POSITION STATEMENT
It is the position of the American Dietetic Association that child-care programs should achieve recommended benchmarks for meeting children’s nutrition needs in a safe, sanitary, and supportive environment that promotes optimal growth and development.

Child-care providers play an important role in shaping the health of our nation’s children. Nearly three quarters of children aged 3 to 6 years in the United States spend time in organized child care (1), with even more cared for in less-formal arrangements such as family, friend, or neighbor care. According to estimates, nearly 9 million children attend child care (2), and the majority of them spend more than 15 hours per week there (3). The number of child-care centers has increased from less than 5,000 in 1977 to roughly 119,000 in 2007, with an estimated additional 238,103 family child-care homes (4). To promote healthful eating in all child-care settings, food and nutrition practitioners need to work in partnership with child-care providers and families to ensure that meals and snacks served in child care meet children’s nutrition needs and that providers support and model healthful eating to create a positive child-care environment.

Child-care programs often serve as homes away from home, where children adopt early nutrition-related behaviors. Young children appear more likely than older children to be influenced by adults in an eating environment (5), and food habits and patterns of nutrient intake acquired in childhood track into adolescence and adulthood (6,7). In addition, young children typically consume half to three quarters of their daily energy while in full-time child-care programs (8,9), making this an ideal setting for the promotion of healthful eating. Thus, achieving recommended benchmarks for nutrition in child-care programs is an important public health priority, and food and nutrition practitioners can play a key role in that charge. This Position Paper identifies nutrition benchmarks for children aged 2 to 5 years attending child care and provides guidance for food and nutrition practitioners, health professionals, and providers regarding recommendations for: nutritional quality of foods and beverages served; menus, meal patterns, and portion sizes; food preparation and service; physical and social environment; nutrition training; nutrition consultation; physical activity and active play; and working with families.

BENCHMARKS FOR NUTRITION IN CHILD CARE
Nutritional Quality of Foods and Beverages Served
Foods and beverages served should be nutritionally adequate and consistent with the Dietary Guidelines for Americans (DGA). Foods and beverages served in child-care programs should be consistent with the DGA (10). Child-care providers can help ensure that children eat nutritious foods that promote optimal growth and development in their early and formative years. The importance of this benchmark is underscored in the Healthy People objectives for the nation to increase the proportion of persons aged 2 years and older whose diets are consistent with the DGA. The Dietary Reference Intakes (DRIs) also provide guidance on children’s nutrient needs (11). Foods and beverages served to children in child care should provide a proportional share of daily nutrient requirements. Children in part-time programs should receive foods and beverages that provide at least one third of the daily nutrient requirements, whereas those in full-time programs should receive foods and beverages that meet at least one half to two thirds of daily nutrient needs (12).

A Variety of Healthful Foods, Including Fruits, Vegetables, Whole Grains, and Low-
Fat Dairy Products, Should Be Offered to Children Daily. A key recommendation in the DGA is that children consume five or more servings of fruits and vegetables, especially dark-green and yellow vegetables and citrus fruits every day (10). Children should be served fruits and vegetables high in vitamin C daily and high in vitamin A at least three times a week. Emphasis should be placed on minimally processed fruits and vegetables when available from a safe and clean source. Choosing fresh fruits and vegetables and serving them raw rather than cooked helps increase the amount of dietary fiber, minimize fat and sodium in the diet, and avoid the loss of nutrients, such as vitamin C, through cooking. Frozen fruits and vegetables are also good options; however, canned fruits and vegetables may be more economical in the child-care setting. Fruits packed in water rather than syrup and vegetables low in sodium are good options when fresh or frozen fruits and vegetables are unavailable or costly. Providers can rinse canned fruits and vegetables to reduce added sugar and sodium before serving them.

Juice is often served in lieu of whole fruits or vegetables in child-care programs for convenience, cost, shelf life, and perceived health benefits. The American Academy of Pediatrics recommends limiting juice to 4 to 6 oz/day, but less should be served in child-care programs because children may consume juice at home (13). Juice provides less fiber and fewer nutrients than whole fruits or vegetables. Moreover, excessive juice consumption may contribute to the development of obesity (14,15).

In addition to consuming adequate amounts of fruits and vegetables, children should consume at least six servings of a combination of breads, cereals, and legumes daily, and at least half of all grains consumed should be whole grains. Whole-grain products such as whole-wheat bread, brown rice, and oatmeal help provide dietary fiber, which may be lacking in meals provided to children in child care (16).

