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Food Insecurity among Children in Massachusetts

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This article focuses on the prevalence among Massachusetts children and families of food insecurity, inadequate access to enough nutritious food for an active and healthy life. It summarizes research findings on the association of food insecurity with less optimal children's health and development from the prenatal period through adolescence. Food insecurity also correlates with other material hardships, such as housing and energy insecurity. Data show families' participation in public nutrition and other assistance program is associated with decreased prevalence of food insecurity and with mitigation of its impact on children's health and well-being. The article concludes with recommendations for policy action at the federal and state level that could enhance Massachusetts' children's food security by streamlining and increasing access to federal nutrition and other assistance programs.

In the wake of the economic crisis in 2008, the number of Americans experiencing food insecurity—defined as limited access to sufficient nutritious food necessary to for all household members to lead an active and healthy life—rose to 48.9 million in 2012, 15.9 million of whom were children.¹

The U.S. Department of Agriculture (USDA) and the Census Bureau began collecting data on food security in the United States in 1995 and established differentiated levels of severity for food security. The terminology used at the federal level to describe food insecurity was changed in 2006 but the older terms are still in use (see Table 1).² Household-food-security status is determined by a household's responses to a series of 18 questions about behaviors and experiences associated with meeting food needs. The technical classifications "high food security" and "marginal food security" comprise the overall category "food secure." Marginally food-secure households, however, are not free from concerns about the adequacy of household food supplies. Marginal food security is positively associated with poor health outcomes compared with food security, but the strength of the associations is weaker than that for food insecurity as reported in the annual USDA data release. Children in marginally food-secure households are at increased risk of fair or poor health and developmental delays, and female caregivers are at increased risk of depressive symptoms and fair or poor health compared with those in food-secure households.³

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Although Massachusetts falls below the national average for low food security—14.9% (also referred to as household food insecurity)—in 2012, 11.4% of households in the state dealt with low food security, including 4.2% who dealt with very low food security.⁴

Table 1. Terms for Food Security

Technical classification	General term USDA uses for reporting	Criteria
High food security	Food security	No reported indications of food access problems or limitations
Marginal food security	Marginal food security	Reports of worry/concerns about household food supply
Low food security	Household food insecurity	Reports of reduced quality, variety, or desirability of diet; little or no indication of reduced food intake
Very low food security	Household food insecurity	Reports of multiple indications of disrupted eating patterns and reduced food intake
Low and very low food security among children	Food insecurity among children (or child food insecurity)	Reports of multiple indications of disrupted eating patterns and reduced food intake among children

Nationwide, households with children experience higher rates of food insecurity than the national average for all households, rising as high as 22% (more than 1 in 5) for households with children under 6. Also at increased risk are households headed by a single parent (36.8% for women and 24.9% for men), and Hispanic and black families (26.2% and 25.1%, respectively).⁵ Of food-insecure families with children, 85% have a working adult in the home and 70% have a full-time worker, underlining the strain that low wages can put on a family’s ability to adequately feed all family members.⁶

Food insecurity threatens health, cognition, and emotional regulation at any age but it particularly jeopardizes the health and development of children, who may experience concurrent and persistent future impairments, depending on the chronicity and developmental timing of food insecurity. Food insecurity thus poses a serious risk to the growth, health, and cognitive and behavioral potential of poor and near-poor children in Massachusetts and throughout the United States.⁷

The evidence on the connection between food insecurity and obesity is inconclusive. Paradoxically, food insecurity can be associated with obesity in adult women and school-age girls.⁸ Insufficient financial resources and the pernicious effects of advertising encourage families to purchase cheap but filling foods that are nutrient poor but energy dense, contributing to children’s iron deficiency and decreased bone density and, in certain subgroups, to obesity.⁹

Food insecurity also has serious and increasing economic costs to the country. In 2005, scholars estimated that the total cost of hunger in the United States—considering factors such as impaired educational outcomes, costs associated with mental and physical illnesses linked to

inadequate nutrition, and charity required to help families get through another day—was, at minimum, \$90 billion a year.¹⁰ The figure for the country has since risen to \$167.5 billion, and for Massachusetts, Donald Shepard and associates estimate that in 2010 food insecurity cost Massachusetts \$2.72 billion in health, educational, and emergency intervention.¹¹

While the USDA provides food-security statistics based on census data at the national and state levels, Feeding America, a national hunger-relief organization, brings together indicators such as poverty, unemployment, and median income to provide statistics on children living in food-insecure families at the state, congressional district, and county levels.¹²

In Massachusetts, the average for child food insecurity (combining the two most severe levels of food insecurity among children) in 2011 (most recent data available), according to Feeding America, was 16.5%, higher than the USDA estimate of 12.7%.¹³ The highest rates in 2011 were in Hampden County (20.7%), Bristol County (17.6%), and Suffolk County (18.5%).¹⁴ Only three counties in Massachusetts, Dukes, Middlesex, and Norfolk, experienced rates lower than 12%.

