Position of the American Dietetic Association: Child and Adolescent Nutrition Assistance Programs

ABSTRACT
It is the position of the American Dietetic Association that children and adolescents should have access to an adequate supply of healthful and safe foods that promote optimal physical, cognitive, and social growth and development. Nutrition assistance programs, such as food assistance and meal service programs and nutrition education initiatives, play a vital role in meeting this critical need. Nutrition assistance programs create a safety net that ensures that children and adolescents have access to adequate food supplies; and women, infants, and children who have nutritional or medical risk factors, such as iron-deficiency anemia or overweight, receive supplemental nutritious foods as well as nutrition education. In addition, federally funded nutrition assistance programs serve as a vehicle for nutrition education and promotion of physical activity designed to prevent or reduce obesity and chronic disease. It is important that continued funding be provided for these programs that have been consistently shown to have a positive influence on child and adolescent well-being. Registered dietitians and dietetic technicians, registered, are the only food and nutrition practitioners with adequate training in food science, nutrition, and food systems to implement research and surveillance programs to monitor, evaluate, and improve the nutritional status of children and adolescents.


POSITION STATEMENT
It is the position of the American Dietetic Association that children and adolescents should have access to an adequate supply of healthful and safe foods that promote optimal physical, cognitive, and social growth and development. Nutrition assistance programs, such as food assistance and meal service programs and nutrition education initiatives, play a vital role in meeting this critical need.

RATIONALE
More than 74 million children and adolescents reside in the United States, accounting for more than 31% of the total population (6). In 2007, 13 million children and adolescents, or 18% of the population under age 18 years, lived in poverty* (6,7). There was a 15% increase in the number of children and adolescents living in poverty between 2000 and 2007 (7,8). Among children younger than age 6 years, 21% are from families with low incomes whereas 16% of children age 6 years or older are from families with low income. African-American and Latino children disproportionately live in poverty compared to their Asian and white peers (prevalence rates for poverty are 34%, 29%, 13%, and 10%, respectively); national data on American Indian and Alaskan Native children are not available for com-

*Poverty is a measure of economic well-being set annually by the federal government that was originally defined in 1963 as three times the cost of the US Department of Agriculture’s economy food plan for a family of three or more people; in 2009 the poverty level was $18,310 for a family of three and $22,050 for a family of four.
Children and adolescents who have at least one immigrant parent, live in female-headed households, and those who live in rural or inner-city areas are also disproportionately vulnerable to poverty. Increases in the prevalence of poverty among families with children are expected due to poor economic conditions and rising rates of unemployment, which necessitates policymakers and providers knowing current poverty prevalence data and guidelines for nutrition assistance program eligibility (6,7).

Households with children and adolescents were twice as likely as households without children to report food insecurity (ie, lack of availability of nutritionally adequate and safe foods or the inability to acquire acceptable foods in socially acceptable ways) (9). Approximately 17% of children and adolescents live in households that were food insecure and just under 1% of children and adolescents experienced very low food security. Almost one third (30%) of children and adolescents living in female-headed households were food insecure, with 10% being classified as very food insecure. Rates of food insecurity are substantially higher than the national average for children and adolescents with immigrant parents and for African-American and Hispanic households (9).

Concurrent to the problem of food insecurity is the high prevalence of overweight and obesity among children and adolescents. Estimates of weight-for-height status among children and adolescents from the 2007-2008 National Health and Nutrition Examination Survey suggest that approximately 32% of children and adolescents are overweight (defined as body mass index >85th percentile for age and sex), with approximately 10% of children aged 2 to 5 years and 20% of children age 6 years and older being identified as obese (defined as body mass index ≥95th percentile for age and sex) (10). The prevalence of obesity is markedly higher among children and adolescents of color at all ages (10,11). Although causes for the high of rates of overweight and obesity among children and adolescents have not been identified, poor physical activity and eating habits of children and adolescents appear to be major factors. The Institute of Medicine (IOM) report, Preventing Childhood Obesity: Health in the Balance (12), outlines a set of prevention-oriented recommendations for reducing obesity and improving the health and well-being of America’s children and adolescents. Many of the recommendations in the IOM report focus on developing and strengthening comprehensive nutrition education and physical activity programs and services within schools and communities and improving the overall nutrition environment of communities (12). Child and adolescent nutrition assistance programs will undoubtedly continue to play a major role as vehicles for the delivery of nutrition education tailored toward the prevention, early intervention, and treatment of child and adolescent overweight and as a means for improving the nutrition environment of states and communities.

