



Improving Infant and Young Child Nutrition During the First 1,000 Days in Communities of Color

NACCHO's Early Childhood Nutrition Convenings
Final Report



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This document can be found at <https://www.naccho.org/programs/community-health/maternal-child-adolescent-health/breastfeeding-support#early-childhood-nutrition>. For more information, contact breastfeeding@naccho.org.

Table of Contents

- Executive Summary 4
- Introduction..... 6
 - Background and Purpose 6
 - Structure, Participants..... 7
 - Goal of report 7
 - Themes Identified..... 8
- Intersectionality and Nutrition Security in BIPOC Communities 9
 - Cultural Considerations 9
 - Eating is a Family – and Community – Business 10
 - Supporting The Family Business 12
 - Impact of Culture and Socioeconomic Status on Utilization of Government Assistance Programs... 12
 - Socioeconomic and Geographic Considerations..... 13
 - Build from Within: Nothing About Us Without Us 14
- Solutions to Achieve Nutrition Goals in BIPOC Communities from The Communities Themselves 17
 - Dietary Guideline: At About 6 Months, Introduce Infants to Nutrient-Dense Complementary Foods 18
 - Encourage Infants and Toddlers to Consume a Variety of Foods from All Food Groups. Include Foods Rich in Iron and Zinc, Particularly for Infants Fed Human Milk. 23
 - Dietary Guideline: Avoid Foods and Beverages with Added Sugars 32
 - Dietary Guideline: As Infants Wean from Human Milk or Infant Formula, Transition to a Healthy Dietary Pattern 35
- Recommendations moving forward..... 41
- Appendix A: Participants in each convening..... 42
- Appendix B: Considerations to check perceptions 44
- Appendix C: Examples of adapting programs in partnership with BIPOC Communities..... 46
- Appendix D: Other Interested Parties and Stakeholders..... 49
- Appendix E: Successful Strategies 51
- Appendix F: Barriers and Approaches to Overcome Barriers..... 59

Table of Figures

Figure 1: Regional distribution of participants for NACCHO Convenings	7
Figure 2: Important reminders for increasing the trustworthiness of public agencies with communities before initiating NUTRITION programs.....	15
Figure 3: Examples of questions that should be asked when partnering with a community-based organization (CBO).....	15
Figure 4: Selected National Partners' activities that support cultural and family considerations.....	16
Figure 5: Responses from National Partners when asked "What does your organization do to support introduction of complementary foods in BIPOC communities?"	22
Figure 6: Suggestions to Increase Access to Benefits.....	24
Figure 7: Community groups that connect with families and may be able to encourage use of non-governmental benefits to increase access to food	26
Figure 8: Local programs support food education and gardening through empowering community member.....	28
Figure 9: Local programs use community-driven solutions to support wellness through healthy living and social change.....	30
Figure 10: Selection of National Partners' efforts to overcome challenges in getting food benefits.	31
Figure 11: Culturally appropriate messaging to decrease sugar sweetened beverages consumption developed through 24-month randomized controlled trial for Black Head Start Parents in Georgia (University of Georgia, choplab@uga.edu)	33
Figure 12: Sample of National Partners' activities to combat marketing targeted at BIPOC families with young children.....	35
Figure 13: Online Cooking and Nutrition Classes help to encourage families to prepare new foods together	37
Figure 14: Community gardens provide food to the local neighborhood, build community, and teach gardening skills.....	37
Figure 15: Preventing early life obesity in populations most at risk through addressing the whole system.....	38
Figure 16: Ecological Approach To (EAT) Family Style - a training program that addresses healthy nutrition choices across the infant and toddler spectrum.....	39
Figure 17: Sample of National Partners' activities in getting the word out to families regarding health nutrition of infants and toddlers	40

Executive Summary

One key component of NACCHO's Maternal Child and Adolescent Health portfolio is to identify successes, challenges, and best practices to improve infant and toddler nutrition infrastructure in Black/Brown, Indigenous, and other People of Color (BIPOC) communities. In 2021, NACCHO produced a report summarizing the findings of 85 interventions and programs focused on early nutrition beyond breastfeeding. The report highlighted (1) BIPOC communities were more likely to have a low intake of fruit and vegetables, (2) toddler milk was the fastest-growing category of breast milk substitutes, and (3) early introduction of complementary foods was also an issue for BIPOC communities.

To identify solutions to best partner with and support BIPOC communities in achieving optimal nutrition in infants and toddlers, in 2022, CPHI and NACCHO convened three in-person two-day regional meetings (n=51) and a two-hour online session with national partners (n=30). The in-person convenings were designed to gather input on what worked for public health experts and community agency representatives. The online meeting highlighted what we learned and sought additional information from national partners. In addition, NACCHO has also partnered with different communities of color (Chinese/Vietnamese, African American, and Latinx) to help diversify the U.S. Dietary Guidelines for infants and toddlers.

Ideas discussed in each of the convenings were shared with the understanding that culture is not a monolith and there is not one BIPOC community but rather a tapestry of unique and complex communities with passionate leaders. These communities require unique solutions to their individualized needs. Key findings include:

- "Eating is a family, and community, business," underscoring the need to ensure any approach embraces this broader concept of family and includes all who help care for the child.
- Trust in governmental systems, public health, and food security programs may be low in many BIPOC communities. Therefore, it is essential to build all programs from within. Whenever possible, hire staff from the community, offer fair wages, and learn from their lived experience.
- Partner with professionals serving families to better disseminate the dietary guidelines and its content, such as responsive feeding, *making every bite count* through nutrient-rich foods, and limiting high sodium, and foods with added sugar.
- Efforts should be focused on how to maximize all the benefits available and reduce stigma. For example, some groups held education sessions about the different benefits available, including non-governmental aid and how to use their benefits together to make them work best.
- Increase awareness around aggressive unhealthy food marketing that targets BIPOC communities, especially for sugar-sweetened beverages.

- Encourage culturally responsive family meals and tap into the resources people have access to. Understand what resources exist for food storage, meal preparation, and meal consumption. For example, while introducing families to fresh produce, consider families' traditional fruit and vegetables. Learning what has worked for others in implementing nutrition programs in BIPOC communities can help those who have not yet begun or have encountered barriers. We hope to elevate future nutrition security within the first 1,000 days in BIPOC communities by sharing best practices.

Thank you to our regional and national convening participants. This report is a result of intellectual work of professionals who contributed thoughts, knowledge, wisdom and lived experience from August to December 2022. We are also grateful for our partners and consultants at CPHI, Marci Sontag, PhD and Yvonne Kellar-Guenther, PhD who helped us facilitate the in-person and virtual discussions, analyze the collective inputs, drew lessons learned and drafted most of this report.

The content of this report does not necessarily represent individual contributor views, or consensus of all who participated in the convenings.

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Introduction

Background and Purpose

The first 1,000 days, the period from pregnancy through a child's second birthday, represent a critical window for establishing healthy dietary patterns that promote healthy growth and development. Fostering a positive feeding environment and healthy eating with adequate nutrition during this period promotes lifelong health by helping to reduce the risk of obesity and associated cardiometabolic disorders later in life.¹ Additionally, for the first time, the United States Department of Agriculture (USDA) has included nutrition guidelines for this critical time in the 2020–2025 edition of the Dietary Guidelines for Americans. These infant and toddler nutrition guidelines include evidence-based recommendations for breastfeeding, the introduction of solid foods, and dietary patterns. However, about 1 in 7 babies in the United States experience food insecurity and therefore, many families are unable to meet national dietary recommendations.

The *Continuity of Care in Breastfeeding Support, A Blueprint for Communities*, was published in 2021 by NACCHO, summarizing the input of over one hundred professionals. The *Blueprint*² is focused on lactation support in the local public health system, including 7 recommendations and 42 strategies. While this *Blueprint* is a key resource for local public health professionals, there is still a need for guidance on the next phase of infant and toddler nutrition, including the introduction of complementary food. Researchers have noted that growth from conception through age 2, or the first 1,000 days, plays an important role on growth and adult health.³

One key component of NACCHO's Chest/Breastfeeding Portfolio is to identify successes, challenges, and best practices to improve infant and toddler nutrition infrastructure in Black, Indigenous, and other People of Color (BIPOC) communities. [Note that the term 'BIPOC Communities' is used in this report and the term 'Communities of Color' was used in some of the convenings. We recognize the terms may have different implications for some readers] To work towards this goal, NACCHO produced a report in 2021 summarizing the findings of 85 interventions, programs, and resources focused on early nutrition beyond breastfeeding. They found that research showed that BIPOC communities were more likely to have a low intake of fruit and vegetables and that "toddler milk" was the fastest-growing category of breast milk substitutes. Furthermore, NACCHO found the early introduction of complementary foods was commonly an issue for BIPOC communities. This report also highlighted that the First 1,000 Days study was impactful in utilizing policy, systems, and environment approaches (PSE) to positively impact health behaviors for low-income mother-partner-infant triads in Black and Hispanic communities in Massachusetts. One recommendation of this report was to "Convene three

¹ Stoody, E. E., Spahn, J. M. & Casavale, K. O. The Pregnancy and Birth to 24 Months Project: a series of systematic reviews on diet and health. *The American Journal of Clinical Nutrition* 109, 685S-697S (2019).

² [Blueprint \(Available at <http://www.breastfeedingcontinuityofcare.org/blueprint>\)](http://www.breastfeedingcontinuityofcare.org/blueprint)

³ Hoffman, D., Arts, M., & Begin, F. (2019). The "First 1,000 Days+" as key contributor to the double burden of malnutrition. *Annals of Nutrition and Metabolism*, 75:99-102. DOI: 10.1159/000503665.

regional meetings to further understand local solutions for improving infant and toddler nutrition infrastructure and continuity of care among local health staff, home visitors, lactation support providers, community health workers, parents of young children, and other key stakeholders” (p. 6).

In 2023, NACCHO convened local, regional, and national public health experts to identify opportunities to best partner with and support BIPOC communities in achieving optimal nutrition in infants and toddlers beyond breastfeeding. In addition, NACCHO has been co-developing culturally diverse infant and toddler nutrition materials based on the Dietary Guidelines with Chinese/Vietnamese, African American and Latinx communities.

Structure, Participants

The information presented in this report came from 51 participants who took part in one of three in-person two-day regional meetings (West held in Denver, Northeast held in Boston, and South held in Raleigh; Figure 1) and 30 participants associated with national nutrition programs who took part in a 2-hour online meeting.

- The Northeast/Boston meeting was held on September 15 and 16th, 2022
- The West/Denver meeting was held on August 17 and 18, 2022
- The South/Raleigh meeting was held on October 12 and 13, 2022

The National meeting was virtual and held on November 29, 2022.

Participants at each meeting are presented in Appendix A.

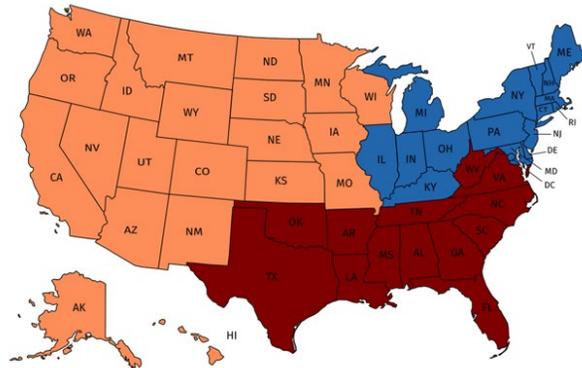


Figure 1: Regional distribution of participants for NACCHO Convenings

Goal of Report

This report aims to summarize the lessons learned from the regional and national convenings on local and regional activities in supporting infant and young child feeding in BIPOC communities.

Themes Identified

Solutions and ideas discussed in each of the convenings were shared with the understanding that culture is not a monolith and there is not one “BIPOC community” but rather a tapestry of unique and complex communities with passionate leaders and individualized needs. Further, the solutions are not uniquely cultural. To reflect the different types of solutions identified, the solutions are presented in four themes:



Cultural considerations: Solutions that encompass language, immigration status, along with cultural norms that affect decisions around nutrition, views on health, and use of governmental programs.



Socioeconomic considerations: Solutions that comprise issues around nutrition security that arise due to low income.



Geographic considerations: Solutions that address issues that exist because of the services, or lack of services, and natural resource restrictions due to where one lives.



Universal considerations: Solutions to problems that all families face regardless of race, income, or where they live, although BIPOC families are disproportionately affected by these structural barriers. These include systemic issues like marketing, political buy-in, and healthcare knowledge.

Throughout the report, we will include the icons used above to highlight the barriers identified.



Intersectionality and Nutrition Security in BIPOC Communities

The main goal of the convenings was to gather information about supporting infant and young child feeding in BIPOC communities. Therefore, participants at regional convenings were explicitly asked about the influence of culture concerning nutrition security. For this project, we adopted the United States Department of Agriculture (USDA) definition of nutrition security. “Nutrition security means all Americans have consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being.” (USDA, <https://www.usda.gov/nutrition-security>, accessed 1/5/2023). Participants identified the intersectionality that is present; the inherent interconnectedness of race and ethnicity, socioeconomic status, gender, and geography that influences nutrition security. Regional participants pointed out that the culture parents grew up in and the community the family lived in played an instrumental role in what foods babies and toddlers had access to and what support, if any, families were willing to utilize.

Cultural Considerations

Participants identified many ways culture influences nutrition in BIPOC children in the first 1,000 days of life. Key topics are listed below (Table 1).



	The language spoken can impact what messaging is easily obtained, processed, and understood. Regional participants mentioned relying on members in the communities to help create effective nutrition messaging.
	The perception of what is healthy is impacted by culture. Some cultures believe a “well fed baby is a well-loved baby.” Thus, what one culture might view as overweight or obese, another culture might view as healthy.
	New parents often feed their children food that is familiar or nostalgic. Regional participants mentioned this might be “sweets” from home countries, formula that they were given as infants, or just cultural meals that may or may not be considered healthy due to their ingredients. Similarly, childcare providers also try to feed food that fits with children's culture.
	The view of breastfeeding versus using formula is also tied to culture. For example, at the regional convening in the South, participants acknowledged the history of slavery, motherhood, and how that negatively impacted feelings towards breastfeeding.
	Culture influences who in the home prepares and serves food to the family. Those working alongside families should be aware of how domestic roles impact the expectations of which parent(s) feed the child.
	How big a role the community plays in child rearing is also impacted by culture. The community can include family members, neighbors, or friends. Messaging around nutrition and nutrition security should focus on all who help care for the child.
	Faith is an important aspect of culture. Religion can impact what foods are eaten, at what times, and during which seasons of the year.
	Culture also impacts how families view government support. At each convening, groups mentioned that being part of community where immigrants live may also deter families from taking advantage of governmental programs.

Table 1: Cultural themes that were identified in the regional convenings.

Eating is a Family – and Community – Business

Culture is paramount because children group up in families and communities. In our first regional convening, we heard eating is a “family business,” and this was reinforced in all regional discussions. This was understood to mean that decisions made by parents are influenced by their childhood experiences, the other family members around them, and the larger community. Likewise, infants and toddlers engage with many individuals in the community who may play an essential role in influencing the child's relationship with food.