Dairy products are an important source of calcium and vitamin D for children. As young children age, they should consume less energy from fat, including fat in milk, and increase their consumption of 1% or fat-free milk for children older than age 2 years (10,17). Despite these recommendations, few children drink reduced-fat or fat-free milk (17,18).

Foods and Beverages High in Energy, Sugar, and Sodium and Low in Vitamins and Minerals Should Be Limited. Foods high in nutrients and low in fat, sugar, and sodium may help prevent the development of chronic diseases such as obesity. Child-care programs are an important setting for the promotion of healthful eating and the prevention of obesity (19,20). Researchers have started to explore the relationship between child-care attendance and obesity, with one study linking part-time child care with a decreased risk of obesity later in childhood compared to children cared for at home (21). Another study found that full-day Head Start programs may provide more protection against obesity (22) than part-day Head Start programs (9). A study examining the quality of foods and beverages served in Head Start programs through a national survey of directors and found that more than half of programs surveyed did not allow flavored milk or vending machines, and nearly all did not allow sugar-sweetened beverages (23). The Head Start program performance standards (24) can serve as a model for other child-care programs. These standards require participating child-care programs to focus on healthful options and to limit foods of minimal nutritional value. More recent studies have found that child-care attendance may actually contribute to development of obesity (25,26). Despite mixed results on the relationship between child-care attendance and obesity, promotion of healthful eating in child care remains an important issue when addressing long-term healthful behavior.

Menus, Meal Patterns, and Portion Sizes Foods and Beverages Should Be Provided in Quantities and Meal Patterns Appropriate to Ensure Optimal Growth and Development. Children typically grow 2.5 in and gain 5 to 6 lb each year from age 1 year through adolescence. Total energy needs increase slightly with age, although energy needs per kilogram of body weight actually decline gradually during childhood.

Meals and snacks should be offered to children every 2 to 3 hours in child-care programs (27). Generally, children in care for 8 hours or less should be offered at least one meal and two snacks or two meals and one snack (27). Children in care more than 8 hours should be offered at least two meals and two snacks or three snacks and one meal (27). Recommended patterns and portion sizes for providing well-balanced meals and snacks are available from a variety of sources, including the US Department of Agriculture’s Child and Adult Care Food Program (CACFP) (28,29). Portion sizes and frequency of meals and snacks affect the energy intake of children (30,31).

By ensuring that children receive adequate amounts of foods and beverages, served at appropriate intervals, child-care programs can make substantial contributions to helping prevent hunger in children. Nearly 15% of families in the United States report food insecurity, and a number of these families include young children (32). Child-care providers should follow current portion size recommendations but should also respond to children’s cues related to hunger and satiety.

Child-Care Programs that Meet Requirements Can Benefit from Participation in the CACFP. The CACFP (28) is a federal nutrition assistance program that provides reimbursement for meals and snacks served to children from families with low incomes and some children with disabilities and chronic health conditions enrolled in child-care facilities. The program also delivers nutrition education, regulates meal patterns and portion sizes, and offers sample menus to help child-care providers comply with nutrition standards. The program provides meal-pattern and child-size-portion guides for feeding infants and children ages 1 through 2 years, 3 through 5 years, and 6 through 12 years. Both child-care centers and family child-care homes are eligible to participate in the program, but homes must work with a sponsoring agency.

Child-care programs not eligible to participate in CACFP are encouraged to follow CACFP guidelines for healthy meals and snacks. Centers that participate in CACFP, including Head Start programs (22) not participating in the National School Lunch and Breakfast Program (33), must
provide copies of menus to ensure compliance with CACFP meal pattern food group requirements.

**Child-Care Programs Should Provide Menus that Reflect Actual Foods and Beverages Served.** Menus are an important source of information for families of children in child care. Sanitation practitioners and researchers post menus to keep families informed about meal patterns and foods and beverages provided. A review found that 39 states (76%) required child-care centers to post menus or make them available to parents, and 19 states (37%) required family child-care homes to post menus or make them available to parents through their state regulations (34). Roughly one quarter of states also specify that menus match foods served to children and required child-care providers to note any deviations from the menu in advance of the meal or snack (34). Previous studies have demonstrated that child-care menus are only partially accurate sources of information about foods and beverages served to children in child care (35). Child-care programs can enhance the accuracy of their menus by aiming to serve foods and beverages listed on menus and when necessary noting substitutions directly on menus in advance of the meal or snack.