Iron deficiency is the most prevalent nutrient deficiency in the United States (2). The prevalence of iron deficiency among children and adolescents varies by age, affecting 7% of children ages 1 to 2 years, 5% of children ages 3 to 5 years, 4% of school-aged children, and 5% to 16% of adolescents. The risk of iron deficiency is highest during infancy and adolescence because high levels of iron are needed to support rapid growth during these periods of life. As toddlers transition from consuming human milk and/or iron-fortified infant formula to solid foods, they often do not consume adequate dietary iron. Children with selective dietary intakes, who live in communities with low income, and who are of African or Mexican descent are also at higher risk for iron deficiency (2,13). Research suggests that overweight and obese children and adolescents may also be at higher risk for iron deficiency (13,14). Iron deficiency has been linked to an increased risk for developmental delays, impaired physical performance, and behavioral disturbances in children (2,15). Iron deficiency may result in impaired growth and development, increased susceptibility to infection, shorter attention spans, poor school performance, and susceptibility to lead poisoning (2,13,15).

Data on food and nutrient intakes of children and adolescents shed light on the need for strengthening federally funded nutrition assistance programs. Estimated intakes of energy among children and adolescents showed small reductions between 2003 and 2006 across all age groups (16,17). Estimated intakes of total and saturated fats and sodium also appear to have decreased slightly among preschool and school-aged children; however, they remained similar among adolescents and are above recommended levels for all age groups (16,17). Intakes of vitamin A appear to have increased slightly among children ages 6 years and older but have decreased among children ages 5 years and younger, whereas the intake of B vitamins has decreased among all groups except adolescents. Inadequate intake of minerals such as calcium remains an issue, with all age groups showing slight decreases in intake during the past 5 years. Fiber intake is low and has remained unchanged in the past decade (16,17).

When recent estimates of dietary intakes of children and adolescents are compared to national dietary guidance using the Healthy Eating Index-2005, the need to expand efforts to improve the nutritional adequacy of children’s and adolescents’ diets is apparent. Total Healthy Eating Index-2005 scores for children and adolescents ages 2 to 17 years ranged from 54.7 to 59.6 out of 100 points (18). All age groups obtained maximal scores for total grains, but only children ages 2 to 5 years met total fruit and milk recommendations. Component scores for total vegetables, saturated fat, sodium, and extra energy were half the maximal value, suggesting a need for dietary improvement in these areas. Unfortunately, it appears that the nutrient density of diets has not improved over time, and adherence to dietary guidelines is low (18).

Federally funded nutrition assistance programs help to ensure that children and adolescents receive meals that provide adequate energy and nutrients to meet their growth and development needs; children and adolescents have access to adequate food supplies; and women, infants, and children who have nutritional or medical risk factors, such as iron deficiency anemia or overweight, receive supplemental nutritious foods as well as nutrition education. In addition, federally funded nutrition assistance programs serve as a means to combat hunger and food insecurity and as a vehicle for nutrition education and promotion of...
physical activity designed to combat obesity and prevent chronic disease. It is imperative that registered dietitians (RDs) and dietetic technicians, registered (DTRs) utilize their unique knowledge, training, and expertise to advocate for and deliver these programs.