The research also supports this. Although conclusions from this research are not specific to BIPOC communities, the Surgeon General’s Call to Action to Support Breastfeeding⁴ and Negin et al.⁵ supports similar recommendations from convening participants that new mothers often turn to grandmothers instead of healthcare providers for information and support about infant-feeding issues. As stated on the thousanddays.org website, a recent study from Generations United, *Family Matters: Multigenerational Living Is on the Rise and Here to Stay*, finds that the number of Americans living in a multigenerational household with three or more generations has nearly quadrupled over the past decade, with a dramatic increase of 271 percent from 2011 to 2021 (7% vs. 26%). Generations United estimates 66.7 million adults ages 18+ in the U.S. live in a multigenerational household; that’s more than 1 in 4 Americans.”⁶ In addition to grandparents, our regional participants mentioned aunts/uncles, community members, family friends, and older siblings as additional caregivers for younger siblings. Wikle et al.⁷ reported that 30% of adolescents in their national study helped with tasks including meal preparation for younger siblings.



Often, a family or a community may have beliefs that can be passed down between generations and engrained in family traditions. For example, many of our participants reflected that parents feel the need to introduce solid foods early due to community influences. Further, feeding a child shows love to that child, and an obese child is a loved child, causing families to ignore the child's internal cues of hunger.

“Why don’t you replace your collard with kale when you make collard greens?” —*Message shared with a family to encourage healthy eating, contradicting the cultural influences of the family*

Perhaps even more importantly, much of the family’s culture is passed down through food. Food bonds families, and it is how we build relationships with others.⁸ Our participants in all regions discussed the importance of ensuring that food recommendations are culturally

relevant; and when food substitutions are recommended, ensure that the recommendations are still inclusive of traditional family foods, and actually address a must-needed dietary change. Participants in the Southern convening noted that many regions in the South are “meat-oriented” and may not be as accepting of vegetables or vegetarian meals. Another group reported that Hispanic families in the South are “eating real, whole, nutritious foods, just too much of them.” Further, if families receive food that is not in line with their cultural values and beliefs, the food may be discarded rather than

⁴ U.S. Department of Health and Human Services (2011). *The Surgeon General’s call to action to support breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Viewed on 1/2/2023.

⁵ Negin, J., Coffman, J., Vizintin, P. et al. The influence of grandmothers on breastfeeding rates: a systematic review. *BMC Pregnancy Childbirth* 16, 91 (2016). <https://doi.org/10.1186/s12884-016-0880-5>. Viewed on 1/2/2023 at <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0880-5>.

⁶ <https://thousanddays.org/updates/on-child-health-day-new-focus-on-grandparents-as-caregivers/>. Accessed 1/2/2023.

⁷ Wikle J. S., Jensen A. C., Hoagland A. M. (2017). Adolescent caretaking of younger siblings. *Social Science Research*, 71, 72-84. <https://doi.org/10.1016/j.ssresearch.2017.12.007>.

⁸ <https://www.hsph.harvard.edu/news/multimedia-article/family-meals-healthy-eating/> accessed 2/6/2023

consumed. The family and broader community form the foundation of eating habits for children. Understanding the unique aspects of families and communities is crucial to walking alongside them.

Supporting The Family Business

Both nationally and locally, public health workers are making efforts to ensure that culture is respected and reflected. This can be seen in federal initiatives such as “MyPlate”⁹; as well as endeavors in efforts around breastfeeding^{10 11}, including the development of several cultural breastfeeding coalitions across the nation. In support of these efforts, NACCHO is working alongside communities to diversify the Dietary Guidelines through the development of culturally relevant and sensitive infant and toddler nutrition materials.¹²

Impact of Culture and Socioeconomic Status on Utilization of Government Assistance Programs

Trust in governmental systems, public health infrastructure, and food security programs may be low in many BIPOC communities due to its history. Participants at the Southern convening noted that breastfeeding and gardening may have negative connotations because of the history of the South and slavery. Specifically, this nation’s history of slavery has detrimentally impacted how African American/Black-identifying communities engage in infant feeding practices or agricultural practices. Systems have misused trust which has impacted how BIPOC communities engaged with governmental systems, public health infrastructure, and food security programs. As an example, throughout the COVID-19 pandemic, a group of researchers described efforts to build trustworthiness among medical and public health systems rather than increasing trust among African Americans in the U.S.¹³ Their insights highlight the critical approach of centering the most marginalized groups in a crisis as a social justice imperative that requires acknowledgment of institutional untrustworthiness, neglect, and failure to address potential on-going structural issues in communities. While this finding is newly published, the results are in line with the sentiments expressed across the three regional convenings: community members with lived experiences are the foundation of all systems, and partnering organizations need to earn their trust.

Historically oppressed communities may have little to no trust in public health programs because, as participants explained in the Northeastern convening, there is a history of “fund one thing, that funding goes away, and a new topic is now funded.” Participants explained this to mean that

⁹ <https://www.usda.gov/media/blog/2013/08/02/enjoy-foods-many-cultures-myplate>. Accessed 1/19/2023.

¹⁰ <https://www.nichq.org/insight/cultural-sensitivity-better-breastfeeding-outcomes>. Accessed 1/19/2023.

¹¹ <https://www.usbreastfeeding.org/>. Accessed 2/16/2023.

¹² <https://www.naccho.org/programs/community-health/maternal-child-adolescent-health/breastfeeding-support#early-childhood-nutrition> Accessed 2/17/2023.

¹³ Best AL, Fletcher FE, Kadono M, Warren RC. Institutional Distrust among African Americans and Building Trustworthiness in the COVID-19 Response: Implications for Ethical Public Health Practice. *J Health Care Poor Underserved*. 2021;32(1):90-98. doi: 10.1353/hpu.2021.0010. PMID: 33678683; PMCID: PMC7988507.

researchers and public health professionals may be actively engaged in the community and disappear when funding ends. Some participants noted it can take 10–12 years to build trust in the community. However, many communities have seen programs come and go within that time span, so the community members become wary of investing resources such as time and energy in a program that is not lasting. Further, in communities with undocumented immigrants or immigrants seeking citizenship, there may be perceived risks in requesting support from other community members. As a result, there exists a lack of trust in food security and/or nutrition security programs. Families with appropriate documentation may avoid working with government agencies to avoid bringing attention to their community.

“Families ‘pull themselves up by their bootstraps’ rather than seek government help.”—*Quote from Western Convening on cultural approaches in region*

Socioeconomic and Geographic Considerations

While culture is significant, there are other influences on a child's nutrition. Participants identified concerns and/or barriers to nutrition security for BIPOC families are tied to low socioeconomic status (Table 2). The American Psychological Association states, socioeconomic status is intimately interwoven with race and ethnicity.¹⁴ Participants identified four challenges low-income families, as well as families who live(d) in low socioeconomic status communities, face.

	Using food benefits can be a challenge. It is difficult to apply for and receive benefits, vendors may not know how to accept them or may choose not to accept them, there is a stigma around using them, and there are not many options to access fresh fruits and vegetables using food benefits.
	Not all members in the community who may need support qualify for food security or nutrition security programs.
	Low income or no income families may not have a lot of space, the resources, nor the tools to store, prepare, or serve food. This makes it difficult to have and prepare fresh fruits and vegetables, or to even prepare and freeze food that can be served later.
	Selection options at food banks lack nutrient-dense foods and are often canned/processed foods. It is difficult to get fresh fruit and vegetables from food banks, which is partially due to the design of food banks.

Table 2: Socioeconomic considerations that were identified in the three convenings.

¹⁴ <https://www.apa.org/pi/ses/resources/publications/minorities>. Accessed 1/19/2023

Participants identified six geographic considerations that impacted a family's ability to access service or a community's ability to provide needed resources (Table 3).

	Rural families may not be able to access reliable internet. This makes it difficult to apply for food benefits and to receive information or education around the benefits. This challenges a family's opportunity to make informed choices about the nutrition for a child and/or a family
	Grocery stores are not always accessible in their area due to distance or transportation opportunities. Instead, residents are forced to shop at convenience stores, dollar stores, and/or even liquor stores within or closer to their neighborhood.
	All programs, including farmers' markets, are harder to do in rural towns where they don't have the tax base to buy in high quantities. Another challenge is that a community may be too far from Farmers so they cannot have a Farmer's Market.
	Living in an "unsafe" community makes it difficult for families to get out and buy food or have food delivered (e.g., online grocery shopping).
	In the West, some communities could not have community gardens because of water shortages.
	The Northeast group mentioned that lack of space in cities made it difficult to have community gardens.

Table 3: Geographical considerations that were identified in the three convenings.

Build from Within: Nothing About Us Without Us

The main goal was to identify local solutions for improving BIPOC infant and toddler nutrition security beyond breastfeeding during the first 1,000 days. While understanding the concerns was important, identifying successful solutions was paramount. A foundational recommendation echoed across all convenings was to build all programs from within. Each community is unique, and programs should embrace and engage the community. Whenever possible, hire staff from the community, offer fair wages, and learn from their lived experience (Figure 2). Longitudinal relationships must be cultivated with families. Some groups highlighted engaging community members to work with families in the roles of community navigators, International Board-Certified Lactation Consultants (IBLCs), or peer counselors serving in roles to share information.



Figure 2: Important reminders for increasing the trustworthiness of public agencies with communities before initiating nutrition programs.

A recurring message across all convenings was the importance of **building programs with the community, ideally within the community**. Engaging with communities directly and with community-based organizations (CBO) that are representative of the community is crucial to the success of all programs oriented at helping the community. One participant suggested “community-rooted” as a preferred term to reflect the true nature of partners that are representing the communities. The participants offered suggestions for questions that can be asked prior to initiating work within the community (Figure 3). **Some successful programs noted that they spent many months or even years engaging with community members and learning their needs before starting any programmatic changes.** Further ideas for building partnerships can be found in Appendix B – Considerations to check perceptions and Appendix C – Examples of adapting programs in partnership with BIPOC Communities.

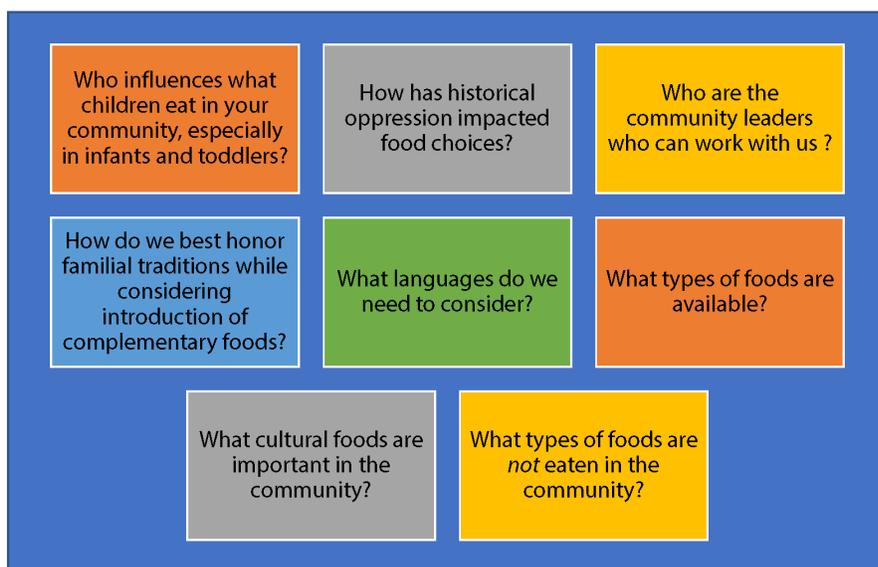


Figure 3: Examples of questions that should be asked when partnering with a community-based organization (CBO).

In addition to gathering feedback from the Regional Convening participants on activities related to cultural and family considerations, we asked the National Convening participants about their activities. While this list is not exhaustive, the breadth and depth of the activities happening at the national level reflect the dedication of the broader community to support improved nutrition in infants and toddlers from BIPOC communities (Figure 4).



Figure 4: Selected National Partners' activities that support cultural and family considerations.

Solutions to Achieve Nutrition Goals in BIPOC Communities from the Communities Themselves

The Dietary Guidelines for Americans 2020-2025¹⁵ included specific guidance for infants and toddlers (Chapter 2) for the first time, emphasizing the importance of establishing a good foundation for proper growth and development. Participants convening discussed topics supporting several recommendations and their impact on the BIPOC communities, while several were beyond the scope of these convenings. Therefore, the solutions are organized with their appropriate recommendations (Table 4).

<ul style="list-style-type: none"> • <i>For about the first 6 months of life, exclusively feed infants human milk. Continue to feed infants human milk through at least the first year of life, and longer if desired.</i> 	<i>Birth to six months - addressed in other documents (ref)</i>
<ul style="list-style-type: none"> • <i>Provide infants with supplemental vitamin D beginning soon after birth.</i> 	<i>Birth to six months - addressed in other documents (ref)</i>
<ul style="list-style-type: none"> • At about 6 months, introduce infants to nutrient-dense complementary foods. 	Solutions presented below
<ul style="list-style-type: none"> • <i>Introduce infants to potentially allergenic foods along with other complementary foods.</i> 	<i>Beyond the scope of this document</i>
<ul style="list-style-type: none"> • Encourage infants and toddlers to consume a variety of foods from all food groups. Include foods rich in iron and zinc, particularly for infants fed human milk. 	Solutions presented below
<ul style="list-style-type: none"> • Avoid foods and beverages with added sugars. 	Solutions presented below
<ul style="list-style-type: none"> • <i>Limit foods and beverages higher in sodium.</i> 	<i>Beyond the scope of this document</i>
<ul style="list-style-type: none"> • As infants wean from human milk or infant formula, transition to a healthy dietary pattern 	Solutions presented below

Table 4: Recommendations from the Dietary Guidelines for Americans, 2020-2025; Chapter 2: Infants and Toddlers. Community-proposed solutions for BIPOC communities are included in this report.

¹⁵ https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf

Dietary Guideline: At About 6 Months, Introduce Infants to Nutrient-Dense Complementary Foods

In a few of the regional meetings, participants stated that “diet issues are systems issues,” not just personal issues. The recommendation was to observe macro-issues, such as the challenge of breast feeding longer because of the need to go back to work as well as the need to put children in childcare – a setting where it can be difficult to provide responsive feeding. Another systemic challenge is that parents are tired and when a child is fussy, it may be easier to provide food to quiet the child because these parents may not know, or have the energy to try, other effective techniques.

SOLUTION:

Co-Create culturally responsive messages with the community about incorporating fruits and vegetables, iron and zinc-rich foods, and other nutrient-dense foods into young children's diet.



Many regional group participants mentioned the importance of having the community lead the efforts and provide their expertise around improving nutrition security. Below are a couple of examples that highlight this partnership.

One participant from a federally qualified health center (FQHC) mentioned that her facility uses a group visit so families could form a community. One regional representative mentioned Focus Points Family Resource Center in Denver.¹⁶ This resource center was created by a Latinx community member for their community to serve as a one-stop shop for resources, and includes parenting classes, food access, etc. Another model is The West Las Vegas Promise Neighborhood¹⁷ which focuses on “cradle-to-college” support for members of their community.