State and federal regulators review menus to ensure that child-care providers are serving foods and beverages that meet nutrient and dietary requirements. They also use menus as a cost-effective method to monitor adherence to program guidelines and state regulations. Food and nutrition practitioners and researchers review menus to assess the dietary quality of foods and beverages served to children to identify opportunities for improvement (36,37).

**Food Preparation and Service**

**Food Preparation and Service Should Be Consistent with National Standards and Recommendations for Food Safety and Sanitation.** Children in child care should be served food that is stored, prepared, and presented in a safe and sanitary manner. The challenges of foodborne illness have changed because of newly identified pathogens and vehicles of transmission, changes in food production and distribution, and decline in food-safety awareness in child-care programs and society (38,39). The Centers for Disease Control and Prevention reported 21,183 cases of foodborne disease in 2007, with the majority of foodborne disease caused by bacterial pathogens (38). Many more cases, however, are not reported and are therefore not documented. In addition, new pathogens have emerged and are transported through the food chain (38). It is important that proper institutional food-management practices be implemented to protect the health and safety of children in child care. Food-service personnel in child-care programs need to assess the safety and quality of their foodservice operation daily using the recommendations of Hazard Analysis and Critical Control Points for the handling, cooking, serving, and storage of food and equipment (40). Moreover, providing sanitary facilities for foodservice staff and enforcing sanitary practices, including thorough hand washing, is one of the most effective strategies for preventing the spread of disease in child care (40-43).

Materials for training foodservice personnel to avoid foodborne illness and cross-contamination are abundant and accessible to child-care providers (40-43). Caring for Our Children—National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs (CFOC) provides detailed standards (27). Chief among these are standards that children and child-care providers wash their hands, that children's food be served on plates or other disinfected holders and not placed on a bare table, that foods be properly refrigerated, that kitchen equipment be appropriately designed and maintained, and that single-service articles such as paper napkins be discarded after each use. Another resource, Making Food Healthy and Safe for Children: How to Meet the National Health and Safety Performance Standards—Guidelines for Out-of-Home Child Care Programs (43), was designed to help child-care providers comply with CFOC standards.

Food allergies are an important issue related to food safety. Food allergies are common in children and prevalence rates have increased in recent years (44). Milk allergy is common, especially in young children (45), but peanut allergy has received considerably more attention because of some children's severe reactions (46). A number of child-care programs no longer allow peanuts or peanut products in the facility to help prevent accidental exposure, although most should be considered peanut-restricted rather than peanut-free (47). Nonetheless, child-care providers should provide a safe environment for children with peanut allergies and recognize and treat a food allergy-based reaction (48). CFOC provides standards for developing medical treatment plans, training staff, and administering medication related to food allergies in child care (27).

**Physical and Social Eating Environment**

**Child-Care Providers Should Model and Encourage Healthful Eating for Children.** Children mimic adults, and thus child-care providers have the opportunity to model and encourage healthful eating. Children learn about food and nutrition from messages conveyed by child-care providers (49). Messages can be conveyed through instruction, in conversation, in guided practice, and through modeling (50). Although modeling healthful eating behaviors by providers is thought to be important, research to date is inconclusive. One study found that provider modeling alone was not effective at encouraging children's consumption of unfamiliar foods (49). When modeling was combined with encouraging comments, children were more likely to accept the new foods (50).

**Child-Care Providers Should Work with Children to Understand Feelings of Hunger and Satiety and Should Respect Children's Hunger and Satiety Cues, Once Expressed.** Young children are aware of feelings of hunger and satiety, but by age 5 years, this ability begins to wane. Specifically, 3-year-olds consumed consistent amounts of food, regardless of portion size, whereas 5-year-olds increased consumption as the size of the portion increased (51). Serving foods and beverages family style, where children select their own portions and serve themselves, may encourage better self-regulation of intake in children (52,53). Division of responsibility is another approach to feeding that may help children self-
regulate food intake (54). This method specifies that adults are responsible for the what, when, and where of feeding, whereas children are responsible for the how much and whether of eating. In theory, this approach facilitates child self-regulation, but there is no direct evidence to support this approach. The method is, however, consistent with other feeding practices that support healthy eating in children, including adult modeling, repeated exposure to novel foods, and family-style meals.

There is also evidence that negative aspects of the mealtime environment may facilitate unhealthful eating behaviors in children. Pressuring children to eat may lead to higher levels of picky eating, greater resistance to eating (55,56), and a dislike of certain foods that can persist well into adulthood (57).