Project Bread – The Walk for Hunger, a statewide anti-hunger organization, reported that the food-insecurity rate in Massachusetts has grown over 43% since the start of the recession in 2008.¹⁵ The increase in food insecurity is connected to the Commonwealth’s widening wage gap, one of the widest in the nation.¹⁶ High average incomes mask the depth of poverty and food insecurity among low-income communities in Springfield, Lowell, Lawrence, Fall River, Brockton, New Bedford, and Worcester, and in rural areas and selected neighborhoods of Boston.¹⁷ Children’s HealthWatch data spanning 2006–12 from the Boston area, for example, reveal a dramatic increase in the rates of household and child food insecurity during the current recession (see Figure 1).

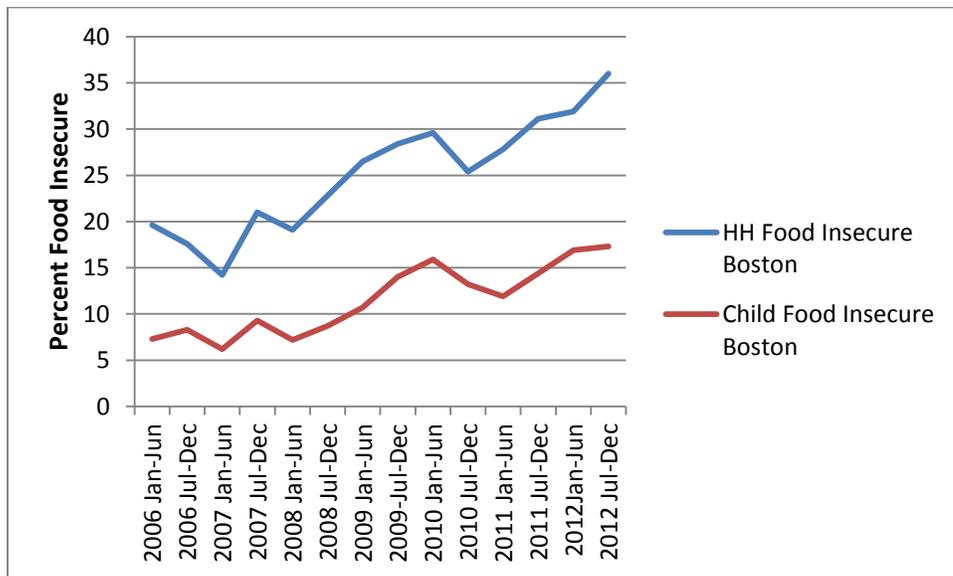


Figure 1. Household and food insecurity among families with young children from the Boston area seeking care at the emergency department at Boston Medical Center

Associations between Food Insecurity and Children’s Health from the Prenatal Period to Adolescence

A woman's nutritional status before she conceives and her experience of food insecurity and poor nutrition during pregnancy are linked to a host of perinatal problems and complications. Of particular concern is the risk of food-insecure mothers' entering pregnancy with insufficient iron stores and low-folate diets, which are linked to complications, such as preterm births, fetal growth retardation, and neural tube defects and other birth defects.¹⁸ These risks are especially critical for black, Latina, and single mothers, whose children, for many reasons, are at heightened risk of adverse outcomes.¹⁹ In addition, food insecurity in pregnancy is correlated with greater emotional distress for expectant women, including anxiety, stress, and depressive symptoms.²⁰

Deprivation in early life after birth also has a dramatic effect on health. Particularly vulnerable are infants and toddlers. Because they are undergoing rapid growth of body and brain, deprivation can shape future trajectories of health and cognitive and motor, social, and emotional development.²¹ The stress that family hardships, such as food insecurity, place on a young child physically alter the development of crucial brain structures controlling memory and psychosocial functioning.²² (Early childhood is the narrow window during which we build our basic capacity to learn and interact with others; disrupting this brief period diminishes children's ability as they grow to acquire more complex school skills, and later job skills.)