SOLUTION:

Include whole family support system (not just “mother and baby”) – *It takes a village* approach



¹⁶ <https://www.focuspoints.org/family-services/health/familias-extraordinarias/> and <https://www.focuspoints.org/family-services/assistance/>. Both accessed 1/8/2023.

¹⁷ <https://nvpartners.org/> Accessed 2/17/2023.

Representatives from Healthy Hearts Plus II¹⁸ mentioned one barrier they face to encouraging young Black mothers to breastfeed is the advice from the new grandmother who did not breastfeed and therefore does not see the value in breastfeeding. One way that Healthy Hearts Plus II has sought to address this cultural issue is to include new grandmothers in Grandmothers' Tea,¹⁹ a program aimed at educating grandmothers on the benefits of breastfeeding, providing current information on breastfeeding, and demonstrating how to support their daughters/daughters-in-law.



In addition to grandparents, regional participants in the Northeast and Southern regions mentioned that what other family members, including school-aged siblings, eat influences what infants and toddlers eat. A 1998²⁰ study demonstrated a strong food preference (82-83% of food preference) for toddlers 28 to 36 months and other family members, including parents and older siblings. Some participants in the Southern region mentioned that school lunches offered foods associated with fast food, which could be problematic.

Fathers (biological and nonbiological), including those who do not live with their children, should also be included in any education efforts. Dr. Jennifer Bellamy, one of the convening attendees from the University of Denver²¹ and Fatherhood Research & Practice Network,²² mentioned some preliminary findings from her research that showed that father engagement reduced child neglect.

Furthermore, fathers outside of the home may have visitation where they are responsible for their child's nutrition.



Convening participants from the Massachusetts General Hospital have also engaged fathers as an additional part of their first 1,000 days collective impact initiative in Boston.²³ Based on the knowledge that during infancy, partner support is associated with higher likelihood and longer duration of breastfeeding²⁴ and associations between father-child dietary intake exist as early as 20 months of age²⁵ they engage mother-father-baby as a triad

enrolled in the 3rd trimester of pregnancy, at 3–4 weeks, and 3–4 months postpartum, and receive continuous multimedia education through text messaging, print material, and videos. The educational

¹⁸ <https://www.healthyheartsplus2.com/services.html>

¹⁹ <https://publichealthweekly.com/tag/grandmother-tea/>

²⁰ Skinner, J., et al. (1998). Toddlers' Food Preferences: Concordance with Family Members' Preferences, *Journal of Nutrition Education*, 30 (1), 17-22. doi.org/10.1016/S0022-3182(98)70270-5.

²¹ <https://socialwork.du.edu/news/dads-matter>. Accessed 1/8/2023.

²² <https://www.frpn.org/>

²³ Whooten RC, Kwete GM, Farrar-Muir H, Cournoyer RN, Barth EA, Kotelchuck M, Taveras EM. Engaging fathers in the first 1000 days to improve perinatal outcomes and prevent obesity: Rationale and design of the First Heroes randomized trial. *Contemp Clin Trials*. 2021.

²⁴ Abbass-Dick J, Dennis C-L. Breast-feeding coparenting framework: a new framework to improve breast-feeding duration and exclusivity. *Fam Community Health*. 2017; 40:28-31.

²⁵ Walsh AD, Cameron AJ, Hesketh KD, Crawford D, Campbell KJ. Associations between dietary intakes of first-time fathers and their 20-month-old children are moderated by fathers' BMI, education and age. *Br J Nutr*. 2015;114:988-994.

curriculum addresses parent health behaviors, social determinants of health, and child feeding, sleep, and development.²⁶

The role fathers play in the lives of their children is dependent on their knowledge of factors influencing the health children and the societal context in which those fathers live, work, and worship. The role of supportive partners of the mother dramatically strengthens the ability of the mother to set and achieve appropriate early life goals for their child, including wise nutrition choices.²⁷

However, each family dynamic and support system are different for each family. Nutrition programs, services, and educational materials tailored to families with young children should also be catered to the range of caregivers and other extended family and friends surrounding the parent-child.

SOLUTION:

Encourage Responsive Feeding



Responsive feeding is defined as recognizing and appropriately responding to infant cues around hunger and satiety.²⁸ Responsive feeding has been linked to the children's development and wellbeing,²⁹ formation of life-long eating behaviors³⁰ and infant BMI between 6 and 18 months of age.³¹ Learning hunger and satiety cues starts when babies are being chest/breast fed and/or formula fed and should continue when they move to solid foods.



EAT
Family Style Dining

Responsive feeding, however, is hard. As one participant in the Southern convening noted, mothers who have to return to work right after birth do not get time to identify and respond to cues. Participants in all convenings noted that it can be difficult for childcare centers to do responsive feeding because there are multiple children, and the "schedule of feeding" may be an easier approach. One participant highlighted that childcare centers were a great place to work on broadening a toddler's diet. She

²⁶ Whooten RC, Kwete GM, Farrar-Muir H, Cournoyer RN, Barth EA, Kotelchuck M, Taveras EM. Engaging fathers in the first 1000 days to improve perinatal outcomes and prevent obesity: Rationale and design of the First Heroes randomized trial. *Contemp Clin Trials*.

²⁷ Bugg Jr., G. Bugg, W., & Bugg, C. *Breastfeeding Communities for Fatherhood: Laying the Groundwork for the Black Fatherhood, Brotherhood and Manhood Movement*. *Breastfeeding Medicine* 2021 16:2, 121-123.

²⁸ Chen TL, Chen YY, Lin CL, Peng FS, Chien LY. Responsive Feeding, Infant Growth, and Postpartum Depressive Symptoms During 3 Months Postpartum. *Nutrients*. 2020 Jun 12;12(6):1766. doi: 10.3390/nu12061766. PMID: 32545540; PMCID: PMC7353384.

²⁹ <https://developingchild.harvard.edu/science/key-concepts/serve-and-return/#:~:text=Serve%20and%20return%20interactions%20shape,of%20communication%20and%20social%20skills> . Accessed 1/22/2023.

³⁰ Chen et al. (2020).

³¹ Khalsa, AS et al. (2022) The longitudinal relation between infant feeding styles and growth trajectories among families from low-income households. *The Journal of Nutrition*, 152(9), 2015-2022. <https://doi.org/10.1093/jn/nxac123>. Accessed 1/22/2023.

noted that “picky eaters” were often pickier at home than at childcare, lending support to the research that toddlers choosing food may be tied to developing their autonomy.

It was also noted that responsive feeding can be challenging when parents are stressed and children are fussy. In these cases, parents may give children foods to calm them and give parents the space they need to reduce their own stress. Participants suggested that parenting interventions need to deal with fussy babies and picky eaters, so parents have ideas to rely on and operationalize in the moment to address the behavior.

“There is an assumption people don’t know the right kind of foods to feed to their child. It is really complex. When your baby is being fussy, you want to give them something to stop them. That may be candy.”—*Participant on challenges experienced by parents who may be exhausted and trying to do their best day to day*

SOLUTION:

Advocate for Paid Parental Leave



One component to encouraging responsive feeding is providing time for parents to care for their infants in the home setting by affording them the opportunity to learn the natural cues of the child.³² Paid parental leave is not universally offered in the United States and is less likely to be offered among lower wage earners and hourly rate positions. The immediate impacts of paid parental leave policies are seen in longer duration of breastfeeding and exclusive breastfeeding. However, less dramatic effects were observed among vulnerable populations suggesting the need for targeted intervention to maximize the benefit.³³

The importance of paid parental leave was brought up in each of the convenings. Participants in Denver noted that it was an important component in addressing aggressive marketing targeted at BIPOC communities, yet it was hard to implement policies to effect change. Participants in the Raleigh convening underscored the impact of paid parental leave on improving rates of breastfeeding, and subsequent impacts on healthy food choices for infants and toddlers.



“I advocated for paid parental leave extensions. It was easier for me to do as a [healthcare] provider. I emailed or called the organization who can fund the family leave. I also got OBs to write a letter to support that. It can be done on individual basis, versus organization wide.” —*Participant in the Raleigh convening*

³² Vilar-Compte M, Teruel GM, Flores-Peregrina D, Carroll GJ, Buccini GS, Perez-Escamilla R. Costs of maternity leave to support breastfeeding; Brazil, Ghana and Mexico. Bull World Health Organ. 2020 Jun 1;98(6):382-393. doi: 10.2471/BLT.19.229898. Epub 2020 Apr 8. PMID: 32514212; PMCID: PMC7265923.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7265923/>

³³ Hamad R, Modrek S, White JS. Paid Family Leave Effects on Breastfeeding: A Quasi-Experimental Study of US Policies. Am J Public Health. 2019 Jan;109(1):164-166. doi: 10.2105/AJPH.2018.304693. Epub 2018 Oct 25. PMID: 30359107; PMCID: PMC6301394.

SOLUTION:

Resources Shared by National Partners



The participants at the National Convening were asked to share examples of activities that their organizations implement related to specific questions. When asked "What does your organization do to support introduction of complementary foods in BIPOC communities?" they responded with a range of topics including training communication and partnering with other national organizations (Figure 5). This list is not all-inclusive but provides a sample of the portfolio of work performed by the national partners.



Figure 5: Responses from National Partners when asked "What does your organization do to support introduction of complementary foods in BIPOC communities?"

PHA –Veggies Early and Often: Veggies Early & Often ³⁴ **AAP** – Complementary Food ³⁵ **1000 Days** – Digital Campaign ³⁶

³⁴ <https://www.ahealthieramerica.org/veggies-early-often-28>

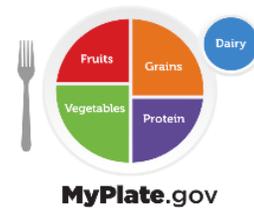
³⁵ <https://www.aap.org/en/patient-care/healthy-active-living-for-families/infant-food-and-feeding/>

³⁶ <https://www.youtube.com/shorts/xn52xZbNVqQ>

A note about Food Insecurity Screenings: Convenings participants discussed and provided feedback regarding food insecurity screenings. Some participants reported that screenings have caused fear, shame, and guilt; and emphasized that to date, there is very little evidence of its effectiveness. A recent presentation from Child Health Watch stated that screening can lead to inadequate response and can create mistrust and frustration when referral processes do not result in obtaining adequate resources. Many professionals are shifting to leading with resources, and asking clients if they are currently participating in SNAP, WIC, EITC and/or CTC. All Medicaid-insured families are eligible for WIC and over 90% eligible for SNAP, so facilitation the connection of families who regularly participate in other programs with enrollment in different models was suggested to be a more effective practice compared to only screening for food insecurity. A successful model mentioned was the *Denver Health's* prenatal and well-child visits integrated with WIC visits. Feedback from parents were overwhelmingly positive as it saves them time, eliminates barriers to participation, and results in improved coordination between WIC and healthcare.

Dietary Guideline: Encourage Infants and Toddlers to Consume a Variety of Foods from All Food Groups. Include Foods Rich in Iron and Zinc, Particularly for Infants Fed Human Milk

As the Dietary Guidelines notes, children need vitamin D, iron, and zinc to grow healthy and strong.³⁷ During the first regional meeting, we asked about improving consumption of fresh fruits and vegetables, which is important but do not provide all the vitamins and minerals infants and toddlers need. Participants were quick to point out that we need to encourage infants and toddlers to eat nutrient-dense foods from all food groups including dairy and fortified cereals. Encouraging families to provide a variety of nutrient-dense foods to maximize their child’s growth is paramount.



One way to get this message out is through texting programs. Two were highlighted – Text2LiveHealthy³⁸ and Bright by Text.³⁹ Both programs provide tips to families with young children who sign up for the service and both are offered in English and Spanish. Many regional group participants mentioned the importance of

having the community lead the efforts and provide their expertise around improving nutrition security. To overcome cultural barriers around food aversions such as a dislike of canned or frozen fruit and vegetables, the Text2LiveHealthy program has members of the community help with the creation of healthy lifestyle tips, including tips to help eat more fruits and vegetables, in order to

³⁷ <https://www.cdc.gov/nutrition/infantandtoddlernutrition/vitamins-minerals/index.html>. Accessed 1/26/2023.

³⁸ <https://snaped.fns.usda.gov/library/materials/text2livehealthy> & <https://coloradosph.cuanschutz.edu/research-and-practice/centers-programs/rmprc/text2livehealthy/our-program> Both accessed 2/17/2023.

³⁹ <https://brightbytext.org/> Accessed 2/17/2023

ensure the tips honor the history and cultural preferences of the various community members who sign up for the program.

SOLUTION:

Support solutions to increasing access to benefits



Regional participants discussed the many reasons the food security benefits are underutilized. These reasons ranged from lack of trust to families thinking their situation was not as bad as others and therefore did not want to tap into resources others may need to the benefits not being worth the hassle. National WIC Eligibility and Participation data demonstrate that in 2019, 98.4% of infants who were eligible for benefits had WIC coverage, but only 64.9% of 1-year old children and only 48.5% of 2-year-olds had coverage.⁴⁰

“Some families are not using benefits because they don’t want to take resources from others [who may have more need]” —*Regional participant on why benefits may not be used*

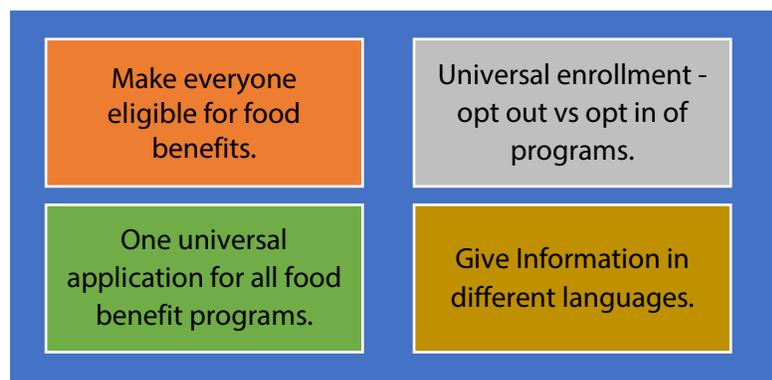


Figure 6: Suggestions to Increase Access to Benefits

Participants offered suggestions to overcome some of these barriers and reduce the stigma around using governmental benefits (Figure 6). These ideas would make enrollment easier, and give individuals the opportunity to opt out of programs vs. having to opt in. One recommendation that we heard in multiple regions was that efforts should be focused on how to increase access to benefits and maximize all the benefits available.

In all three regions, it was noted how hard it was to (1) know what nutrition security benefits programs existed, (2) how to gain access to them, and (3) how to enroll in more than one. During the Northeast session, one participant noted Medicaid as presumptive entry for WIC will end when the public health emergency ends; people will need to reenroll in Medicaid but many Medicaid recipients, as well as several programs at the convening, were not aware of this change. This discussion reinforced how difficult it was for families to access resources.