**Furniture and Eating Equipment Should Be Age-Appropriate and Developmentally Suitable for Children.** Chairs, tables, and eating equipment and utensils should be comfortable and suitable in size and shape for children, with accommodations made for children with developmental disabilities (27). It is important that the eating environment support children’s health and safety. Eating utensils should be appropriate in size and weight for the children’s motor skills and protect them from choking. Children should be able to sit in chairs that allow them to rest their feet on the floor or a footrest to minimize the risk of falling. Posters, pictures, and decorations that communicate nutrition messages can help reinforce nutrition concepts taught by child-care providers and modeled during meals and snacks (58).

**Nutrition Training**

*Child-Care Providers Should Receive Appropriate Training in Child Nutrition and Should Be Aware of the Benchmarks Put Forth in this Position Paper.* Child-care providers should be knowledgeable about the basic principles of child nutrition, strategies for creating a positive mealtime environment, development of healthful eating habits, and the other benchmarks included in this Position Paper. In addition, they should be offered training that promotes their own health and well-being. Foodservice personnel, including cooks and other providers who prepare food for children, should have training in how to plan, prepare, and serve nutritious, safe, and appealing meals and snacks that are consistent with the DGA and the DRI. Food and nutrition practitioners can provide training to child-care programs on these benchmarks. Having a regular schedule for training of providers is also important owing to high turnover rates. Half of providers and one third of center directors leave their centers within a 4-year period (59). Annual program-related training is required for child-care programs that participate in CACFP (28), and CFOC recommends nutrition-related education tailored to the level of involvement that providers have with foodservice within the child-care program (27).

**Nutrition Consultation**

*Food and Nutrition Practitioners, Including Registered Dietitians and Dietetic Technicians, Registered, Can Provide Consultation to Child-Care Programs on Nutrition for Children.* Food and nutrition practitioners can provide consultation to child-care programs to assist with menu planning and evaluation and nutrition information and training for foodservice personnel, providers, and families. Other important tasks that ensure high-quality nutrition in child-care programs include screening and assessment, information and education activities, and counseling that take into account physical, emotional, and financial considerations. Tools and assessments are available to help food and nutrition practitioners evaluate the achievement of these benchmarks in child-care programs (61). In addition, a unique opportunity exists in states requiring menu review from a food and nutrition practitioner through state licensing regulations. Based on a 2008 review, eight states require child-care centers and three states require family child-care homes to undergo menu reviews by a food and nutrition practitioner (34). In those states, food and nutrition practitioners may have substantial influence over foods and beverages served to children in child-care programs. In states without this regulation, food and nutrition practitioners may encourage adoption of new policies related to nutrition in child care, including menu review by a food and nutrition practitioner.

**Physical Activity and Active Play**

*Food and Nutrition Practitioners Can Work with Child-Care Providers to Encourage Active Play in Children.* Active play is an important part of quality child care. Regular physical activity promotes a healthy weight, enhances motor skills, and improves cardiovascular function (62,63). Studies have also linked physical activity and children’s ability to pay attention and focus (64,65). Some research suggests that physical activity and other weight-related behaviors begin in early childhood and track over time (66,67). Thus, encouraging physical activity in early childhood may have long-term benefits. DGA recommendations state that children should accumulate 60 minutes of physical activity daily or on most days of the week (10). The National Association for Sport and Physical Education recommends that children accumulate at least 60 minutes of structured physical activity daily and up to several hours of daily, unstructured physical activity, and...
children should develop gross motor skills that serve as the foundation for more advanced movement (68). The American Academy of Pediatrics recommends that children participate in a variety of activities, including unstructured play, and also engage in activities such as running, tumbling, throwing, and catching, with adult attention to safety and supervision (69).

Children are more active when playing outdoors (70,71) and engaging in moderate and vigorous physical activity in short bursts throughout the day (72). Evidence also suggests that children’s physical activity levels depend on their child-care programs (73). Providers can help achieve this benchmark by creating opportunities for children to engage in both structured and unstructured physical activity throughout the day and facilitating outdoor time at least once per day and preferably more often. Recent studies have found that children in child care are largely inactive (74,75). In addition to providing ample time for active play, it is important to limit sedentary time to 30 to 60 minutes per full day of child care for children while they are not sleeping or eating (58,68).