AN OVERVIEW OF CHILD AND ADOLESCENT NUTRITION ASSISTANCE PROGRAMS

In fiscal year (FY) 2008, the US Department of Agriculture (USDA) spent approximately $61 billion on food assistance programs (19). These programs include the following:

Supplemental Nutrition Assistance Program (SNAP)

SNAP is the largest food assistance program in the United States. It provides monthly food benefits to purchase specific food items at authorized stores. SNAP is an entitlement program, providing benefits to all individuals who are eligible based on household income level and work and immigration status requirements (3-5,19). In FY 2008, $37.5 billion was spent to provide food assistance to individuals and families with low incomes; this represented an increase in spending of 13% and a total of 62% of the overall USDA food assistance budget. SNAP benefits averaged $101.53 per person per month in FY 2008 (19). In FY 2007, approximately 12.7 million children and adolescents lived in households receiving SNAP benefits (7,8,19). It should be noted that only 87% of families with children and adolescents eligible to receive SNAP benefits applied for and received these benefits in FY 2007 (8).

The SNAP Ed Program is a nutrition education program authorized by federal regulations for the purpose of providing nutrition education to program participants (20). Under this program, state agencies may apply for funding that will cover up to 50% of SNAP Ed Program activities; states are required to provide matching funds for additional funding required to support the program. The goal of the SNAP Ed Program is to provide learning experiences that improve the likelihood that SNAP participants will make healthful food choices within their limited budget as well as adopt an overall healthy lifestyle (20). The USDA’s Food and Nutrition Service encourages SNAP Ed Programs to prioritize women and children for nutrition education activities.

Nutrition Assistance Programs

The federally funded nutrition assistance programs were developed to subsidize meals served to children and adolescents in schools and other organizations in which they receive instruction or care. The programs include the National School Lunch Program (NSLP), the School Breakfast Program (SBP), the Child and Adult Care Food Program (CACFP), the Summer Food Service Program (SFSP), the Afterschool Snack Program (ASP), and the Fresh Fruit and Vegetable Program. In FY 2008, $14.6 billion was spent on these programs (19,21).

The NSLP is the largest of the child nutrition assistance programs. It was established in 1946 to safeguard the health of children and adolescents by providing food through the establishment and maintenance of nonprofit school lunch programs (3-5,19,21). The NSLP is an entitlement program that provides federal reimbursement to School Food Authorities in the form of cash and commodity foods (through the USDA Food Program) for the provision of nutritious lunches for children and adolescents enrolled in public and nonprofit private schools and residential child care institutions. To receive these benefits, participating agencies must serve meals that comply with the current Dietary Guidelines for Americans (22). Meals must also provide at least one third of the Recommended Dietary Allowances for protein, vitamins A and C, iron, calcium, and energy. Children and adolescents from families with incomes at or below 130% of the federal poverty guidelines may apply to receive free meals, whereas those children and adolescents from families earning between 130% and 185% of the poverty guidelines may apply for reduced-price meals (4,5,19,20). Children and adolescents from families with incomes >185% of the poverty guidelines pay full price for meals served through NSLP. During FY 2008, the NSLP provided lunches to nearly 31 million children and adolescents each school day (19,21). Approximately 3 million students purchased NSLP lunch at reduced cost, whereas almost 50% of students (14.6 million) received free NSLP lunches (19,21). The IOM report, School Meals: Building Blocks for Healthy Children (23), focuses on the importance of the NSLP and the SBP in supporting the nutrition and health of children and adolescents in the United States by providing nutritionally balanced, low-cost or free lunches each school day (23).

The NSLP also offers reimbursement to schools that serve snacks to children who participate in supervised afterschool programs that provide an educational or mentoring component through ASP (24). Sports teams and other organized physical activity groups are not eligible to participate in ASP. Snacks served through ASP are reimbursed at the free rate regardless of an individual’s ability to pay if at least 50% of students in the school are eligible for free or reduced-price lunches, whereas those served in schools with fewer children and adolescents from families who are income eligible for the NSLP are reimbursed according to the individual’s eligibility (24).