⁴⁰ <https://www.fns.usda.gov/wic/2019-eligibility-coverage-rates#2> Accessed 1/26/2023



Participants highlighted programs to maximize food security benefits. In all regions, the “Double Bucks program”⁴¹ ⁴² was mentioned. In some communities, the Double

Bucks program provides more SNAP funding to families so they can purchase more fresh fruit and vegetables. In another community, their Double Bucks Program doubled the funding for all food, not just fresh fruit and vegetables. This program doubled SNAP, WIC and cash at farmers’ markets for families on WIC/Housing vouchers. All participants who talked about the Double Bucks programs did point out that these programs are funded through grants and as one participant said, “We need help to get sustainable funding for these programs so they aren't fighting for dollars every year.” (Northeastern participant)

One regional participant had received WIC benefits and stated she got \$20 a month for fresh fruit and vegetables so “there was no point [in trying to buy fresh fruit and vegetables]. The group noted that as of 2023, the benefit in that region only provided \$35 per month for fresh fruit and vegetables, \$43 if the recipient was pregnant (*note that coverage may vary by region*).

They emphasized utilizing an empowerment frame instead of an assistance frame. Some agencies plan to hold education sessions telling people about the different benefits and how to use their benefits together to make them work best.

A participant from the City of Boston described her program. She explained that the education sessions helped communities learn about programs they may not be using, which can make their benefits more useful, like SNAP Match. SNAP Match is a program that allows SNAP participants to get two times the fruit and vegetables for their funds.

“Not limiting what type of food the benefit was used for increased program participants' mental health, decreased stigma of food assistance program, and families in the program did increase their consumption of fresh fruit and vegetables.”—*Regional participant on opportunities to reduce stigma and increase participation in food benefit programs*

SOLUTION:

Encourage access to non-government resources



While government food benefits play an important role in nutrition security, participants noted there are a lot of community programs that families should be encouraged to use. Programs in the community often have established trusted relationships. These community programs also able to tailor their programming to suit the needs of their community. The participants suggested community groups who may be able to add to benefits families receive and/or provide services for families who do not want to or are unable to tap into food benefit programs (Figure 7).

⁴¹ <https://www.boston.gov/departments/food-justice/boston-double-food-bucks>. Accessed 1/19/2023.

⁴² <https://healthydurham.org/double-bucksrwjf>. Accessed 1/19/2023.



Figure 7: Community groups that connect with families and may be able to encourage use of non-governmental benefits to increase access to food

Farmers' markets are a key partner within communities to provide locally grown produce to families, and many welcome the use of WIC and SNAP benefits. Some communities help individuals use all their money, elevating both the farmer and the user. These programs may be harder to implement in rural towns where they don't have the tax base to buy in high quantities (to reduce the cost to the community while paying enough to support the farmers). Transportation may be a challenge, and some communities assist with transportation to get to farmers' markets that may not be in the community.

The USDA's Cooperative Extension System model is often thought of as a translational center in the community, implementing research from land-grant university systems into local farms to improve farming practices at the local level.⁴³ While this can increase local utilization of farming and support the growth of farmers' markets, some participants noted that there are challenges, including lower wages for cooperative extension staff, and students teaching farmers with 20 years of experience about their own field.

The Raleigh group discussed helping communities address nutrition security issues beyond government benefits. Examples given were 1) LPH writing grants for community groups to get funding (e.g., farmers markets) to support nutrition security, and 2) getting funding from their organization (i.e., a university) to provide the community funding for a program. Ensuring the success of these programs may vary based on the organization sponsoring the work. A local public health employee stated she did not require any credit for programs or the success of a program which made it easier to help them out. This sentiment was not shared by the researchers in the group who noted they must demonstrate contributions through new grants and publications. One solution proposed is to publish with community partners to help academicians and get information about community programs into the literature, so others know about it.

"Don't assume they are choosing not to cook; ask why they need the accommodation." — Advice from a participant on not making assumptions. She shared a story of a mom who asked for already prepared foods in bags. Some assumed this mother did not want to cook but they found out that her oven had been broken for years.



Session at the Boston convening

⁴³ <https://www.nifa.usda.gov/about-nifa/how-we-work/extension/cooperative-extension-system>

SOLUTION:



Partner with Early Care and Education (ECE) Spaces

Infants and toddlers are likely to enter early care and education (ECE) centers or childcare homes in the first weeks or months after birth, spending formative time under the care of ECE professionals or Family, Friends, Neighbors (FFN) providers. While these challenges are not unique to BIPOC communities, ECEs play a critical role in the nutrition of infants and toddlers. The need for assistance may be amplified in historically neglected communities where financial resources are limited and parental leave may be minimal following the birth of a child. The USDA's Child and Adult Care Food Program (CACFP) provides resources for ECE and in-home childcare to support the provision of nutritious foods, based on the Dietary Guidelines.⁴⁴ Even with this support, ECEs may be limited in resources to be able to successfully introduce complementary foods for infants and toddlers. Responsive feeding may be inhibited by schedules for the care and feeding of multiple children around the same time. Further, ECE staff may not be trained or educated on the importance of nutrient-dense foods, balanced meals for optimal child growth and development, nor be passionate about preparing foods, influencing what they cook and serve, and how they present it to the children. Evidence presented by the AAP tells us "Babies and toddlers are more likely to eat foods they see their peers and parents eating."⁴⁵ Finally, tight budgets and center spaces may limit the ability to buy fresh food as well as the time staff have to prepare and introduce it.

Community organizations and public health professionals have responded to these challenges with a number of solutions. Training and technical assistance to provide ECEs appropriate knowledge on nutrition and skills to prepare the food along with options to serve healthy family style meals that encourage children to try new foods. Further, additional training in responsive feeding and listening to a child's natural hunger and satiety cues may also support the adoption of

Figure 8: Local programs support food education and gardening through empowering community member

⁴⁴ <https://www.fns.usda.gov/cacfp/meals-and-snacks> accessed 1/26/2023

⁴⁵ <https://www.aap.org/en/patient-care/healthy-active-living-for-families/infant-food-and-feeding/> accessed 1/20/2023

healthy eating habits. Ideally, training should include continuing education credits to incentivize staff participation (Figure 8). One program has worked with a local restaurant to reach their goals of serving more fresh produce and less fried food for their ECC catering program. Participants noted that many ECE centers have implemented the Go NAPSACC program.⁴⁶ NAPSACC is a SNAP-Ed program that supports early nutrition and physical education in ECE programs, including supporting breastfeeding, promoting healthy meals, and implementing farm-to-ECE activities. They also provide guidance on provider-child interactions around food and physical activity and educational opportunities for parents.



Photos from the Denver convening



⁴⁶ <https://snaped.fns.usda.gov/library/materials/go-napsacc> accessed 1/26/2023



Lifespan Local (Denver) cultivates community well-being through partnerships with local residents and community champions. Multicultural programs include:

1. [Supporting Southwest Denver Food Coalition](#)
2. Distribution of local and fresh food to families through schools, churches, early childhood education centers, FFNs.
3. Home visitation programs for multicultural communities supporting mental health and wellbeing.
4. Parenting and nutrition classes for families and FFNs in English and Spanish

Figure 9: Local programs use community-driven solutions to support wellness through healthy living and social change

The early care and education system also includes the role of Family, Friend, and Neighbor (FFN) providers who are informal, often unlicensed providers, and offer care in a home setting. This care may come from grandparents, other relatives, or family friends. FFNs are the care providers for a significant portion of infants and young children⁴⁷ LifeSpan Local shared their activities in providing boxes of healthy, local and culturally responsive foods to FFNs and families, as well as and nutrition trainings (in both English and Spanish, for Spanish-speaking FFNs) in partnership with other members of the Southwest Denver Food Coalition.⁴⁸

Economically, ECE spaces run on limited budgets, especially in historically marginalized neighborhoods. One solution to

combat this is to provide both food and food benefits to ECEs through the Child and Adult Care Food Program (CACFP). The University of Connecticut's Rudd Center has demonstrated that delivering meal kits to ECE spaces increases healthy food selection among recipients.⁴⁹ Convening attendees also reported working with other programs that have sought grants to purchase local foods for ECE spaces, paired with training on how to prepare the foods, followed by resources that continue once grants end. Another sustainable solution is helping ECE spaces start gardens, using the produce in their meals and snacks, and teaching toddlers the benefit of growing and eating their own foods. Successful solutions with ECE spaces were built upon partnerships and growing relationships with ECE space directors. The Centers for Disease Control and Prevention have been working to improve policies, systems, and environmental (PSE) solutions within ECE spaces as can be seen in The Spectrum of Opportunities Framework for State-Level Obesity Prevention Efforts Targeting the Early Care and Education Settings.⁵⁰

⁴⁷ Office of Early Childhood, Colorado Department of Human Services. (2019) Colorado Shines Brighter: Opportunities for Colorado's EC System Birth to Five Needs Assessment. Denver, Colorado.

⁴⁸ <https://www.lifespanlocal.org/> accessed 1/26/2023

⁴⁹ Stein EC, Stowers KC, McCabe ML, White MA, Schwartz MB. Ingredient bundles and recipe tastings in food pantries: a pilot study to increase the selection of healthy foods. *Public Health Nutr.* 2019 Jun;22(9):1717-1722. doi: 10.1017/S1368980019000259. Epub 2019 Mar 19. Erratum in: *Public Health Nutr.* 2019 Jun;22(9):1723. PMID: 30888310.

⁵⁰ https://www.cdc.gov/obesity/strategies/early-care-education/pdf/TheSpectrumofOpportunitiesFramework_May2018_508.pdf. Accessed 2/16/2023.

SOLUTION:

Resources Shared by National Partners



The ability for families to get access to high-quality nutritious foods in sufficient quantities was a consistent challenge for many solutions. Food deserts, food swamps, limited benefits, cultural differences in foods, and lack of exposure to foods all influence families' ability to provide foods for young children. The National Partners provided a variety of solutions when asked "What does your organization do to overcome challenges in getting food benefits?" (Figure 10)



Figure 10: Selection of National Partners' efforts to overcome challenges in getting food benefits.

Dietary Guideline: Avoid Foods and Beverages with Added Sugars

As stated in the Dietary Guidelines for Americans 2020–2025⁵¹ "infants and young children have virtually no room in their diet for added sugars" (p. 61). As the guidelines state, children under 2 are developing their taste preferences so it is important they are not introduced to overly sweet foods, which includes sugar-sweetened beverages. However, a recent study reported that sugar-sweetened beverages contributed to almost a third of the beverage intake for Black youth.⁵² This may be because marketing around sugar-sweetened beverages targets low-income communities and families of color.⁵³ Sugar sweetened beverages can include soda, sports drink, some flavored waters, fruit drinks, and toddler milk. Toddler milk is a beverage most often created by infant formula manufacturers and marketed as appropriate and even necessary for the healthy growth of children ages 1 to 3 years. It consists mostly of powdered milk, sweeteners, and vegetable oil, has less protein than cow's milk, and can cost up to four times as much. It consists mostly of powdered milk, sweeteners, and vegetable oil.⁵⁴ Providing sugary drinks to toddlers likely increases their preference for sweet beverages and may cause them to dislike unsweetened drinks such as plain milk and water—the only two drinks experts say young children should consume besides human milk.⁵⁵

"The marketing of food 'undoes' the interventions. What is promoted is highly processed food." —A participant in the Northeast Convening

The American Academy of Pediatrics (AAP) and the World Health Organization (WHO) recommend continuation of breastfeeding for 2 years or longer.⁵⁶

⁵¹ https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf

⁵² Cotwright, C., Okoli, C., Sharpe, K., & Shieh, J. (2022). P094 Black Parents' Perceptions About and Barriers to Limiting Sugar-Sweetened Beverages Among Young Children: A Qualitative Study, *Journal of Nutrition Education and Behavior*, Volume 54, Issue 7, Supplement, <https://doi.org/10.1016/j.jneb.2022.04.134>. Accessed 1/2/2023.

⁵³ Choi, Y.Y., Andreyeva, T., Fleming-Milici, F., & Harris, J.L. (2021). U.S. households' children's drink purchases: 2006-2017 trends and associations with marketing. *American Journal of Preventive Medicine*. <https://doi.org/10.1016/j.amepre.2021.06.013>. [https://www.ajpmonline.org/article/S0749-3797\(21\)00409-8/fulltext](https://www.ajpmonline.org/article/S0749-3797(21)00409-8/fulltext) accessed 1/2/2023.

⁵⁴ <https://www.parents.com/toddlers-preschoolers/feeding/breastfeeding/toddler-formula-vs-milk-whats-best/>. K accessed 1/22/2023.

⁵⁵ Healthy Eating Research. Healthy Beverage Consensus Statement. Available at: <https://healthyeatingresearch.org/wp-content/uploads/2019/09/HER-HealthyBeverage-ConsensusStatement.pdf>

⁵⁶ Meek JY, Noble L; Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics*. 2022 Jul 1;150(1):e2022057988.

SOLUTION:

Increase awareness about aggressive food marketing that targets BIPOC communities, especially for sugar-sweetened beverages



Representatives from the University of Connecticut's Rudd Center for Food Policy and Obesity and 1,000 Days at FHI Solutions mentioned that sugar-sweetened beverages are expanding beyond soda and

juice to include toddler milk. One person stated that toddler milk came about because formula companies are losing sales due to the success in getting new moms to breastfeed. This highlights that marketing is an ongoing problem that will need to be continually addressed in the fight to promote healthy eating for infants and toddlers. Currently, the Rudd Center and 1,000 Days at FHI Solutions have counter-marketing educational videos^{57 58} aimed at families, including grandparents, to promote the message that children just need to drink water and milk.

Participants from our South convening suggested that (1) BIPOC parents should be educated on the marketing community's concerted effort to encourage drinking more sugar-sweetened beverages, which would heighten their awareness and possibly motivate them to seek out healthier options, (2) BIPOC parents are educated on the negative ways

Figure 11: Culturally appropriate messaging to decrease sugar sweetened beverages consumption developed through 24-month randomized controlled trial for Black Head Start Parents in Georgia (University of Georgia, choplabor@uga.edu)

⁵⁷ <https://uconnruddcenter.org/healthydrinksfortoddlers/> accessed 1/29/23

⁵⁸ <https://www.youtube.com/watch?v=zrbPgpiFu4I&list=PLNEN4w93BoO0hC20QQ2t7AW4RGTALWPj> accessed 1/29/23

sugar impacts their child's brain development,⁵⁹ and (3) the impact sugar-sweetened beverages on tooth decay.⁶⁰

The messages need to be developed in a culturally appropriate way. The University of Georgia has tested culturally appropriate beverage messaging through a randomized controlled trial for black head start participants. One representative at our meetings, a doctoral student at the University of Georgia Childhood Obesity Prevention Laboratory, Cassidy Sharpe, is testing the use of culturally appropriate social media messages aimed at increasing water consumption in Black families with her advisor Dr. Caree Cotwright. It should be noted that part of these messages includes having people in the campaign that look like those in the desired audience. (Figure 11)

SOLUTION:



Resources Shared by National Partners

We asked the national stakeholders what their organizations do to combat marketing targeted at BIPOC families with young children. Their responses spanned the education and awareness of family members to advocating for better policies at the Federal and State levels (Figure 12).



⁵⁹ <https://news.uga.edu/sugar-not-so-nice-childs-brain-development/>

⁶⁰ Chi DL, Scott JM. Added Sugar and Dental Caries in Children: A Scientific Update and Future Steps. Dent Clin North Am. 2019 Jan;63(1):17-33. doi: 10.1016/j.cden.2018.08.003. Epub 2018 Oct 29. PMID: 30447790; PMCID: PMC6242348.