Early childhood is also critical for establishing the roots of lifelong health. Our work at Children's HealthWatch, which focuses on the youngest children from birth to age 4 in five states, including Massachusetts, has found in comparison with young, food-secure children, young, food-insecure children had 90% greater odds of having their health reported as fair or poor and 31% greater odds of having been hospitalized since birth.²³ A study by a different group in Worcester is relevant for the consequences of this problem within Massachusetts. This study found that moderate hunger significantly predicted poor health in preschool-aged children, while more severe hunger significantly predicted chronic illness among preschool-aged and school-aged children and was associated with the child's anxiety and depression.²⁴

Also at heightened risk are children of recent immigrants. Though 93% of children of immigrants are U.S. citizens and therefore eligible for federal assistance, these programs often do not reach them because of confusion about eligibility within mixed-status families, fear of the impact on future ability to adjust the family's immigration status, and other barriers, such as parents' limited English proficiency. Thus, children of immigrants participate in child-nutrition programs at much lower rates than children of U.S.-born parents, in turn increasing their chances of food insecurity.²⁵ Studies show that though immigrant mothers are more likely to be married, to breast feed their children, and to have fewer low-birth-weight babies than U.S.-born mothers, children of immigrant mothers are at increased risk of household food insecurity and consequent poor health.²⁶

Many studies have examined associations between household food insecurity or food insufficiency (an earlier measurement tool for food insecurity) and older children's health, school performance, and psychosocial functioning. Behavioral, emotional, and academic problems are more prevalent in hungry children, with aggression and anxiety having the strongest association with hunger.²⁷ In comparison with children aged 6 to 11 years in food-sufficient families, children aged 6 to 11 years in food-insufficient families have lower arithmetic scores and are more likely to repeat a grade, to see a psychologist, and to have difficulty getting along with other children.²⁸ Children younger than 12 years categorized as hungry or at risk of hunger are significantly more likely than non-hungry children to have impaired functioning, hyperactivity, absenteeism, and tardiness.²⁹ Among children 15 to 16 years old, children from

food-insufficient households are significantly more likely to have dysthymia, thoughts of death, and a desire to die and to have attempted suicide.³⁰

Association of Economic Stressors with Food Insecurity and the Impact of Public Programs

The Commonwealth leverages federal programs to address food insecurity in childhood. These programs include the Supplemental Nutrition Assistance Program (SNAP—formerly food stamps), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Child and Adult Care Feeding Program (CACFP), and the National School Lunch and School Breakfast Programs (free or reduced-price school meals) Eligibility is determined primarily by income, using a percentage of the federal poverty guideline—in 2012 a household of four people was considered poor if it earned no more than \$23,050 a year or \$1,921 a month.³¹ Program eligibility for families with children in Massachusetts includes having gross income no greater than 200% of the federal poverty guidelines for SNAP, 185% for WIC and reduced price school meals, and 130% for free school meals.³² Some nutrition programs, such as the Massachusetts Emergency Food Assistance Program (MEFAP), are state specific.

Children's HealthWatch and other research groups have shown that these programs exert important protective effects on children's food security and health and development, though not all eligible children receive the needed benefits nationally or in Massachusetts.³³ In Massachusetts, however, with the state's high cost of living, even maximal allowable benefits are often not adequate to meet the true cost of basic needs. Research conducted in Boston consistently shows that the maximum SNAP benefit is not enough to buy even the Thrifty Food Plan—the minimally nutritious diet on which calculation of the maximum SNAP benefit is based—much less a diet that meets current understanding of a healthy diet. The annual difference between the cost of the Thrifty Food Plan and the maximum SNAP benefit was \$2,520 in 2008, a gap the majority of low-income families would have great difficulty closing.³⁴ The Institute of Medicine recently published an extensive scientific report based on nationwide data that reaches the same conclusion—the current SNAP benefit is inadequate in most regions of the United States and the calculation must be revisited.³⁵ Research has also demonstrated that higher SNAP benefits make a difference to food security and health. After the SNAP benefit was increased temporarily by an average of 13.6% in April 2009 for all recipients as part of the American Recovery and Reinvestment Act (ARRA), among low-income households, food insecurity decreased, food expenditures increased, and young children's health improved.³⁶ From a physician's perspective, SNAP and other nutrition assistance programs are very good medicine, but the dose is often not fully therapeutic.

