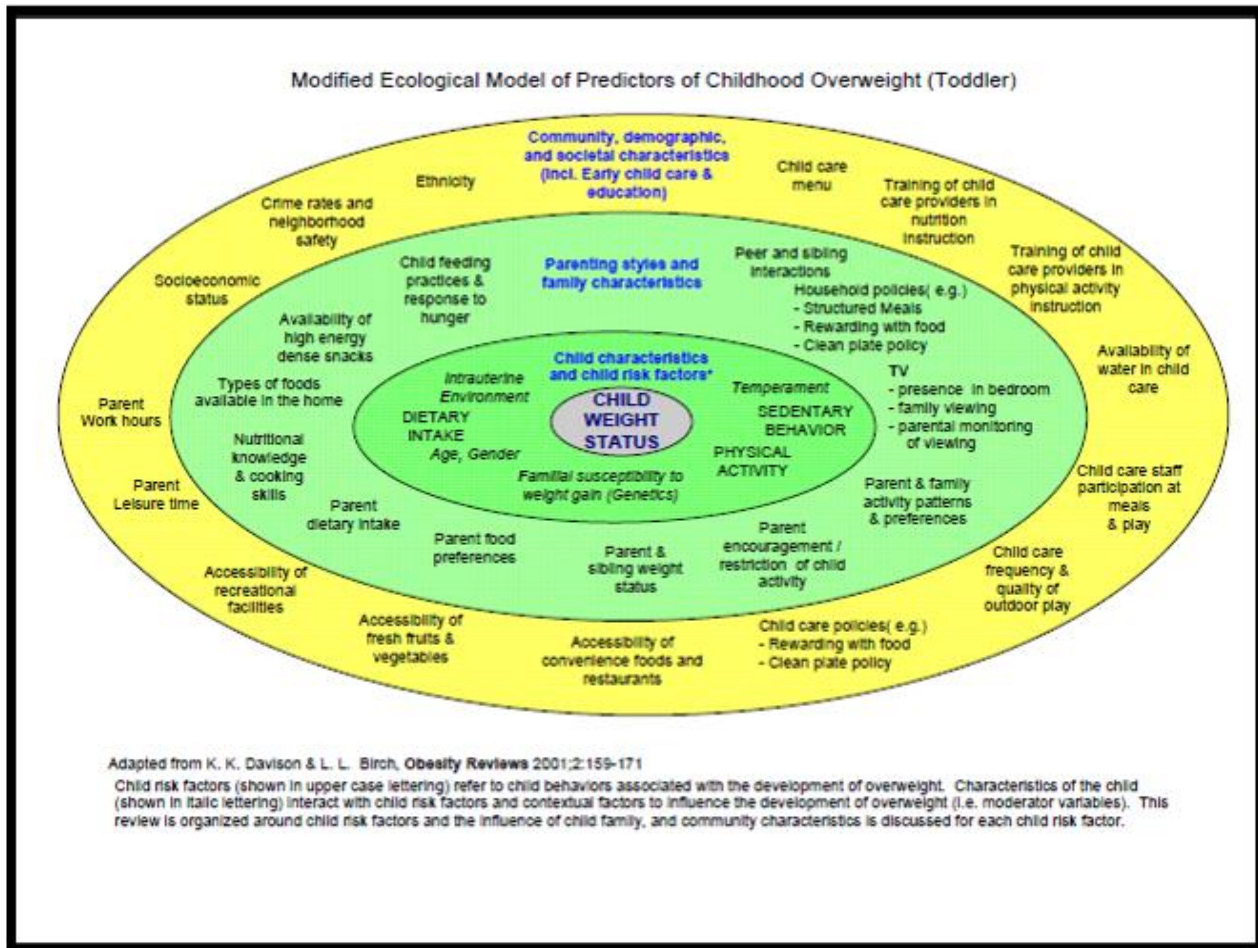
high levels of stress, and limited access to health care make it more likely that food insecure families will be especially vulnerable to obesity. Good nutrition is not only an essential component of chronic disease prevention and treatment; it also helps treat the effects of chronic hunger.