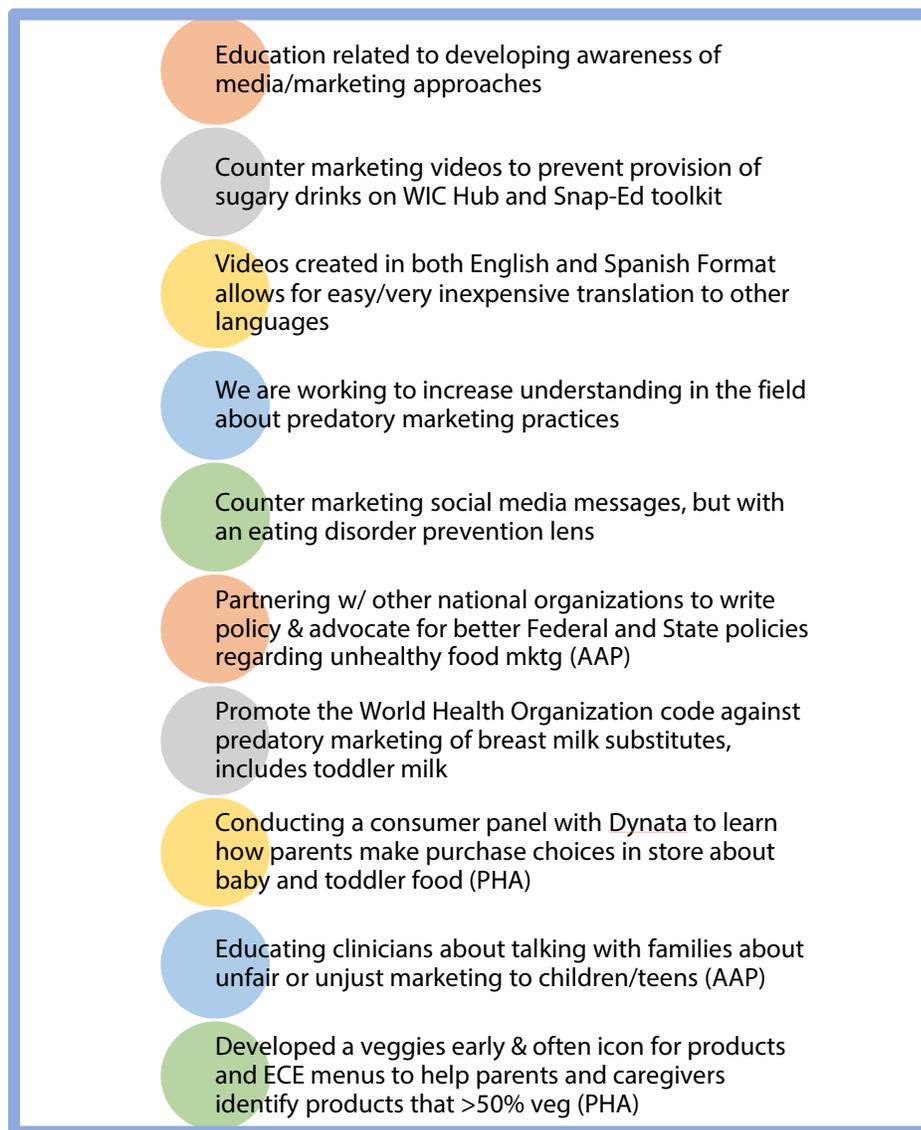


Figure 12: Sample of National Partners' activities to combat marketing targeted at BIPOC families with young children

Dietary Guideline: As Infants Wean from Human Milk or Infant Formula, Transition to a Healthy Dietary Pattern

Encouraging healthy dietary patterns when a child starts complementary feeding (at around 6 months of age) may be complicated by cultural, socioeconomical, geographical, and other factors. Infants have a predisposition to sweet, but preferences can be shaped by repeated exposure to other tastes (salty, sour, etc.).^{61 62} Therefore, the foods the families, and other caregivers, expose children to early

⁶¹ Savage JS, Fisher JO, Birch LL. Parental influence on eating behavior: conception to adolescence. *J Law Med Ethics*. 2007 Spring;35(1):22-34. doi: 10.1111/j.1748-720X.2007.00111.x. PMID: 17341215; PMCID: PMC2531152.

⁶² Borowitz SM. First Bites-Why, When, and What Solid Foods to Feed Infants. *Front Pediatr*. 2021 Mar 26;9:654171. doi: 10.3389/fped.2021.654171. PMID: 33842413; PMCID: PMC8032951.

impacts what foods they will prefer later on. These factors can influence when transition begins as well as what foods are introduced. As a result, it is important to help parents and caregivers gain access to a variety of healthy foods that they can introduce their child to and tips on how to introduce these foods. The Center for Disease Control and Prevention (CDC) has a web page with suggestions and links to resources.⁶³

NACCHO has also been co-creating diverse nutrition materials with recipes for babies and toddlers based on the 2020-2025 Dietary Guidelines. It is available at <https://bit.ly/earlychildhoodnutrition>

SOLUTION:



Encourage Family Meals, Provide Cooking Instruction

Several participants in regional meetings talked about programs in which families were provided food that they could serve, and in some cases cook and serve, to their families. However, participants talked about seeing families sort through the bags and leave produce behind. Families may not be familiar with the foods provided to them, causing them to revert to foods that are more familiar to them. Further, many families may not have the knowledge or experience to cook the foods provided. There were several suggestions to overcome this with the most common being providing recipes and showing families and other caregivers how to prepare and cook the produce.

Just as with children, parents and caregivers may also be resistant to trying new foods. This is problematic because it can limit what is provided in the home or childcare

environment. Providing information to communities that is culturally sensitive and contextually appropriate helps to span gaps and create trust. Solutions may be as simple as choosing more familiar words, such as *fruits and vegetables*, vs. *produce*, or more time-consuming as providing training and education on foods and the preparation of meals to families.

When providing produce, include pictures of the produce with the names, how to store and prepare the produce. Some programs take this a step farther and include recipes that use that produce or use the produce in a cooking class. *Suggestions from participant to encourage the introduction of new foods*

⁶³ <https://www.cdc.gov/nutrition/infantandtoddlernutrition/foods-and-drinks/when-to-introduce-solid-foods.html>. Accessed 1/24/2023.

The Boston Organization of Nutritionists and Dietitians of Color (BOND of Color) is a CBO whose mission is to offer nutrition education and in-services that address cultural concerns around health inequity and disparities, food access, healthy eating and overall wellness.⁶⁴ They partner directly with organizations such as farmers' markets, health centers, and community groups to grow the network to provide healthy choices and educational support (Figure 13).

Cooking with Confidence is an online four-week cooking class led by BOND of Color that incorporates the whole family into cooking and healthy eating. Instruction is provided on general cooking skills, recipe preparation and healthy habits and lifestyles, while respecting the cultural traditions of the families that they serve.



Figure 13: Online Cooking and Nutrition Classes help to encourage families to prepare new foods together.



Community Teaching Gardens at the East Side Health District in East St. Louis, Illinois provides resources for the local community to learn how to garden and grow their own fresh fruits and vegetables. Produce from the garden are also sold in the farmers market outside the Eastside Health District Offices.

Figure 14: Community gardens provide food to the local neighborhood, build community, and teach gardening skills

The East Side Health District from East St. Louis, Illinois serves a population with very high levels of poverty (>40%) through a variety of programs including community teaching gardens, food pantries, and education.⁶⁵ Often families are only able to get food from the local corner stores, which may be stocked with processed foods and alcohol with very limited fresh fruits and vegetables. To counter this, they partnered with local farmers to create a farmers' market that is available every week just outside the district offices, during WIC clinic times, providing a convenient location for families to receive services and use their benefits to acquire fresh food at the same time (Figure 14). They also

offer cooking demo classes and have learned that participants need very basic food preparation skills prior to demonstrating recipes and cooking new foods. This level of service helps families to build trust with the local health departments while also providing much needed skills that will likely be shared among generations within the families.

⁶⁴ <https://bondofcolor.wixsite.com/home/about>

⁶⁵ <http://www.eastsidehealthdistrict.org/>

SOLUTION:

Identify solutions to support the family unit and the broad system



Attendees at the convenings shared solutions targeted at addressing the broad system, focusing on the infant and parent, and incorporating stakeholders across the community and the infant-toddler period. Participants offered ideas of other people in the family and community that may play an important role in influencing nutrition decisions in the family (Appendix D: Other Interested Parties).

Dr. Melissa Kay from Duke University is researching strategies to prevent early life obesity in populations most at risk by supporting the mother-infant dyad. This includes assessing and improving diet quality among mothers and children, with a focus on those enrolled in WIC. Her main intervention strategy for changing behavior is using digital technologies since mobile phone use is ubiquitous across racial, ethnic, and socioeconomic groups and offers a way to augment the clinical encounter with WIC staff (Figure 15).

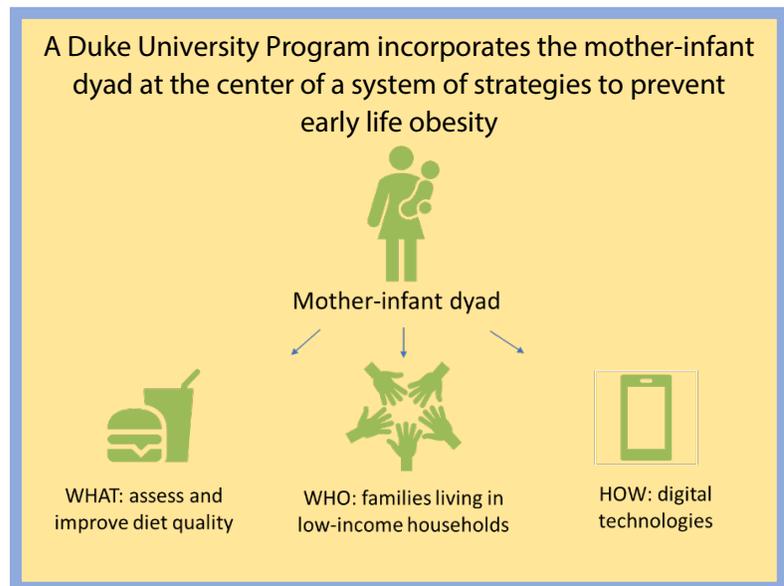


Figure 15: Preventing early life obesity in populations most at risk through addressing the whole system

Engage the full family by focusing less on denying a whole food group, like sweets, but instead focus on making small changes. — *Suggestion from participant to build trust and make realistic changes with families*

Another example of programs that span the infant and toddler spectrum to support healthy nutrition choices can be found within EAT (Ecological Approach to) Family Style (Figure 16).⁶⁶ Training caregivers on the EAT model has been found to positively impact children's eating.^{67 68} Specifically, allowing toddlers to pick their own food from healthy options allows the toddlers to develop their sense of autonomy while actively choosing a healthy food.⁶⁹ Dr. Dipti Dev from the University of Nebraska shared this work that uses the RE-AIM framework to address responsive eating in childcare.

Participants discussed how it can be overwhelming for parents to know what is healthy and what is not due to marketing.

Furthermore, new parents are stressed and changing their diet may increase this stress. The

Southern group talked about

promoting small changes in diets for parents and caregivers to help them improve their own nutrition. This group also mentioned that forcing parents to make changes by limiting what type of food they can purchase on food security benefits could also backfire, leading to them choosing not to use benefits. One suggestion was to allow parents to purchase all food groups on benefits. As mentioned earlier, this is an approach used in the Durham program and they found that parents purchased more fresh fruit and vegetables when they were not limited in how they could use their food benefit.



Figure 16: Ecological Approach To (EAT) Family Style - a training program that addresses healthy nutrition choices across the infant and toddler spectrum

⁶⁶ Dev, D. A., Padasas, I., Hillburn, C., Carraway-Stage, V., & Dziewaltowski, D. A. (2022). Using the RE-AIM Framework in Formative Evaluation of the EAT Family Style Multilevel Intervention. Accepted in *Journal of Nutrition Education and Behavior*

⁶⁷ <https://childpd.unl.edu/index.php?menu=EAT>. Accessed 1/22/2023.

⁶⁸ Sleet K, Sisson SB, Dev DA, Love C, Williams MB, Hoffman LA, Jernigan VBB. The Impact of Responsive Feeding Practice Training on Teacher Feeding Behaviors in Tribal Early Care and Education: The Food Resource Equity and Sustainability for Health (FRESH) Study. *Curr Dev Nutr*. 2019 Sep 20;4(Suppl 1):23-32. doi: 10.1093/cdn/nzz105. PMID: 32258996; PMCID: PMC7101487.

⁶⁹ Leung AK, Marchand V, Sauve RS; Canadian Paediatric Society, Nutrition and Gastroenterology Committee. The 'picky eater': The toddler or preschooler who does not eat. *Paediatr Child Health*. 2012 Oct;17(8):455-60. doi: 10.1093/pch/17.8.455. PMID: 24082809; PMCID: PMC3474391.

SOLUTION:

Resources Shared by National Partners



The national partners that participated in the convening had many activities targeted towards transitioning infants to a healthy dietary pattern and ensuring healthy nutrition for infants and toddlers. A snapshot of these activities is provided in Figure 17.



Figure 17: Sample of National Partners' activities in getting the word out to families regarding health nutrition of infants and toddlers

Recommendations Moving Forward

We convened local, regional, and national public health experts to identify opportunities to best partner with and support BIPOC communities in achieving optimal nutrition in infants and toddlers beyond breastfeeding. Achieving nutrition security and appropriate introduction of complementary foods for families with infants and toddlers, along with the other recommendations in the Dietary Guidelines in BIPOC communities is a complex challenge with multifaceted solutions. One challenge is the myriad of people in a child's life who impact what they eat and drink. An infant or toddler may be cared for by their mother, father, grandparents, other family members, family friends, and childcare providers. Nutrition security programs should account for all the care providers. Further solutions and ideas suggested by the participants are provided in Appendix E: Successful Strategies and Appendix F: Barriers and Approaches to Overcome Barriers.

Each care provider brings with them cultural, socioeconomical, and geographical considerations that impacted the willingness and ability to meet their child's nutrition security needs. Recommendations by health professionals, including public health professionals, can get drowned out by marketers, familial routines passed down by generations, and lack of trust in governmental agencies. Families in BIPOC communities may also find it difficult to follow recommendations because of lack of access to the necessary resources.

Despite the complexities, we identified underlying solutions that were common across all the convenings.

1. **Nothing about us without us.** Community members should lead and shape the nutrition security efforts in their neighborhoods, so it reflects their values and meets their needs.
2. **Building from within the community.** Honor the expertise within the community. Value their knowledge, their experience, their community collaborations by paying them for their time and expertise.
3. **Building sustainable programs that continue when outside funding stops.** Communities are more likely to partner and invest in programs that meet their needs and will not end when political will or grant funding ends.



Because **each community is unique**, organizations implementing nutrition security programs to improve the local first 1,000 days nutrition infrastructure should center community members in planning efforts and partner with community members and nutrition professionals who are representative of the population as experts to lead or co-create implementation plans and programs.

It is unreasonable to expect that families will change their behavior easily where so many forces in the social, cultural, and physical environment conspire against such change.