A mother's receipt of WIC is associated with decreased risk of low birth weight and therefore lower attendant special-care costs. Postnatally, infants and toddlers who receive WIC are more likely to be in good health and to have no developmental delays and a healthy weight and height for their age than those who are unable to receive WIC benefits because of access problems.³⁷ Similarly, SNAP, whose benefits are fully funded by the federal government, partially mitigates the effect of food insecurity on the health of infants and toddlers, though it does not eliminate it completely.³⁸ SNAP can also protect against obesity among food-insecure girls, improve children's dietary intake, and reduce the risk for developmental delays among young children.³⁹ SNAP has lifelong benefits; a longitudinal study shows prenatal or early

childhood exposure to SNAP reduces the likelihood of developing metabolic syndrome (obesity, hypertension, diabetes, and heart disease) in adulthood.⁴⁰

For parents who struggle to provide enough food for their families, meal programs such as CACFP and the school meals programs are a lifeline. CACFP provides reimbursements for food served to young children in child-care centers, family day-care homes, after-school programs, and emergency shelters, and to adults in long-term-care facilities. Parents often rely on child-care and after-school programs so that they can work. CACFP plays an important role in raising the quality of the care by providing nutritious meals and making the programs more affordable to parents, since the care providers receive a reimbursement for the meals served.⁴¹ CACFP has been shown to sustain the health of young children in child care. For example, a 2010 study found that children who were likely receiving CACFP meals were more likely to be a healthy weight and height for their age, 28% less likely to be in fair or poor health, and 26% less likely to be hospitalized than children whose meals were supplied from home.⁴²

Similarly, the national School Lunch and School Breakfast Programs ensure that school-age children are receiving nutritious meals. Across the state on an average day, 80% (277,101) of children who are eligible for free or reduced-price meals participate in school lunch and 35% (122,273) of children eligible for free or reduced-price meals participate in school breakfast. The School Breakfast Program is an important component of the nutritional safety net and has been linked to positive changes in nutritional and educational outcomes. A study conducted in Lowell in 1989 demonstrated that the implementation of school breakfast in elementary school was associated with decreased absenteeism and tardiness and increased standardized test scores, a finding replicated in Philadelphia by an independent research group from Massachusetts General Hospital.⁴³ The School Breakfast Program reduces the risk of household food insecurity by providing meals to children who might otherwise have to miss a meal, by freeing up household resources to feed other family members, and by reducing the uncertainty surrounding availability of sufficient food.⁴⁴ School lunch has an additional effect; USDA research indicates that children who participate in the School Lunch Program have superior nutritional intakes compared to those who do not participate.⁴⁵

These programs cannot, however, fully buffer other shocks to family incomes. Other inadequately met survival needs contribute to undernutrition in children. Sometimes getting ahead may mean falling behind. This phenomenon has been described as the “Cliff Effect.”⁴⁶ For example, many families whose incomes exceed the eligibility cut-off for benefit programs, such as child care, SNAP, or WIC, may still be unable to avoid food insecurity without assistance, if the costs of competing basic needs (e.g., energy or housing) or work supports (e.g. child care) overwhelm their household budgets.⁴⁷ Two factors that are often not considered when talking about food security are energy prices and housing costs. Both are very high in Massachusetts. Among all states and the District of Columbia, Massachusetts ranks eleventh highest for energy prices and sixth highest for housing costs.⁴⁸

Children’s HealthWatch examined the relationships between receiving housing subsidies and nutritional and health status among low-income, food-insecure children younger than 3 years, living in rented housing. The outcome of interest was underweight, an indication of undernutrition. Among these children, those whose families were on waiting lists for housing subsidies had significantly lower weight for their age than children in similar families already receiving subsidies.⁴⁹ In January 2012, Massachusetts Section 8 Housing had a waiting list of 103,226 households and 64% of these households had children.⁵⁰ Because very few new housing vouchers are currently being issued in Massachusetts, most households on the list must depend

on turnover, resulting in an average wait time of years rather than months,⁵¹ during which time the health of their children may be jeopardized by poor housing and nutritional deprivation. Moreover, cuts at the federal level due to sequestration will mean that up to 10% of those currently receiving housing vouchers through Section 8 could be cut from the program in Massachusetts.⁵²