The SBP was established in 1966 to provide free or reduced-price breakfasts to students living in poor areas and to students who had to travel long distances to attend school (3,4). Approximately 10 million students receive breakfast through the SBP daily, with more than 78,000 schools participating (5,19,21,23). More than 7 million students (70%) who participate in SBP are served free breakfasts and another 1 million (10%) receive reduced-price breakfast. Other nutrition assistance programs provide meals and snacks to children and adolescents through school programs and during summer school vacations when they do not have access to the SBP and NSLP.

A relatively new nutrition assistance program is the Fresh Fruit and Vegetable Program, which provides fruit and vegetable snacks to children and adolescents attending participating schools at no cost. Started in 2002 as a pilot program, the Fresh Fruit and Vegetable Program became a permanent program through the 2004 Child Nutrition and WIC Reauthori-
zation Act, and was expanded as part of the 2008 Farm Bill (25). It is preferentially offered in schools throughout the United States that serve a high proportion of students from families with low incomes.

In its 2009 report *School Meals: Building Blocks for Healthy Children* (23), the IOM recommended that the USDA adopt standards for menu planning, including increasing the amount and variety of fruits, vegetables, and whole grains; setting a minimum and maximum level of energy; and focusing more on reducing saturated fat and sodium intake. The IOM supports the key role that the national child nutrition programs play in supporting the nutrition and health of children and adolescents in the United States (23). Through these nutrition assistance programs, children and adolescents who might otherwise experience food insecurity because of family financial constraints are served meals that provide the energy and nutrients required for physical growth and social and cognitive development.

During the summer months, the SFSP serves meals to nearly 2 million children and adolescents from families with low income (3,19,21,26). The SFSP operates in settings such as schools, residential camps, nonprofit and religious organizations, and parks and youth sports programs (5,26). All meals served by the SFSP must meet SFSP nutrition standards, with the exception of SFSP sites vended by schools; those meals may meet NSLP meal standards. SFSP is an entitlement program that could be made available to all 17 million children and adolescents who are eligible to receive free or reduced-price meals, yet only a small fraction of these children and adolescents are served each year (5,7).

The CACFP provides reimbursements for meals served to more than 3 million children each day in family day care homes, child care centers, homeless shelters, Early Head Start and Head Start programs, and after school programs serving children from families with low income (3-5,19,21). The CACFPs are generally administered by state departments of education. Child care homes and centers may receive reimbursement for up to two meals (breakfast, lunch, or supper) and one snack, or two snacks and one meal, for each eligible participant. Homeless shelters may receive reimbursement for up to three meals (breakfast, lunch, and supper) for each child. After school child care programs may request reimbursement for one snack per child. Snacks provided through the CACFP must provide at least two food items from the meat, milk/milk products, grains, and fruits/vegetables food categories and must comply with USDA regulations for CACFP meals (21).

As part of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, tiered reimbursements to child care homes (similar to reduced- and free-priced meal reimbursements for the NSLP) were mandated to encourage greater workforce participation by families with low income (3,5,21). Higher reimbursements are provided to child care homes that serve predominantly children from families with low income, are located in areas with a high population of families with low income, or where the provider’s household income is at or below 185% of the federal poverty guidelines (5,21). The tiered reimbursement system does not apply to child care centers.

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

WIC was established in 1972 by an amendment to the Child Nutrition Act of 1966 and became a permanent program in 1975 (3,4,19,21,27). WIC provides nutritious foods to supplement usual dietary intake, nutrition education, breastfeeding education and support, and referrals to health care and other social service providers to pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 years. Participants in the program must have a family income <185% of the poverty guidelines and have a documented medical or nutritional risk such as anemia, overweight, underweight, history of pregnancy complications, or failure to meet the current Dietary Guidelines for Americans (22,27). Unlike SNAP and the NSLP, WIC is not an entitlement program, so participation in the program is limited by the availability of federal funding rather than the number of individuals meeting program eligibility criteria.