In food insecure households, parents reported poorer health and developmental risks in their children including more frequent stomach aches, headaches, colds, hospitalizations, anemia, and chronic conditions. Parents also reported more anxiety, depression and difficulties in school.[v] Infants are more likely to have insecure attachments and perform more poorly on cognitive assessments.[vi]

As a pediatrician who has specialized in caring for children suffering from overweight and obesity, I can tell you firsthand that we have an urgent public health problem facing our children. Nearly 1 in 3 school-age children and adolescents has overweight or obesity and only half of all children ages 2 to 17 meet federal diet quality standards. Children who have overweight or obesity as preschoolers are 5 times as likely as normal-weight children to have overweight or obesity as adults. Children with obesity are at increased risk for high blood pressure, high cholesterol, cardiovascular disease, type 2 diabetes, asthma, and social and psychological problems. Obesity disproportionately affects minority children and the highest rates of obesity are found in people with the lowest incomes.

When I started my practice in childhood weight management 27 years ago, I was seeing adolescents. When I retired last October I had a special clinic for children under 5 with obesity. These children were already showing the effects of their increased Body Mass Index on their blood pressure, and measures of blood sugar control. We saw obesity related liver disease in 4 year olds and had children with prediabetes as young as 6.

First and foremost, we must recognize that there is no single factor responsible for obesity. Obesity is the end result of a complex interplay of different issues. Davidson and Birch described the “socio-ecologic” model of obesity, which illustrates the many factors that impact weight. The concentric circles of this model show the issues related to the individual, family, community, and larger social structure that either promote or inhibit good nutrition, physical activity, and overall health. Any meaningful attempt to stem the rising tide of obesity must address many of these issues simultaneously and over a prolonged period of time in order to produce sustainable change.



Adapted from K. K. Davison & L. L. Birch, **Obesity Reviews** 2001;2:159-171
Child risk factors (shown in upper case lettering) refer to child behaviors associated with the development of overweight. Characteristics of the child (shown in italic lettering) interact with child risk factors and contextual factors to influence the development of overweight (i.e. moderator variables). This review is organized around child risk factors and the influence of child family, and community characteristics is discussed for each child risk factor.

Effective Policies and Recommendations

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). In existence for 40 years, WIC serves more than 8 million pregnant women, infants and children including more than 50% of all infants born in the U.S.

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. 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.[vii] WIC is particularly effective at improving birth outcomes in the moms with inadequate prenatal care and who are particularly high risk cases.[viii] One study found that WIC helps eliminate socioeconomic disparities in birth outcomes.[ix]

Recommendations

1. **Protect and preserve adjunctive eligibility with Medicaid** – Optimal nutrition in pregnancy and infancy is essential to lifelong health. Since 1989, eligibility for WIC is tied with eligibility for other federal health and social service programs. Linking WIC (a preventive health program) to Medicaid (a health insurance program) makes sense: WIC helps prevent nutrition related illnesses, developmental problems, and chronic diseases, which would be paid for by Medicaid. 74.6% of WIC participants apply for WIC through adjunctive eligibility. Over 67% of WIC participants reside in families with income below the poverty level. In 2012, less than 2% of WIC participants had income above 185% of the Federal Poverty Line, the federal standard for WIC eligibility. Eliminating or capping WIC adjunctive eligibility would result in untold numbers of pregnant women and children losing access to WIC, a vital nutritional assistance program. It would significantly increase administrative costs, create unnecessary paperwork requirements, and force this capped discretionary program to spend less on services and more on administrative functions.

2. **Promote and support breastfeeding in WIC** – Breastfeeding is the optimal nutrition for infants. 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.[x] 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 authorization and funding for the breastfeeding peer counseling program within WIC be increased to $180 million so that more WIC mothers will have access to peer counselors in their local community. The successful breastfeeding peer counseling program has contributed to increases in rates of breastfeeding among WIC mothers over the past 40 years of the program.

3. **Protect and preserve science-based decisions in WIC and other federal nutrition programs and guidelines -** 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. Attempts by political interests to circumvent the scientific review process as we saw last year with white potatoes, threaten the success of the WIC program. The Institute of Medicine is currently undertaking a second review of the food packages, expected to be released in 2016, with a view to updating them to meet the 2015 Dietary Guidelines for Americans (DGA). Unfortunately, politically-motivated interests in the food industry and congress have included policy rider language in several federal spending bills that would severely limit the recommendations that can be included in the 2015 DGA and set a dangerous precedent for future dietary guidelines. This concerted attack on nutrition science is troubling for the future success of federal nutrition programs.