**Working with Families**

**Child-Care Providers Should Work with Families to Ensure that Foods and Beverages Brought from Home Meet Nutrition Guidelines.** A number of child-care programs require families to provide meals and snacks for their children. Child-care programs may provide culturally sensitive written guidelines or policies to families to help outline requirements and prohibited foods. Few studies have examined the nutritional quality of foods and beverages brought to child-care programs from home. A study found that lunches brought from home provided inadequate amounts of total kilocalories, vitamin A, iron, calcium, zinc, and fiber and that sodium was 114% of the DRI (76). In addition, foods and beverages provided did not meet CACFP standards for fruits, vegetables, and milk in the majority of lunches. The authors recommended communication and education to help ensure that meals and snacks sent from home meet children’s nutrition needs (76). Providers can work with families to help ensure that foods and beverages meet the nutrition guidelines outlined in this Position Paper. Child-care programs should have food available to supplement meals and snacks brought from home if the food provided does not meet children’s basic nutrition needs (27).

**Families of Children in Child Care Should Encourage the Provision of Healthful Foods and Beverages in Child-Care Programs.** As more parents rely on providers to share their role as caregiver, it is important that food and nutrition practitioners help families communicate with providers about foods and beverages served to their children. One study found that parent suggestions to improve healthful eating and physical activity in their child-care program were consistent with national recommendations (77), and interactions between providers and families should be encouraged. Food and nutrition practitioners can help families advocate for improved nutrition in their child-care programs.

**OPPORTUNITIES TO PROMOTE HEALTHFUL EATING IN CHILD CARE THROUGH INTERVENTION**

A primary way to achieve these benchmarks is through interventions, a number of which have been developed by researchers and food and nutrition practitioners and disseminated for use in states and communities, or by child-care programs directly. Three programs are included in this Position Paper, two of which were highlighted in the national Childhood Obesity Task Force Action Plan: Solving the Problem of Childhood Obesity Within a Generation (78). Other programs exist and may be used to promote healthful eating in child care (79).

Hip-Hop to Health Jr. is a classroom-based intervention designed to promote healthy weight in racially and ethnically diverse children aged 3 to 5 years. The intervention was successful in controlling excess weight gain in African-American children attending 12 Head Start centers at both 1 and 2 years postintervention (80). In addition, saturated fat intake was substantially lower in children attending intervention centers at 1-year follow-up, but not at 2-year follow-up. Researchers evaluated Hip-Hop to Health Jr. in 12 Head Start centers serving predominately Latino children, but did not find significant differences in weight or dietary intake between children attending intervention centers compared to those attending control centers (81).

I Am Moving, I Am Learning (82) is another program developed for use in Head Start centers. The program aims to enhance both fine and gross motor skills as well as to improve dietary intake among children attending Head Start programs. The goals of the program are to increase the amount of time children spend in moderate to vigorous physical activity each day, improve movement quality of structured activities, and promote healthful eating. The intervention materials are centered on a character called Choosy that was developed to help children make good choices related to food and physical activity. Preliminary results from pilot testing are favorable and suggest that the program increased children’s physical activity levels, decreased sedentary time, and enhanced family involvement in the child-care program (83).

The Nutrition and Physical Activity Self-Assessment for Child Care program is an environmental intervention designed to improve policies and practices in child care that promote healthy weight in children aged 2 to 5 years. The intervention encourages child-care centers to self-assess their nutrition and physical activity environments, select areas for improvement from the self-assessment instrument (61), and make environmental changes with the help of a health professional (58). Pilot testing in 19 child-care centers and evaluation in 84 additional centers found that participating centers improved their nutrition environments, but were less likely to make substantial changes related to physical activity (84,85).

**OPPORTUNITIES TO PROMOTE HEALTHFUL EATING IN CHILD CARE THROUGH POLICY AND REGULATION**

A second way to help achieve these benchmarks is through policy and regulation. Child care is regulated primarily at the state level, and each state establishes its own regulations for licensed child-care programs and sets minimum enforcement standards to improve adherence. In some cases, cities and other municipalities...
have enacted regulations that are more robust than those in their states but not all cities and municipalities have the authority to do so. New York City, for example, enacted healthful eating and physical activity regulations in 2006 revisions to the New York City Health Code (86).