(Institute of Medicine, 2003)

Appendix A: Participants in each convening

Convening	Participant	Organization
West – August 2022	Leisha Andersen	Bright by Text
	Emily Bash	Colorado WIC
	Megan Berry	Denver Dept of Public Health & Environment
	Jessie Boukarim	Monarch Montessori
	Gabriela Buccini	University of Nevada Las Vegas
	Nicole Bungum	Southern Nevada Health District
	Giulia Chioetto	MotherWise Colorado
	Paulina Erices	Lifespan Local
	Alana Gowin	Colorado WIC
	Lucy Guereca	Community/Cuenta Conmigo Lactancia leader
	Tawanda McIntosh	Dignity Health/Maternal Child Health/ Black community
	Anni McKinnon	Salt Lake County Health Department
	Jini Puma	University of Colorado - Anschutz Medical Campus
	Trina Robertson	Dairy Council of California
	Briana Sherlock	Plumas County Public Health Agency
	Jollina Simpson	Kijiji Sisterhood
	Sandra Stenmark	University of Colorado Medical Center
	Madeline Weinkauff	Thriving Families
Allison Wilson	Jefferson County Public Health	
Northeastern - September 2022	Jennifer Bellamy	University of Denver
	Akua Odi Boateng	DC WIC State Agency
	Angela Brown	Boston Organization of Nutritionists/Dietitians of Color
	Jennifer Cabezas	Center for Families
	Sonia Carter	Boston Public Health Commission
	Rachael Cross	Cambridge Public Health Department
	Dipti Dev	University of Nebraska-Lincoln
	Frances Fleming-Milici	UConn Rudd Center for Food Policy and Health
	Zipporah Freeman-Baa'ith	Healthy Hearts Plus II
	Jeanmerli Gonzalez	Lowell Community Health Center
	Martine Hippolyte	FRESHFARM
	Bhagya Kolli	East Side Health District
	Renada Lewis	Healthy Hearts Plus II - Mommies, Bellies, Babies & Daddies
	Brandon Meline	Champaign-Urbana Public Health District
	Niem Nay Kret	Lowell Community Health Center
	Cara Ruggerio	Massachusetts General Hospital
	Blythe Thomas	1,000 Days
	Rachel Whooten	Massachusetts General Hospital
Angela Conway	Baby University	

Convening	Participant	Organization
South – October 2022	Funke Ajenikoko	American Heart Association
	Melissa Kay	Duke University
	Raven King-Edwards	Share Our Strength
	Brenda Koester	University of Illinois Urbana-Champaign
	Cherise McManus	Family Connects Durham
	Becky Posada	Durham County Department of Public Health
	Ana Paula Richter	University of North Carolina at Chapel Hill
	Gina Rose	Family Connects Durham
	Kassidy Sharpe	University of Georgia Childhood Obesity Prevention Laboratory
	Gizem Templeton	Duke University World Food Policy Center
	Kelly Warnock	Durham County Department of Public Health
	Heather Wasser	University of North Carolina at Chapel hill
	Toni Watt	Texas State University
National – November 2022	Lisa Powell	ZERO TO THREE – HealthySteps
	Heather Hamner	CDC
	Traci Hamilton	Healthy Steps - Still Water Pediatrics
	Blythe Thomas	S 1,000 Days Initiative
	Madison Whitworth	The Chickasaw Nation
	Jennifer Anderson	Kids Eat in Color
	Cheryl Lebedevitch	U.S. Breastfeeding Committee
	Caliste Chong	Nemours Children’s Health
	Sandy Procter	ASPHN
	Angela Brown	Massachusetts WIC and Boston Organization of Nutritionist and Dieticians of Color (BOND)
	Melinda Kelsey	The Chickasaw Nation
	Fran Fleming-Milici	UCONN Rudd Center for Food Policy and Health
	Ella Daniels	Partnership for a Healthier America
	Laura Krug	ZERO TO THREE – HealthySteps
	Jazmyn Covington	ASTHO
	Lindsey Miller	Healthy Eating Research
	Bethann Mwombela	Share our Strength
	Sanaa Akbarali	ASTHO
	Sandy Perkins	ASPHN
	NaDa Shoemaker	AHA - Voices for Healthy Kids and NCIT
Jeanne Lindros	American Academy of Pediatrics	
Jill Cox	PSU - Better Kid Care	
Caron Gremont	Share our Strength	
Minerva Delgado	Alliance to End Hunger	

Appendix B: Considerations to check perceptions

Participants at the convenings identified important tips to check perceptions of groups interested in working alongside BIPOC communities in Nutrition and Nutrition security. Some of those tips are listed here.

- The Northeastern group noted Medicaid as presumptive entry for WIC will end when the public health emergency ends; people will need to re-enroll in Medicaid but this is not widely known. Several programs in the room were not aware of this change. Additionally, it was stated “Medicaid is ‘unwinding.’”
- Public health funding is seen as unreliable or funding de jour. Funding may be provided for one thing but when it’s no longer seen as an issue, the funding for it disappears and is reallocated for a new issue. (fund one thing, and it goes away, new topic, not consistent).
 - It takes 10-12 years to build the trust, see the change and funding does not last that long.
- The Denver group noted that not all cultures have a hierarchy. There may not be a community representative per se, therefore we must engage with the broader group in the community.
- The Northeastern group noted different religious beliefs can influence how families interact with food.
- The Denver group suggested that the community can’t be expected to seek help. Therefore, the community must be sought out, and often. It was discussed whether there is some sort of clearinghouse or other place to find resources for those attempting to create programs. How to make it easy for people creating programs to find resources? – collapse resources into a clearinghouse or place easy to see? Do these already exist?
- The Northeastern group noted that just as groups such as “Latinx” are not a monolith, the language spoken by these groups are not a monolith. One example is Spanish. Spanish is not spoken the same way in all Spanish speaking communities. Therefore, there is a need for translation by the community vs by a machine so that the dialect spoken and word choice are more meaningful.
- The Northeastern group also noted that some solid foods and manufactured goods, particularly ones from other countries, can be contaminated. Imported milk/candy were noted as examples as well as some Mexican pottery, that can contain lead in the paint.
- Multiple groups noted the current funding approach is problematic. In some cases we need to get out of the way - give funding to communities directly vs giving them funds and dictating how they’re used.
 - Work between funding agencies and programs should make sure the amount provided, and reporting needed, fits their needs and resources.
 - Sustainable funding for programs, such as one aimed at helping people afford fresh produce from farmer’s markets, is needed so they aren’t fighting for dollars every year. (Double Up Food Bucks - <https://www.boston.gov/departments/food-justice/boston-double-food-bucks>).

- One group asked about ways to ensure equity for those community members who are not eligible for programs but are still struggling financially. Training is needed for the people working with families, to educate them on asking the right questions rather than making assumptions. For example, in one case a mom asked for already prepared foods in bags. A non-trained person may have assumed she didn't want to cook. But by asking the right questions, they discovered her oven had been broken for years. The Raleigh group suggested asking "what are the foods you want?"
 - Some programs have rules that get in the way (e.g. CACFP has a rule the grain needs to change everyday). A participant shared a story of a child care provider who wanted to serve rice with cultural stews every day because that was their cultural food but they couldn't because of CACFP rules. Therefore, they didn't use the program.
 - Part of the success of the Double Bucks Program is the lack of restriction on the food that could be bought. They could purchase sweets, and carbs, which also made them more open to buying FFV.
- One system issue the Raleigh group noted is that sugar-sweetened beverages are more heavily advertised to the Black and Brown communities.
 - These companies also give money to Black and Brown Community Rooted Organizations, which makes it hard to push back against them.
 - Fast food franchises like McDonalds may be owned by Black and Brown community members so there will be some loyalty to the company because it's supporting a fellow community member.
- Ideas for getting Black communities engaged concerning sugar-sweetened beverages:
 - Explain that "advertising is making a concerted effort to get you to drink more" vs "there is a disparity. . .".
 - Stress protecting their children's teeth because kids with tooth decay is seen as bothersome.
- The Raleigh group asked, Can we define/agree on what healthy nutrition is? (sugar not best, processed foods not great, clear guidelines)
 - Can't say "trans fats" are bad, say "limit trans fats"
 - Can we do this without politics?

Appendix C: Examples of adapting programs in partnership with BIPOC Communities

Convening participants were asked to share approaches that they have implemented to adapt programming in partnership with BIPOC communities.

- Community engagement
 - BIPOC Specific
 - Moving towards supporting BIPOC and community rooted organizations in their missions instead of creating our own programming.
 - Including all culturally relevant factors related to the issue (advertising & beverages).
 - Community collaboration
 - Hosting community workshops with community members to determine target foods for an intervention.
 - Locating our program in the community in which we serve, which provides accessibility in a non-clinical, open-door way. Incorporating community voice and community feedback at all stages of project development.
 - Honoring community members as those with the most experience and knowledge (uplifting and empowering over time).
 - Integrating feedback continuously from participants so it evolves with generations, the times, etc; more nuanced
 - Ensuring more community driven input through=focus groups, and community advisory boards. When doing participant engaged research, concentrate on translational piece so participants feel valued.
 - Intention
 - Being intentional about building relationships and rapport to illicit the most honest feedback, recommendations and sharing.
 - Considering Hierarchy of respect in the family, Man/Husband, Elder, etc. and how it influences how food is distributed in the family.
 - Building and sustaining relationships within communities, resulting in trust.
 - Being consistent in visibility and connections. Being on the ground and showing up.
- Family centered
 - Using a family-centered approach.
 - Making our program family friendly, not just for moms.
- Mental Health
 - Integrating caregiver mental health into parenting programs.
 - Eradicating parenting stress screeners due to high defensive responding. Assuming stress is common and offering strategies to reduce stress around feeding practices.

- Messaging
 - Creating a toolkit so that others can adapt resources to use with their own communities (along with a question guide for things they should consider when adapting).
 - Focusing on building babies' brains rather than on baby weight. Don't focus on baby weight, talk about building babies' brains. Adapting messaging for different communities (e.g., policymakers, media, the public, etc.).
 - Targeting materials for low-income populations – focused on WIC-approved foods.
 - Targeting outreach and modified language or marketing based on target population. Various modes of education to consider all needs and learning styles.
 - Using more imagery for immigrant families, with less reliance on written materials.
 - Working with experts in the community to adapt handouts – including culturally specific food items and photos.
 - Creating videos with words on the screen (fun music is the audio) so they can be easily translated to many languages as well as allowing for hearing impaired audiences.
 - Understanding that some groups are not homogenous including the languages spoken. Understanding general limitations about the community and learning to meet them where they are.
 - Adapting language around obesity.
- Methods
 - Restructuring websites to include an app to download for direct services and questions.
 - Training in plain language as well as in using the Hemingway app in order to make readable materials.
 - Adapting Formative Research Test messages to allow for re-testing of Focus groups, and interviews.
 - Adapting iOTA, Interactive obesity treatment approach, for families.
 - Addressing social determinants as basis for next steps.
 - Making programs sustainable and partnering with existing infrastructure and programs.
 - Keeping modules and educational information short and engaging.
 - Using focus groups and interviews with community members to get perspectives/lived experience to identify barriers/ facilitators/adaptations.
 - Using cooking and food for fun and engaging education and skill building rather than focusing too much on the nutrition components.
 - Offering paid incentives for participating in focus groups.
- Partnering vs. Teaching
 - Entering conversations with humility and conversational model vs “teaching.”
 - Teaching classes from a conversation standpoint, with open discussion, and open ended questions.
 - Disavowing the assumption that we are the “experts” and know it all. Avoiding being paternalistic when attempting to form relationships with the community.
 - Allowing the priorities to be determined by the parents.
- Representation
 - Representing visually in the content the present community.

- Working to incorporate lived experience into policy development and center equity across the organization.
- Diversifying team members.
- Hiring members of the community that speak other languages (need to have, hard to do).
- Diversifying pictures in materials.
- School-aged Kids
- Reaching out to younger people is a way to engage the adults in their lives. Working with elementary and middle schoolers, teaching them how to cook and introducing them to culturally appropriate foods empowers them to change the eating habits of adults.
- Stakeholders
 - Working with groups who have established relationships and offering support and services through them as trusted community members.
 - Partnering with agencies to tailor programming (e.g., being explicit about what parts of the program can be changed by the provider).
 - Working with food pantries and anti-poverty agencies to form focus groups. Compensating them for time.
- Translation
 - Translating to Spanish using a national team of native-Spanish speakers.
 - Providing education materials in Spanish. Trying to meet the patient where she/he is.
 - Using language line (clunky in use).
 - Translating all documents, including curriculum, into Spanish.
 - Translating all handouts into major languages for the target community. Always have a native speaker review the translation to avoid mistakes.

Appendix D: Other Interested Parties

The convening participants provided a comprehensive list of other interested parties that is broad, reflecting wide community interest in infant and toddler nutrition in BIPOC communities.

Families (multi-generational)

- Grandparents
- Fathers (biological or those acting in the role), even if not at home
- Aunts/uncles/cousins/friends/neighbors

Infants and Toddlers

Anyone Who Works with Families with Kids under 5

- Healthcare
 - American Academy of Pediatrics (AAP)
 - All providers including Nurse Practitioners, pediatricians, paraprofessionals, Ob/Gyns),
 - American College of Obstetricians and Gynecologists (ACOG)
 - Federally Qualified Health Centers (FQHCs)
- Education (below)
- Community Groups (below)
- Home visitors/home visiting program providers
- Medicaid & other insurance providers
- Immigration organizations
- Lactation Groups/Lactation Support Providers

Educational Agencies

- Head Start
- Education at all levels (K-12, colleges and universities)

Community Agencies/Groups

- Churches, Faith-based organizations
- Chamber of Commerce and businesses
- Community Brokers/Navigators
- Community centers
- Libraries
- Food banks, food pantries, food rescue organizations
- Community Based Organizations (CBOs)
- Barber Shops
- Grocers

Mental Health Agencies

- Mental Health Centers

- Nutrition Psychiatry

Housing Agencies

- Resident leadership/housing groups trained to provide social support and housing support

Environmental Health Agencies (food, water)

Federal Agencies, City and State Government

Community Members – formal role

- Community Health Workers (CHWs)
- Community partners who work to serve families
- Cultural groups
- Café Moms - <https://cafemom.com/tag/nutrition>
- Politicians

Agencies Focused on Nutrition (Federal and Local)

- Women, Infant, and Children (WIC) food nutrition service
- Supplemental Nutrition Assistance Program (SNAP)
- Children and Adult Care Food Program (CACFP) & US Department of Agriculture (USDA)

Community Members – informal role

- Friends/neighbors/family in community who got services (word of mouth)
- Playgroups
- Influencers

Childcare Providers

Food Stores (big box stores, Amazon Corner Market, etc.) –

<https://www.brookings.edu/blog/techtank/2017/08/29/how-the-amazon-whole-foods-merger-shrinks-food-deserts/>

Food & Formula companies

Policy Makers

- White House conference on nutrition, health, and hunger

Farmers

Local Foundations

- For example, Colorado Health Foundation

Appendix E: Successful Strategies

Participants across all three convenings suggested strategies that have been implemented for their programs or programs they are families with. If a strategy was “emphasized,” meaning at least one other person mentioned it, it is noted this as an important strategy.