In FY 2008, more than 2.1 million women, 2.2 million infants, and 4.3 million children younger than age 5 years received benefits through WIC (19,20,27). Nearly half of all infants born each year and one quarter of children age 4 years and younger participate in WIC (5,21,27). More than $4.5 billion was spent to provide foods and beverages, and $1.6 billion was spent to provide nutrition education and administrative services for participants in FY 2008 (19,21,27). The average participant received approximately $43 in food vouchers each month (19,21,27).

In 2009, new food packages were integrated into WIC to provide a variety of foods to match the ethnic diversity of the WIC participants, promote whole grains and fruits and vegetables, and allow for milk substitutes for some participants (28). The WIC Farmers’ Market Nutrition Program, established in 1992, provides coupons for the purchase of fresh fruits and vegetables at participating farmers’ markets (5,19,27). During FY 2008, more than 2.3 million participants received these benefits (19,21). Also during FY 2008, more than 16,000 farmers, 3,367 farmers’ markets, and 2,398 roadside stands benefited from receiving Farmers’ Market Nutrition Program coupons worth more than $20 million.

**Food Distribution Programs**

Federal food distribution programs that serve children and adolescents include The Emergency Food Assistance Program (TEFAP), the Food Distribution Program on Indian Reservations (FDPIR), the Department of Defense Fresh Fruit and Vegetable Program (DODFFVP), the Disaster Feeding Program, the Commodity Supplemental Foods Program (CSFP), and the Food Distribution Programs for Charitable Institutions and Summer Camps (29). TEFAP provides commodity foods to local food distribution and service agencies such as food banks, food pantries, emergency (soup) kitchens, homeless shelters, and other organizations that serve meals to individuals who are homeless or with low income (5,30). More than half of the emergency kitchen and food pantries and 84% of the food banks receive and distribute...
food through TEFAP (29,30). TEFAP accounts for almost 15% of food donated through community agencies (9,30). The program was instituted in 1981 and was first known as the Temporary Emergency Food Assistance Program. The program name was subsequently changed to The Emergency Food Assistance Program as part of the 1990 Farm Act. Under 1996 welfare reform, TEFAP subsumed the Commodity Distribution Programs for Charitable Institutions, Soup Kitchens, and Food Banks (5,29,30).

The FDPIR was formed under the Food Stamp Act of 1977 to address food assistance needs among American Indians and Alaskan Natives living on or near reservations due to the remoteness of these locations that created barriers to participation in SNAP (5,29). The FDPIR was designed to provide monthly supplemental foods including staple foods such as meats, fruits, vegetables, and dried or canned milk to individuals with low incomes residing on reservations. FDPIR participants may also receive nutrition education.

The DODFFVP links schools to the national defense food distribution system to increase the availability of fresh produce in schools (29). Because of the successful implementation of the DODFFVP in schools, which began as a pilot project in 1995, the program was expanded to include purchases for the FDPIR in 2005. The Disaster Feeding Program is a part of the National Response Plan to provide food supplies to disaster relief organizations in the event of a natural disaster or other emergency situations (29,30). Food supplies can be distributed as commodities to households or as meals served in congregate dining centers.

The CSFP provides monthly food assistance to nearly a half million individuals each month. Like the FDPIR, individuals with low income must choose between participation in SNAP or the CSFP. Originally the CSFP was designed to serve individuals with low income, including pregnant women, infants, young children, and older adults (5,29). Upon the creation of WIC, CSFP participation by pregnant women dropped dramatically. Currently the CSFP provides commodity foods to a small number of individuals who are eligible for WIC but choose to participate in the CSFP, and predominantly serves older adults.

Nutrition Education Programs and Related Initiatives

The Expanded Food and Nutrition Education Program (EFNEP) and Team Nutrition Initiative focus on providing nutrition education to support healthy eating and to help ensure that food resources within a household or organization are utilized to their full potential. The EFNEP and Team Nutrition play an important role in shaping the knowledge, attitudes, and behaviors of children and adolescents through experiential educational efforts aimed at children and adolescents and their families as well as to teachers, school foodservice personnel, and community members who serve as role models for children and adolescents and are influential in determining the food environment in which children and adolescents live and learn.