Most states license a number of different classes of child-care facilities, but the majority of them include both child-care centers and family child-care homes (87,88). Generally, regulations related to nutrition are more common for centers. Two reviews of state regulations found that most states lacked adequate regulations related to healthful eating. In a 2007 study, researchers examined state regulations and recorded mention of eight items, including water, sugar-sweetened beverages, foods of low nutritional value, forcing children to eat, using food as a reward, supporting breastfeeding, limiting screen time, and requiring physical activity daily (88). The study found substantial variation among states. Tennessee had six of the eight regulations for child-care centers, whereas the District of Columbia, Idaho, Nebraska, and Washington had none of them. For family child-care homes, Georgia and Nevada had five of the eight regulations, and California, the District of Columbia, Idaho, Iowa, Kansas, and Nebraska had none. A similar 2006 review of state regulations also found substantial variability among states (20). Centers were the most heavily regulated and had more specific regulations, followed by large family and group child-care homes. Small family child-care homes had the fewest and most general regulations. The researchers found that 12 states had regulations that limited foods of low nutritional value in centers, seven states had regulations for large family and group child-care homes, and four states had regulations for small family child-care homes. It is important to note that child-care regulations represent minimum standards, or “the floor.” Actual practice of child-care programs should exceed standards put forth in state regulations.

States have the opportunity to enhance regulations to help achieve these benchmarks. Food and nutrition practitioners can help by providing their expertise and understanding of how regulatory and policy changes happen in their states. To make changes in regulations, some states must work through their legislature. In other cases, the legislature has empowered an agency to amend and enact new regulations for child care. The existence of a regulation does not guarantee provider compliance or state enforcement of the regulation, but child-care providers are likely a compliant group, given that their livelihoods and the health of the children in their care depend on their adherence. States can improve their regulations by enacting more stringent CACFP policies. A number of state regulations require that all child-care programs comply with their CACFP standards, and thus in many states there are two potential avenues for enhancing policies governing child care. In 2006, roughly 60% of states specified CACFP or similar meal pattern requirements for child-care centers, approximately 50% did for large family or group homes, and approximately 40% did for small family child-care homes (20). A few states have made policy changes and revised their standards for CACFP. Delaware limited less-healthy foods, such as cheese food products, fried vegetables such as french fries, and processed meats (89). New CACFP standards in Delaware also limit juice served to children (no juice for infants aged 12 months and younger) and promote whole grains. Because Delaware state child-care regulations defer to state CACFP standards, this policy change affects all licensed child-care programs. Efforts to enhance child-care environments through both state regulations and CACFP are warranted. Policy and regulation, however, rarely reach children in unregulated child-care arrangements such as family, friend, or neighbor care. Additional efforts are needed to promote the health of children in these less-formal types of child care.

References
5. Addessi E, Galloway AT, Visalberghi E, Birch LL. Specific social influences on the


32. Oakley CB, Bomba AK, Knight KB, Byrd SH. Evaluation of menus planned in Mississippi child-care centers participating in the Child and Adult Care Food Program. J Am Diet Assoc. 1995;95:765-768.


48. Fisher JO, Rolls BJ, Birch LL. Children’s bite size and intake of an entrée are greater with large portions than with age-appropri-
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Authors: Sara E. Benjamin Neelon, PhD, MPH, RD (Duke University Medical Center, Durham, NC); and Margaret E. Briley, PhD, RD, LD (The University of Texas at Austin, Austin, TX).

Reviewers: Sarah C. Ball, MPH, RD (University of North Carolina at Chapel Hill, NC); Pediatric Nutrition dietetic practice group (DPG) (Lynn S. Brann, PhD, RD, Syracuse University, Syracuse, NY); Public Health/Community Nutrition DPG (Lisa S. Brown, PhD, RD, Simmons College, Boston, MA); Sharon Denny, MS, RD (ADA Knowledge Center, IL); Hunger and Environmental Nutrition DPG (Fern Gale Estrow, MS, RD, CDN, FGE Food & Nutrition Team, New York City, NY); Mary A. Musil, MS, RD (Montana Department of Public Health and Human Services, Helena, MT); Esther Myers, PhD, RD, FADA (ADA Research & Strategic Business Development, Chicago, IL); Mary Pat Raimondi, MS, RD (ADA Policy Initiative & Advocacy, Washington, DC); Lisa Spence, PhD, RD (ADA Research & Strategic Business Development, Chicago, IL); and Jennifer A. Weber, MPH, RD (ADA Policy Initiative & Advocacy, Washington, DC).

Association Positions Committee Workgroup: Alana Cline, PhD, RD (chair); Katrina Holt, MPH, MS, RD; and Dayle Hayes, MS, RD (content advisor).

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