Strategies Around Working with Interested Parties and Stakeholders

Education

- Continuing education (CE) opportunities for advocates/community members.
- Providing CEs for healthproviders (e.g., doctors, nurses, dietitians, lactation providers, etc.).
- Offering support services in “one-stop” center – mental health, physical health, nutrition support, etc. (mentioned in stories and success strategies during introductions as well as in strategies to get families support as well).
- Training childcare providers in nutrition security and sound nutrition for 0-3 year olds.
- Having in-person classes/training.

Collaborations/Partnerships

- Tapping into/creating Academe/Community partnerships.
- Tapping into/creating Public Health/Community partnerships.

Strategies To Help Families Get Needed Support

Be flexible

- Giving families more benefits if they buy certain things (e.g. more money if buy more FFV)

Advocacy

Recognize the multiple facets of a person

- Transgendered
- Disabled (toolkit for professionals supporting lactation people with a disability – <https://www.youtube.com/watch?v=i4snMmfJVMl>)

Healthy Literacy Approach

- Obtain, Process, Understand
 - For obtain – text messages to families about nutrition programs created by/with members of that cultural group (e.g. don’t suggest frozen or canned fruit for some groups, others love it) .
 - For obtain – increase access to underserved communities.
 - For obtain – community-based health centers.
 - For process – multiple languages (native speakers help with vs “translated”).
- Educate on media literacy – teach communities how to process and understand advertising directed at them to make good decisions for themselves.

Minimize Burden on the Family Seeking Support

- Sharing intake/info/screening tool between support agencies so family does not have to repeat information over and over.
- Meeting people/family where they are – start with small changes (SMART goals) that they want (Motivational Interviewing).
- Having support services in “one-stop” center – mental health, physical health, nutrition support, etc. (came up in stories and success strategies during introductions).

- Removing the barriers to Child Tax Credit.
- Asking the question, “Why are we policing what people eat just because they are poor?”

Build Skills to Sustain Change/Empower families

- Helping the family build skills for resiliency.
- Helping the family advocate to get the resources they need.
- Providing Information/education for choices.
- Helping parents learn skills to negotiate with children when they push back.
- Providing cooking skills.

Connect Families to Services

- Connecting to WIC (emphasized).
 - Focusing on improving WIC participation rates.
- Connecting to SNAP.
- Providing Emergency kits to families for feeding support and supplies.
- Assisting families in applying for programs, including food pantries (it was noted that there was a program that helped you apply for Medicaid but not SNAP. Recommended help them to apply for everything).
- Sharing resources such as Durham’s Interactive Food Resource Map - <https://durham-area-food-resources-durhamnc.hub.arcgis.com/>

Equity/Minimize Stigma/Universal Access

- Mandating that everyone get WIC and Medicaid at birth (opt out vs opt in)
- Mandating School lunch/breakfast programs.
- Mandating food assistance for everyone on Medicaid.

Strategies Around Nutrition Security

Messaging/Education Should Be Coordinated

- Providing a unified message and up-to-date guidance. (American Heart Association published paper with definition of nutrition security – <https://professional.heart.org/en/science-news/strengthening-us-food-policies-and-programs-to-promote-equity-in-nutrition-security/top-things-to-know>)
- Ensuring equal Modes – from faxing to training to social media to modeling to being in people’s homes.
- Securing culturally appropriate social media campaigns with celebrities and others who are from the targeted groups.

Get Foods to Families

- Having produce boxes delivered to childhood daycare centers (some kept and used the food and some gave it to families).

Wholistic Nutrition

- Discussing whole nutrition – fruit, vegetables, dairy, meat, nuts, iron enriched cereal, whole grains, etc. MyPlate (which has cultural examples – <https://www.snap4ct.org/snap4ct-blog/myplate-for-all-cultures>, <https://www.usda.gov/media/blog/2013/08/02/enjoy-foods-many-cultures-myplate>).
- Discussing nutrition for whole family (needs by age groups including elderly, young children, adolescents, etc.).
- Talking about/addressing connection between trauma and food (eating unhealthy when stressed, upset).
- Explaining the Toddler Diet Quality Index - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8229507/>

Connect with Nature and fresh fruit and vegetables

- Community/school gardens that include young children
- Exposure to fresh fruit and vegetables for young children and repetition (may not like initially or may make a face when trying initially) (Montessori)
- WIC Farmer’s Market

Educate Care Providers for Children 0-8

- Choices for Charlie book (<https://www.goodreads.com/book/show/60534820-choices-for-charlie>)
- Menus tend not to change even when staffing changes

Education/Resources to Helpers/Providers

- Includes strategies/tools/information in FDA SnapED Toolkit - <https://snapedtoolkit.org/>
- Local and statewide interest in 1st 1,000 Days

Collaboration Between Providers/Agencies

- Local and statewide interest in 1st 1,000 Days
- Rules that agencies need to partner (Wildwood CACFP – <https://www.wildwoodonline.org/> & WY example)

Financial Support

- Grant funding
- Give funding to community agencies (vs have them go through someone who will take some of the money to cover their costs)
- Healthy foods grant that is now directed at children 0 to 5 years

Policy/Regulations

- Different Interpretations for Policies (may allow group to do nutrition security work under a policy)
- Update regulations to include nutrition (breastfeeding, activity) and early childhood (0–3)
- Vending machines only carry healthy options (don't sell soda)
- Update rules and regulations regarding family wishes vs best practices in childcare setting.

Strategies Around Introduction of Complementary Foods

Policies That Are Effective at Improving Timely Introduction of Complementary Foods and/or Nutrition Security for BIPOC Families

- Existing programs
 - CACFP (food nutrition security and complementary foods) (multiple sheets)
 - SNAP (food nutrition security) (emphasized)
 - SNAP at farmers' markets (emphasized)
 - Online ordering
 - WIC (complementary foods) (emphasized)
 - WIC provides appointments for follow-up education however this is much less effective now that it is virtual. (emphasized)
 - Peer support programs (<https://wicbreastfeeding.fns.usda.gov/wic-staff>, La Leche League International - <https://www.llli.org/peer-counselling/>) (emphasized)
 - Temporary changes that expanded WIC allowed foods during COVID/food shortages (emphasized)
 - Summer food service program (food nutrition security) (<https://www.fns.usda.gov/sfsp/summer-food-service-program>)
 - P-EBT -<https://www.fns.usda.gov/SNAP/pandemic-ebt-summer-2022-memo> (summer food service program for school children and SNAP-enrolled children under 6 (latter group has some restrictions))
 - Universal school meals (food nutrition security) (emphasized)
 - Expanded Food and Nutrition Education Programs - <https://www.nifa.usda.gov/grants/programs/capacity-grants/expanded-food-nutrition-education-program-efnep>
 - Head start (emphasized)
 - Text 4 baby (CDC) (https://partners.text4baby.org/index.php?option=com_content&view=article&catid=8&id=87)
- Food programs that deliver food, recipes, and ingredients to children's homes (emphasized)
- FQHC integrated behavioral health programs in primary care (emphasized)
- Quality Improvement Rating System child-care regulations (complementary foods) (emphasized)

- Child tax credits (food nutrition security) (emphasized)
- Peer Support Workers (emphasized)
- Durham Double Bucks – (emphasized) <https://healthydurham.org/double-bucksrwjf>
 - They double funding for all food, not just FFV. Market fiscal sponsor is Blue Cross/Blue Shield. Affected participants' mental health, decreased stigma of food assistance program. Found when they doubled funding for everything, consumption of FFV went up because participants felt they weren't being forced. \$90,000 of local produce went to 500 households. Doubled WIC and cash for people on WIC/Housing vouchers.
- Root Causes (Duke Medical Students) is another org/model - https://wfpc.sanford.duke.edu/student_groups/root-causes/
- More training for pediatricians regarding complementary food/infant feeding
- Medicaid coverage of Registered Dieticians and IBCLCS – not tied to a condition code
- 2020-2025 Dietary Guidelines
- Food menus at child centers tend not to change even when staff changes. Keep that going.

Programs/Resources Around Complementary Feeding

- Partnership for a Healthier America - <https://www.ahealthieramerica.org/>
 - Healthy America's Veggies Early and Often – <https://www.ahealthieramerica.org/articles/partnership-for-a-healthier-america-recognizes-eight-companies-for-setting-a-new-standard-in-the-marketplace-to-promote-veggie-introduction-for-young-867> & [Resources for Clinicians and Champions of First Foods DrYum Project](#)
- Carolina Global Breastfeeding Institute. Ready, set, baby program. UNC and Duke team really liked it and felt it was effective. It is evidence-based, and although it is mostly focused on breastfeeding could also include more guidance on complementary and toddler feeding practices. Available for printout in English, Spanish, Arabic, Burmese, Chinese, French, Nepalese, Russian, Ukrainian, and Uzbek; and also virtual education in English and Spanish. Available at: <https://www.readysetbabyonline.com/>

Approaches/Challenges Around Complementary Feeding

- Study in UK and Durham finds fetuses smile when mom eats a carrot but frowns when it is kale. <https://journals.sagepub.com/doi/full/10.1177/09567976221105460> . Our group thought ordering the introduction of foods based on this is important.
- Responsive Feeding is important but hard to do
 - There is an assumption that people don't know the right kind of foods. Really complex - and related to stress. Parents want to give foods to baby to make them stop being fussy.
 - Parenting interventions need to deal with fussy babies/picky eaters.
 - An approach to responsive parenting is "Serve and Return" (<https://developingchild.harvard.edu/science/key-concepts/serve-and-return/#:~:text=Serve%20and%20return%20interactions%20shape,of%20communication%20and%20social%20skills>).
 - There is a study of children eating at home and in childcare center - less picky at ECE (could not find the study)

- When families have to send kids back to daycare it affects responsive feeding. Paced bottle feeding - babies see cues from families. In daycares, babies override all those cues. They overeat. Then the school systems build on that.
- Do food art with kids

Strategies Around Working With/Co-Creating with Community/Meaningful Involvement of Community Members

Listen to community members (emphasized)

- Start with qualitative work (interviews, focus groups).
- Work with experts in the community/people with lived experienced (emphasized).
- Engage community leaders.
 - All leaders/decision makers must have approval of the community
- Work with faith-based leaders. Trust is already there.
- Learn the power structure. Who has respect and who can be an influence in the community. (emphasized) (e.g., unless husband agrees, mom may not be able to make changes).
- Ask the community how they hear about things.
- Understand the services they are using and where they use them.
- Go to their community meetings and engage/ask. (emphasized)
- Go to where they are (barber shops, BIPOC owned businesses. (emphasized)
- Provide multiple modes of feedback – surveys, focus groups, town halls. (emphasized)
- Work with local city departments & health depts. The program must align with the needs of the community. (emphasized)
- Be culturally aware. Recognize where people are coming from – need to talk, gain knowledge based on their experience. (emphasized)

Community leaders design programs & supervise implementation

- CHWs or community champions from the community provide education, information, training, etc. (emphasized) Representation matters.
- Build their voices into all programming and facets of the project (ideation, implementation, course correction/edits, execution). (emphasized) (Community-based Participatory Research (CBPR – emphasized))
- Invite them to community health planning meetings. (emphasized)
- Community advisory boards need to be part of the research

Bring in Community to Help Identify What Is Needed

- Have a listening session - ask community what do you want?
- Invite communities to the meetings held by Public Health Depts and Hospitals as they do community health assessments which are required every 3-5 years . This sets policy.

Build Trust/Be honest (emphasized)

- Mean what you say and say what you mean. (emphasized)
- Go in to learn rather than teach (emphasized)

- Provide benefits that equate to the trouble that is taken. Not a “token”. A \$20 coupon does not cover childcare or gas.

Workforce Capacity

- For programs – hire within/from the community and pay a fair, living wage. Pay them in the currency they want and quickly (maybe a cash app) (don’t expect them to wait 3 weeks or a month to get paid). (emphasized)
- For community events - pay for their time and travel to be there. (often they’re taking time off work to attend, may have to find others to fill in).
- Mentor, train, support, and hire people in the community to do the work.

Leverage Social Networks

- Word-of-mouth

Invest in the long-term health of the community

- Provide programs that will build-up community and give back (ex-trade programs, college). (emphasized)
- Use our power (LPH, academe) to bring the money and power to those doing the work.

Long-term sustainable, flexible funding directly to the community

- Provide programs that will build up the community and give back (e.g., college programs, etc.).
- Think about/strategize how you will sustain grant funding.

Setting up support systems/networks

- Build a faith-based network for engagement. (emphasized)
- Match community members to families, parents to do outreach. (emphasized)

Use relatable culturally appropriate language

- Ensure translation needs are met. (emphasized)

Make meetings family-friendly/children can come

Approaches:

- Art of Hosting - <https://artofhosting.org/> & https://www.researchgate.net/publication/272170381_Practicing_the_Art_of_Hosting_Exploring_what_Art_of_Hosting_and_Harvesting_workshop_participants_understand_and_do
- Community Based Participatory Research (above as well)

If doing research/have a grant program, ask:

- Do we need to research them again? Or do we already know a lot of information.
- How can we ensure research, findings, etc. get back to the community. Make sure the community benefits, don’t take advantage of community. You can lose the community’s trust. Tangible results (want to see them, tell the community how this helps them/what they can do).

- Don't come in, do something, and leave. My community is still the same after you leave.
- Funding is a short cycle, research staff have temporary jobs. How do we support researchers so they can continue to work with community?
- Partner with the community so there is someone who can stay long term. Work with local PH agencies in community so they can continue the work, continue the relationship.

If they have a program that is grant funded, consider:

- When we have a grant and money disappears, the community expects the support and funding to continue. "What happened to the money you had?"
- Funders see success as an indicator box that is checked so you can move on.

Appendix F: Barriers and Approaches to Overcome Barriers

Pressure from the Community, Older Family Members

- Culturally – feel need to start food early
- Pressuring a child to eat is a way of showing affection for a child/cultural norm that an overweight/obese child is a loved child
- Obesity is seen as culturally healthy weight (Boston group, said true for Hispanic families)
- Not respect child’s internal cues
- Culture around supplements

Time Consuming for Families to Provide Nutritious Foods

- Family members often have multiple jobs and therefore limited time.
- Time consuming to cook.
- Time consuming to cook new foods & learn how to cook new foods.

Healthcare Providers

- Language used by providers, including health care providers.
- Up-to-date training for professionals to ensure understanding of the definition of good nutrition for children. (i.e. healthcare providers handing out coupons for toddler milk).

Conflicting Information

- Multi-generational households where not everyone understands what is healthy for the baby/toddler given what we know today.
- Inconsistent messaging regarding complementary feeding.
- Marketing messaging may confuse families, providers on what is healthy and needed. Marketers are targeting BIPOC community - <https://uconnruddcenter.org/research-archive/food-related-ads-targeting-black-and-hispanic-youth-almost-exclusively-promote-unhealthy-food-and-drinks/>
- Differing opinions between groups of friends and family members, or between friends/family and providers or marketing.
- Misinformation around products like formula, toddler milk.
- Lobbyists for formula, juice.
- WIC free formula/formula rebates.
- Inconsistent dissemination of information about services/programs following the departure of staff.
- Poor nutrition choices within food security programs, such as WIC.