EFNEP provides education and training to individuals with low income to assist in improving their nutrition knowledge, attitudes, and behaviors through skill-based, interactive activities (31). Program participants engage in multiple lessons provided by Cooperative State Research Education and Extension Service paraprofessionals, peer educators, and community health workers. Children and adolescents from families with low incomes are key target groups for EFNEP activities (31).

The USDA launched Team Nutrition in 1995 to complement existing child nutrition assistance programs and to assist schools and communities in promoting the nutritional health of children and adolescents (32). Team Nutrition provides training and technical assistance to school foodservice and other personnel, educators, child care providers, and community groups to support healthy eating and physical activity. An expansion of the program was authorized in the 2004 Child Nutrition Reauthorization Act, but funding has not been appropriated to implement this program expansion.

Participation in Nutrition Assistance Programs Benefits Children and Adolescents

Evaluations of nutrition assistance programs provide evidence of their ability to improve the diets and overall health status of children and adolescents. Data on the effects of nutrition assistance programs on long-term health outcomes are very difficult to determine as these programs provide only a portion of the overall food consumed by children and adolescents. Data are more readily available on the influence that nutrition assistance programs have on overall dietary quality as well as intakes of specific nutrients that are targeted through food packages and nutrition education efforts.

Most evaluations of SNAP have focused on food purchasing power and food insecurity. Researchers have examined the effects of participation on reducing food insecurity and very low food security among households with low income, controlling for other economic factors such as unemployment, nonlabor income, and labor force participation (31). Their results suggest that SNAP benefits were more successful at reducing very low food security compared to an increase in cash benefits. This finding is supported by research showing that SNAP participation increases household food expenditures to a greater extent than cash alone by increasing the marginal propensity to spend on food (ie, the increase in food expenditure per increased dollar of income). Data suggest that for every dollar in SNAP benefits, a household was able to further expand their food purchases by an additional $0.17 to $0.47 (5). Early evaluation data for SNAP suggested that participation may improve intakes of energy, protein, and some vitamins and minerals; however, more recent data have not supported these findings (5,33).

Participation in WIC has been shown to increase birth weight, reduce the incidence of low birth weight, prevent preterm delivery, increase breastfeeding rates, and reduce Medicaid costs among high-risk pregnant women (5,27,33-37). A study of WIC in five states showed a savings of $3.13 in Medicaid costs for infants during the first 2 months of life for every $1 spent on WIC prenatal services (5,33). Program evaluation data also suggest that participation in WIC may improve infant growth, reduce rates of failure to thrive, and improve the overall health status of children (5,33-36).

An evaluation of the effect of WIC...
participation on the quality of dietary intake among children found that WIC participants consumed a more nutrient-dense diet than income-eligible, non-WIC participants, with intakes comparable to children from families with high income (38,39). WIC participants were more likely than income-eligible, non-WIC participants to consume fruit, meat, and dried beans, less likely to consume sweetened, noncarbonated beverages, and had more appropriate intake of solid fats and added sugars (40). This finding is supported by previous research that suggested that participation in WIC resulted in increased intake of energy and nutrients, including protein, vitamin C, iron, and calcium (5,41). Data on improved intake of vitamins A, B-6, and E; thiamin; niacin; riboflavin; folate; and magnesium also provide evidence of the program’s effectiveness at enhancing dietary quality among participants (5). In addition, children who participated in WIC were found to be half as likely to suffer from iron deficiency compared to income-eligible, non-WIC participants, with rates comparable to children from families with high income (42). This finding is supported by data from the Feeding Infants and Toddlers Study (43) that demonstrated that a greater percentage of infants who participated in WIC had adequate intakes of iron than did non-WIC participants.