4. **Expanding the reach of WIC** –Optimal nutrition is a foundation of health for every child. WIC is a highly effective public health nutrition program that enjoys strong public and bipartisan congressional support. There are eligible children that are not enrolled, those that roll off the program in early childhood and those that fall through the cracks just prior to starting kindergarten. As such, we should look for ways to give states the option to streamline enrollment. For example, by allowing WIC to certify infants for up to two years, the program can eliminate duplicative paperwork and focus on health, nutrition, breastfeeding, immunization, and pediatric referral services that will make a significant difference in the lives of lower income infants and young children.

   WIC provides nutrition assistance to children up to age five at which point many enter public school where they may qualify for school breakfast and lunch programs that continue to supplement their intake of healthy food choices. A child's birth date impacts their eligibility to enter school and a significant number of children remain ineligible well past their 5th birthday – sometimes for as much as a year. Allowing states to extend eligibility for WIC through age 6 would allow low-income, nutritionally at-risk children to continue receiving nutrition services to help assure a continued strong health and nutrition foundation upon entrance into school.

   The WIC program is partnering with pediatrician clinics and hospitals and even with AAP state chapters. Given the public health nature of the WIC program and the growing number of pediatricians who care for food insecure families, the AAP looks forward to increased opportunities for collaboration with the WIC program in communities across the country.

School Meals

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 more than 31 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 meals 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. According to USDA, 95 percent of schools currently comply with these new standards, and our school food service personnel deserve tremendous credit for this success.

However, some lawmakers have proposed to roll back or delay implementation of healthier foods in schools, threatening the progress that has been made. Our children deserve the best possible chance at success, and the means having access to healthy meals while they're in and outside the classroom. It may take offering these healthy foods two, three or even four times, it may take adults modeling good habits for children, and it may take creativity from food service providers. That is a commitment we can and should take on: to continue offering nutritious school meals 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 low-income children are participating in the program and not dissuaded by paperwork requirements, fear of 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 Community Eligibility Provision, 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 6.4 million children in almost 14,000 schools in the last school year but many more schools that are eligible have not yet signed up to participate.

Recommendations

1. **Maintain science-based nutrition standards for school meals and other foods sold in schools.**

2. **Increase reimbursement for the School Breakfast Program.**

3. **Increase participation in the Community Eligibility Provision by eligible but unenrolled schools.**

Summer Feeding

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 summer. 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.

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.

Recommendations

1. **Expand the summer EBT program to all states through passage of the Stop Child Summer Hunger Act of 2015 (S. 1539/H.R. 2715) which would provide low-income families with children an electronic benefit transfer (EBT) card, for the summer to purchase food, offering another food resource for low- income children in addition to the Summer Nutrition Programs.**

2. **Strengthen and expand access to Summer Nutrition Programs through passage of the Summer Meals Act of 2015 (S. 613/H.R. 1728) which expands the number of summer meal sites, reduces administrative barriers to participation in the Summer Nutrition Program, and would allow for innovative approaches to reaching children especially in rural areas.**

SNAP

No child should have to worry about whether they will have enough to eat. Children who are hungry and live in households where food is scarce have difficulty learning, and are more likely to experience educational, health and behavioral problems as a result. In total, more than 8.6 million children lived in food insecure households in 2013.

This is why preserving access to the Supplemental Nutrition Assistance Program (SNAP) is so important. More than 44 percent of SNAP recipients are children and more than 70 percent of SNAP recipients live in households with children. SNAP not only reduces hunger, but it alleviates

poverty and supports family economic stability. Keeping children fed at home is essential to their physical health and their academic success. We can't expect our children to concentrate on a complicated algebra equation if they haven't had enough to eat.

SNAP has been shown to improve beneficiaries' dietary intake, health and well-being. The higher the level of SNAP benefits is, the larger is the positive nutritional effect of program participation. Studies examining the impact of the temporary boost in benefits for SNAP recipients under the American Recovery Reinvestment Act demonstrate this effect. SNAP-Ed plays a key role in promoting nutrition education and obesity prevention among SNAP participants.

Recommendations

1. **Maintain access to SNAP benefits for children and work to address the current shortcomings of the SNAP monthly benefit which is not currently enough to get most families through the entire month let alone be able to afford healthier, higher quality food.**

2. **Invest in innovative, incentive models to promote increased fruit, vegetable and other healthy food consumption that *supplement, not supplant* the existing SNAP benefit.**

Good nutrition in childhood sets the stage for lifelong health. Just like we vaccinate to protect against the flu, so too can we provide children with nutritional assistance to protect against chronic disease.

Thank you for this opportunity to provide written testimony to the National Commission.

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