Family “need”

- Families may not perceive they have a need/don’t see self as “food insecure.”
- Stigma associated with needing help/using government programs (rugged individualism, pull self up by bootstraps – especially in Rocky Mountain Region)
 - Should have to opt out vs opt in so everyone has it
- Green card seekers may not apply because they’re afraid it will hurt their green card application (also listed in BIPOC communities)

Stigma Around Using Food Benefits

- Addressing stigma of vendors who accept federal nutrition benefits. Widely inaccurate myths.
- Users may save for use where they perceive less shame (e.g., crab leg party, more accepting vendor).

Distrust of System

- Not check box – is this to help me or hurt me?

Hard to Get Food Benefits/Adequate food benefits

- Barriers to enrollment – why SNAP office, then WIC office, then next office. (need one catch-all place or website to enroll)
- Transportation to use benefits can be hard (Need to bus, farmer's market not in community)
- WIC participants only receive \$20 for fresh fruit and vegetables so they see no point. (personal story of a former WIC recipient who was at Boston meeting) Now is \$35 or \$43 if pregnant
- Time is money - amount of red tape and barriers. "Because you are poor, we don't trust you." If families can get all the benefits, they are doing well.

Getting Community Buy In & Political Buy in

- Food is not seen as a right (economic and social injustice).
- Healthcare dollars are not focused on early years.
- Child poverty reduction is not a national priority.

Silos Between Programs (should note you may want to silo service providers from those who are mandatory reporters)

- No communication.
- No sharing of information about the family.
- No coordination. Good resources are hard to find and share. Need to create a repository.

Lack of Reliable Internet for Rural Families

Lack of Long-Term Access to Nutrient-Dense Foods

Food Storage Issues

- Need to know how much preparation and storage space families have.
- It takes a while for people to be open about their space. That is the value of home visitors and CHWs.
- It is possible someone thinks they don't like a food item because it went bad before they tried it.

What Food Is Available

- Current Agricultural policies.
- Food Options at food banks.
- Wasted food items.
- Food Deserts/Food Apartheid.
- Dollar Stores.
- Electronic WIC – bundled food packages – harder to educate.

- Hard to get delivery. There are areas no one will deliver to (including Amazon and Walmart) because it is too dangerous.

Layout of Stores

Safety

Those Doing the Work in the Community May Face a Safety Risk

Children's Preference for Sweet Foods

Food Allergies/Choking Messages

Low Pay for Volunteers and/or Community Health Workers

- Hiring people from the community can be hard. There is a benefits cliff so you must strike a balance between paying them enough and ensuring that it's enough to care for their family if they lose benefits.
- Some groups require that their contracts have a \$1 million insurance policy. This makes it hard for local groups to be contractors.
- Many graduates cannot afford to do unpaid internships due to student loans.
- Some positions require a degree, therefore it can be hard for community members to fill the role. Also, online degrees can be difficult to get because institutions charge out of state tuition rates.
- Some noted that expertise does not come with a degree and we need to take that into account.

Burnout/Exhaustion of Those in the Field

Supply Chain Issues

- Are there enough people in schools to prepare good food.

Fraud at the System Level (e.g., Brett Favre, CACFP in MN)

Our Idea of Success May be Wrong

- Need to show impact to keep programs funded - a lot of times making progress if don't go backwards vs gaining ground.
- Building trust is not being funded. It takes time, it's hard to measure, and it's hard to measure the importance of building trust.

Overcoming Barriers

- Insist on common ground. For example, solving the problem with vocabulary by using fruits and vegetables rather than produce.
- Connect with coalitions, community-based organizations, regarding how to address social determinants of health.
- List a problem this community has identified?
 - Name those who help figure this out - more one-on-one approach especially in beginning. Advocates.
 - Map assets we have in the community.
 - Connect with others - Unite Us - <https://uniteus.com/>
 - Go to websites of resources to understand communication, historical implications, cultural food norms (falls on researcher not the community and then ask questions to clarify).
 - Activate ICTS (Academic Community Partnership grants).

- Elevate the value of keeping people healthy (providers need to not just refer but make sure the connection is made). It is more profitable to do things this way.
- Create robust home visiting program.
- Engage the small community in order to help build trust with providers by sharing experiences and getting others to classes/resources.
- **Examples of Building Political Will**
 - Have the Director meet with local mayors in the county.
 - Don't wait for an invitation, say why you should be at the table.
 - Schedule time with the mayors.
 - Have an empowered champion.
 - Have the community share with politicians how the issue impacts them - politicians are driven by stories.
 - Start at local level (state, city, community, school).
 - Allow local school wellness policies (K-12, preschool) set the standards and policies to make it easier.
 - Bring in non-traditional partners, as Michelle Obama did (e.g. Walmart), bring in all political sides, and create a multi-sector coalition.
 - Highlight how much money can be saved. Show financial benefit (ST and LT gains).
 - Educate politicians - do you know what CACIP is, how it impacts your constituents, talk to aides (they make it happen) and talk to them yearly so they get to know you.
 - Engage advocate agencies who can speak up for a topic and who will buy-in/be part of your work.
 - Find allies in the decision-making spacing. Need to get BIPOC community members in so they can share their voice, their experiences.
 - Involve officials at the community level
 - City, county, state rep., etc. Election officials on health board
 - Invite them to health events, activities
 - Program used as a model for mayor's breastfeeding initiative. Given city declaration by mayor. Get grants from city counseling rep and health agencies.
 - Program provides weekly & annual report - pictures, even after funding ends
 - Research - do press releases on findings and include links to products (e.g. videos). Acknowledge work that has been done, even when doing new work. Become the expert they call for issue.
 - Identify someone who is good at speaking. Someone from community who stays on talking points.
 - Make your message fit your audience - Marketing prevention is not politically sexy.
 - Left side wants service, access, humanity.
 - Right side wants cost savings as a result of work.
 - Give talking points aimed at both sides, nuance to ask. Tailor message to audience.
 - Show up to city council meetings so they see your face the entire time. It shows we have a vested interest in the communities too.
 - Mobilize Federal Advocacy
 - Be a resource for them - share information, acknowledge people in the office are not experts, we are. Treat them with respect (all of them).

- Know who you are talking to. If it's a more conservative policymaker, they may not say 1st 1,000 days from conception (maybe say early childhood). Don't let language trip you up.
 - Engage social media – prepare a graphic and thank the legislator to help build the relationship.
 - Develop messaging for influencer/implementer. Write out key points for them. Elevator pitch.
 - Prep and help those with lived experience so they can tell their story effectively.
 - Co-facilitate community group
 - Raise up issues and have community groups tell politicians
 - Build Political Will at the Community level
 - Build relationships with the community, learn what is important to them and let politicians know (find out what is important to politician; politicians have a lot of pressure we don't always see – need to know constituents are behind it so they can support it).
 - Create Parent ambassador programs – so they can say what they care about, getting them to politicians (getting transportation), getting their voices heard (empower families) (pay parents to do this work),
 - Advocacy training - let people know can call or text
 - Research Areas
 - Federal level – go on hill visits and share a strength. Explain this is what the evidence says and then have partner ask for policy change (marry research and policy).
 - Marianna Chilton witness to hunger program (look at) – photovoice, bus to federal spaces (show pictures of what food prep space looks like, etc.).
 - Mom's Rising (podcast)
 - Can amplify what is already being done like Witness to Hunger or Mom's Rising
 - Identify whose voices aren't being heard and how to ensure it is (e.g., single moms) (highlighting them, bring to meeting) (parent ambassador program).
 - Participatory action research – pay them for time, can shape the research
 - Strategize in an election year vs not. During an election year, reach out to politicians/candidates who are passionate about nutrition security.
 - During political process, make sure this is part of the discussion (Durham CAN is a model for this).
- **Make SNAP better/easier to use (examples of what is being done from Northeastern and Southern group).**
 - Tie in TA piece if opening grocery and restaurants and want to be a SNAP vendor, here is how you do this (IL doing this).
 - Want a whole foods vs dollar store vendor.
 - MA has a rule - if qualify for one service, Common Application.
 - Communities in MA did SNAP matching if going to farmer's market. Cambridge is the only one doing this because the city pays for it.
 - Wrap around services to support it better.
 - DC has reloadable card – how do they check balances without vendor.

- Supermarket in Richmond decided that if a family comes in with WIC, they double the size of the order but only in the produce department. (4 lbs. vs 2 for grapes)
- Supermarket has a program to show “non-perfect” produce so WIC/SNAP participants can buy it at a reduced price.
- Allow self-check-out for WIC. (Walmart is piloting)
- **Examples of how to ensure families can use healthy foods**
 - Cooking with confidence class – shows how combine all the benefits getting (WIC, SNAP, local program) how maximize what get when grocery shopping.
 - In-home cooking class, using culturally appropriate recipes.
 - Have a team in the store making recipe which they give out and then they purpose the food.
 - When providing food bag, one program has a QR code which provides information such as what is in the bag, how to prepare it, flavor profiles. Other history about how grown isn’t necessary – just the basics.
- **Address Food Storage Issue**
 - Find out how much prep space is available.
 - Find out how much freezer space is available.
 - Give examples of how you can eat together as a family if there is not a table. One participant said they tell them to get on floor, on blanket, have picnic.
- **Address Food Preparation Issues**
 - Adjust food from pantry for those with no electricity or microwave.
- **The Southern group discussed using privilege to help communities address nutrition security issues.**
 - Examples given were the LPH writing grants for community groups to get funding (e.g. farmers markets) to support nutrition security.
 - Another example was getting funding from their organization (e.g., Duke) to provide the community for a program.
 - An LPH employee stated she didn’t need any credit for programs or the success of a program which made it easier to help them out. This was not as true for the academicians in the group.
 - There was a suggestion to publish with community partners to help academicians and get information about community programs out there so others know about it.
- **Cooperative Extension model – some thought this was a good model, others did not (Southern)**
 - Positive – Translational center in the community
 - Barrier –
 - Usually attached within agricultural college within the institution.
 - Cooperative extension staff get paid less, haven’t gotten an increase in funding for a long time.
 - Negative –
 - Students teaching 20-year farmers how to farm – academe treats others poorly.
 - The amount of money the university takes if co-writing a grant.
- **Representation - people who look like me make it easier to talk about needs/wants. How do we partner and bring them in the space/work?**

- Partner with HCBU (USDA has calls where need to partner with HCBUs) – funding shows priority.
- Research is important but how it is done is also very important.
- Maximize Usage of Food Benefits or Food Programs for the BIPOC Communities Attendees Serve (Southern silent brainstorming) (noted when an idea was emphasized by at least one more participant)
 - Understand why participants aren't maximizing usage. Ask. (emphasized)
 - Dissemination of information (e.g., eligibility requirements, etc.)
 - Make it so documentation status is not an issue. (emphasized) (so those who work with communities that may interact with or be undocumented do not have to fear that using the programs will harm them or someone close to them).
 - Build strong relationships (emphasized)
 - Include community members
 - Have paid community members to help enroll/navigators (emphasized)
 - People with lived experience oversee outreach/administration of food programs.
 - Participatory research – program participants guide the research design. (emphasized) work with community (emphasized). Make school meals free for all.
 - Expand eligibility (emphasized)
 - Increase WIC enrollment; major gap in NC between Medicaid and WIC.
 - Cooking/nutrition classes in primary care. (emphasized)
 - Address transportation barriers. (emphasized)
 - Provide transportation to farmers' markets (emphasized)
 - Delivery/online access – more innovation – so transportation is not a barrier. (emphasized)
 - Deliver Meal kits to ECEs and/or schools (emphasized)
 - <https://uconnruddcenter.org/research-archive/meal-kits-and-recipe-tastings-increase-selection-of-healthy-foods-among-food-pantry-clients/>
 - Make it easier to enroll in and use benefits. (emphasized)
 - Universal approach (universal school meals (emphasized), CACFP, SFSP, universal school breakfast, universal paid parental leave, universal nutrition education.
 - It would be great if summer feeding programs were for families, not just kids.
 - Reduce paperwork/technology barriers. (emphasized)
 - Make programs accessible in groups to build community feeling. Especially important for Latinos. (emphasized)
 - Don't make renewal so difficult and so frequent.
 - Provide adequate benefits/create SNAP/WIC packages that are seen as valuable. Current food benefits, especially for FFV, are not enough. It is not worth the effort to get the food. (emphasized)
 - Cost of living is increasing and cost of food is increasing but benefits have not kept up.
 - Reduce restrictive policies on what a family can buy with food stamps/WIC (emphasized).

- Modernization of benefit system (i.e., online options, telehealth). (emphasized)
 - Make benefits available to groups so people can band together, and we can capture some who are missed.
 - Address Food Vendors
 - Unbiased food vendors/grocery store staff (emphasized)
 - Train grocery store owners and staff so there's less bias and can take food benefits.
 - Greater incentives for food grocers to accept. (emphasized)
 - Culturally appropriate/representative (emphasized)
 - Food packages that are culturally sensitive. (emphasized)
 - Food packages that are easy to interpret and remember. (emphasized)
 - Culturally appropriate options for programs.
 - Make sure messaging (promotional, informational) is culturally relevant and representative. (emphasized)
 - Access data to understand what is and is not being purchased. (emphasized)
 - Dismantle "boot traps" thinking about accepting government support. (emphasized)
- Work on overcoming lack of trust in government/system to create food security (silent brainstorming in Southern convening).
 - Have an open discussion about expectations and intentions when it comes to program implementation. (emphasized)
 - Explain existing rules/regulations regarding immigration status affecting participation in WIC/SNAP/Medicaid. (emphasized)
 - Be intentional about EDI commitment and assessing overall "readiness" of government/system entity. (emphasized)
 - Implement higher diversity in the public health workforce. (emphasized)
 - Partner with community rooted organizations. (emphasized)
 - Work hard on relationships with BIPOC – led by community organizations that function outside of institutions. (emphasized)
 - Getting buy-in from community leaders & CBOs
 - Show up when the community needs it/invites you. Go to their tables and help with their issues. (emphasized)
 - Promoters/community workers. (emphasized)
 - Hire staff who speak native language or who are from the BIPOC community. (emphasized)
 - Work with trusted community partners/food businesses and decline credit for our work – our name doesn't need to be on it.
 - Listen more. Talk less. (emphasized)
 - Follow through on commitments. Put relationships first.
 - Connect families to non-institutional food support (farmers' market, farmers, etc.). (emphasized)
 - Connect people to programs that are dedicated to helping families apply to certain programs, for example "more in my basket" (emphasized)
 - Use empowerment frame instead of assistance frame (which is sadly in the name of SNAP).
 - Partner with local government officials from BIPOC community.
 - Listen to BIPOC. (emphasized)

- Identify and make explicit common goal. (emphasized)
- Create more informational campaigns on programs.
 - Explain the available programs (food pantry, WIC, mental health) and the benefits they provide.
- Provide opportunities for input (surveys, interviews). (emphasized)
- Validate feelings. (emphasized)
- Opt-out so no hoops/paperwork to participate. (emphasized)
- Inform, repeatedly, Latino patients that applying for WIC will not affect the citizenship process. Show them government documents outlining this. (emphasized)