A study that examined the effects of participation in both SNAP and WIC found that participation in one or both programs was associated with positive nutrition and health outcomes (44). An inverse relationship was found between program participation, jointly and independently, with the rates of children being diagnosed with anemia, failure to thrive, and nutritional deficiencies. A similar relationship was found between program participation and rates of report of child abuse and maltreatment, suggesting that nutrition assistance program participation may provide health effects that extend beyond improvements in dietary intake.

An evaluation of the effects of participation in the NSLP on dietary intake and adequacy among children found that intakes of vitamins A, C, and B-6; folate; thiamin; phosphorus; magnesium; potassium; calcium; and fiber were more likely to be adequate among program participants compared to children that did not participate (45). Children and adolescents who participated in the NSLP were more likely to consume milk, fruit, and vegetables at lunch and less likely to consume desserts, snack foods, and beverages other than milk or 100% fruit juice compared to children and adolescents who did not participate (46). Participation in the NSLP may have economic benefits for families with low income beyond the meals served at school. Household food expenditures may decrease by up to $0.61 for each $1 in NSLP benefits a family receives, resulting in an additional $0.39 of food expenditure capacity for each dollar spent on the NSLP (47).

An evaluation of a universally free SBP demonstrated that program participation increased the likelihood of consuming milk and fruit or 100% fruit juice at breakfast and decreased the likelihood of consuming other beverages (46). SBP participants were less likely to have inadequate intakes of vitamin A, phosphorous, zinc, and magnesium and had higher intakes of potassium and calcium (45). Previous research had also found that SBP participation increased protein, riboflavin, and energy intakes among children and adolescents (5).

Evaluations of SBPs in various states have shown that program participation improves reading, math, and writing scores, vocabulary skills, and memory in children in elementary school (5,48-51). Reductions in tardiness, suspensions, disciplinary referrals, and school nurse visits as well as improvements in student behavior and attendance have been reported among older children and adolescents (5,48-51).

EFNEP participants have been shown to eat a variety of foods, know more about nutrition, select lower cost and more healthful foods, and practice better sanitation methods (31). EFNEP evaluation data have found that families who participated in the EFNEP reduced their yearly food expenditures by $124 to $234 while simultaneously increasing their intakes of iron, vitamins B-6 and C, and fiber (52). An evaluation of the EFNEP in Virginia found that every $1 spent on the EFNEP resulted in a net savings of $10.64 in health care and other costs (53).

In schools where Team Nutrition has been implemented, children exhibit improvements in identifying healthy food choices, understanding and utilizing the Food Guide Pyramid, exhibiting positive attitudes toward healthy foods, and understanding the health consequences of increased fruit, vegetable, and whole grain consumption (5). Improvements in children’s consumption of low-fat foods, fruits and vegetables, and a variety of foods have also been reported after implementation of Team Nutrition in schools.

CONTINUING SUPPORT OF CHILD AND ADOLESCENT NUTRITION ASSISTANCE PROGRAMS

The percentage of children and adolescents living in families with incomes <50% of the poverty guidelines increased from 6.6% in 1980 to 7.4% in 2007 (48). From 1996 to 2000, SNAP expenditures declined by 33%, with average monthly participation rates also falling from 25.5 million to 17.2 million recipients (54). It is estimated that 65% of the decline in SNAP participation was due to welfare reform and 35% was due to an improved economy (54). However, in recent years, expenditures in SNAP have increased. Participation for September 2008 topped 31.6 million individuals, which is the highest it has been in the history of the program. An expansion of SNAP benefits in the 2002 Farm Bill and concentration on outreach and improving access to SNAP benefits factor into this record high usage of the program (54). Recent economic troubles contributed to the increase as well. Since 2001, federal spending on nutrition assistance programs has increased by 140% to $82.1 billion, or 60% of the national budget (54,55). Overall, FY 2008 was the eighth consecutive year that federal spending on food assistance programs increased above the historical amount spent the year before (55,56).

In 2008, the School Nutrition Association reported 425,000 more students participating in free or reduced-price lunch and breakfast programs despite slightly lower student enrollment compared to previous years (56). As of December 2008, food banks reported a 30% increase in the need for emergency food assistance, with 90% of respondents citing unemployment and
Millions of children and adolescents live in families that lack the financial resources to purchase food to prepare nutritious meals. These children and adolescents are also likely to lack adequate health insurance and a source of health care, resulting in reduced access to nutrition screening, education, and counseling. Federally funded nutrition assistance programs are the safety net through which these children and adolescents are assured a reasonably sufficient and safe supply of nutritious food and are provided with the knowledge and skills required to make healthful food choices. National nutrition initiatives to reduce the prevalence of overweight among children and adolescents and prevent future chronic diseases are increasingly important, given that more than one in four children and adolescents are overweight (10). Rates of medical and psychological complications such as hypertension, type 2 diabetes, depression, and orthopedic disorders among overweight children and adolescents are increasing dramatically, as are the costs associated with treating these complications. Many children and adolescents do not consume diets that adhere to national dietary guidelines; thus, programs that target increased consumption of fruit, vegetables, whole grains, and low-fat dairy products are needed to reduce future risk of chronic diseases. Permanent and adequate levels of funding for nutrition assistance programs are critical to ensuring that all children and adolescents attain optimal nutrition and overall health.

ROLES AND RESPONSIBILITIES OF RDs and DTRs

RDs and DTRs are the health care practitioners most qualified to administer programs that help ensure that all children and adolescents obtain safe, nutritious, and adequate food in-takes for optimal nutrition and health. RDs and DTRs are preeminently qualified to provide nutrition screening and assessment, education, and counseling for children and adolescents in accordance with national health recommendations, as well as to monitor nutrition assistance program compliance with local, state, and national regulations. To be successful in these roles, there are a variety of responsibilities that need to be carried out by RDs and DTRs (58-60). To maximize their role in child and adolescent food assistance programs, RDs need to work with policy makers and academic institutions to assure that food and nutrition practitioners are specifically trained to serve in public health and community settings. The roles and responsibilities of RDs and DTRs include, but are not limited to, the following:

- **Advocate for continued and adequate funding of nutrition assistance programs at local, state, and federal levels.** Such funding should support food assistance, meal service, and nutrition screening and education programs targeted toward children and adolescents.
- **Advocate for an integrated health curriculum that highlights healthy food choices and stronger school wellness plans to emphasize the importance of healthy eating and physical activity to children from an early age.**
- **Participate in the development, provision, and evaluation of cutting edge, evidence-based nutrition assistance programs.** Use evidence-based practice guidelines (eg, the American Dietetic Association’s pediatric weight management guidelines) when providing medical nutrition therapy or developing policies relating to nutrition assistance programs and services.
- **Provide technical assistance and training to practitioners that provide nutrition-related services to children and adolescents in health and education settings.**
- **Participate in program evaluation and the collection of nutrition surveillance data that can be used to advocate for adequate and continued funding for nutrition surveillance efforts and nutrition assistance programs.**
- **Advocate for child care and school environments that include comprehensive nutrition education coupled with the provision of meals, beverages, and snacks that meet national dietary guidance.**
- **Work with school administrators, teachers, parents, and communities to ensure that all foods and beverages made available or served in child care and educational settings contribute to the overall quality of a child’s or adolescent’s diet.**
- **Provide guidance on outreach and educational activities that focus on healthy food purchases and preparation to ensure they are culturally relevant and socially acceptable.**
- **Support state and federal efforts for universal health care reimbursement that specifically include comprehensive nutrition screening and assessment, education, and developmentally appropriate anticipatory guidance.**
- **Provide leadership on the development and implementation of emerging public policy issues (eg, menu labeling) to promote healthy eating and active living.**
- **Emphasize and strengthen the provision of program planning and evaluation, communication, and public policy and legislative training in dietetics education programs to support the ability of RDs and DTRs to administer nutrition assistance programs in various practice settings.**

References


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