Another study evaluated the association between a family's participation in the federal Low-Income Home Energy Assistance Program (LIHEAP) and other forms of state and philanthropic energy assistance and the size, weight, and health of its young children. This study found that children in nonrecipient households had a greater likelihood of being at nutritional risk for growth problems. Moreover, children from eligible households not receiving LIHEAP had a greater likelihood of acute hospitalization on the day of the interview.⁵³ These findings highlight the trade-offs that low-income parents must make during the harsh Massachusetts winter months.⁵⁴

Housing and heating are directly related to food insecurity as parents face their finite income and the bills that must be paid; seasonal fluctuations such as higher costs for heating in winter can force parents to make choices between affording housing and heating and affording nutritious food. Recent trends in energy and food price increases indicate that this "heat or eat" threat to child health, growth, and development is likely to grow.⁵⁵

Another factor that affects children's food security is out-of-pocket medical costs, whether for adults or for children. Children whose families struggle to pay for health care are at increased risk for health problems, developmental delays, and food insecurity.⁵⁶ When the high cost of health care forces families to forgo paying for basic household expenses, children's health suffers. The study found that children in families that reported not paying their rent, making mortgage payments, or paying bills for food, utilities, transportation, or other basic expenses in order to pay for medical care or prescriptions were more likely to be in fair or poor health, to be at risk for developmental delays, to be food insecure, and to have mothers who were in fair or poor health or showed symptoms of depression.

Although we do not yet have quantitative data, clinical experience shows, for example, an added financial and health burden on families whose children or other family members have special nutritional needs because of severe food allergies, failure to thrive, neurologic difficulties with oral feeding, or other nutrition sensitive conditions, such as cystic fibrosis. Failing to meet those needs in a timely manner may result in secondary illness and increased health care expenditures.

Policy Proposals

The research and data detailed here has several important policy implications for state lawmakers.

At the Federal Level

Current ideologically driven budget cutting measures in Washington, including sequestration (which went into effect March 1, 2013) and changes to the Farm Bill, which includes SNAP, as well as cuts in housing and energy programs, will increase the problem of hunger and food insecurity in Massachusetts and around the country. One study estimates 60,497 jobs will be lost in Massachusetts when the cuts are fully implemented.⁵⁷ To help reduce the negative effects of these measures, state lawmakers can advocate with colleagues on the federal level to prevent cuts

and restore funding to nutrition programs, citing the projected impact in Massachusetts. At risk are key programs, such as WIC, with more than 9,600 pregnant women and children likely to lose benefits, and SNAP, though technically protected under sequestration, could be used to offset cuts to another program, as has happened in the past, or be slashed in the Farm Bill, as has been proposed. These cuts would come in addition to the planned rollback of the ARRA SNAP benefit increase in November 2013, which is equivalent to a \$61 million loss for Massachusetts alone.⁵⁸

At the State Level

Sustain and Increase State Contributions to SNAP and WIC The federal-level Healthy, Hunger-Free Kids Act of 2010 provides \$4.5 billion in resources for child-nutrition programs; Massachusetts received \$2,707,427 from this fund for SNAP in 2010. In addition, Massachusetts already has in effect the Act Establishing School Based Nutrition and Childhood Hunger Relief Programs.⁵⁹ This act includes authorization for a SNAP outreach program and the implementation of the WIC program. With increased need in the community, however, comes increased need for the state to respond effectively. Lawmakers can support the continuation or the increase of state contributions to SNAP administrative funds, which include funds for frontline caseworkers who process applications and determine eligibility, and to the Massachusetts WIC program to ensure that pregnant women, infants, and young children can access the nutrition support and education to support their health.

Advocate with USDA for Reconsideration of SNAP Overpayment Charges Massachusetts is currently facing a \$27 million USDA assessment of overpayments of SNAP benefits. During the recent recession, unemployment rates rose to double-digit figures and SNAP caseloads surged across the nation. Between January 2009 and January 2011, the Massachusetts SNAP caseload grew from 318,286 households to over 439,836, a 72.3% increase that demonstrates the huge surge in need in the state. Since 2005, the average SNAP caseload also climbed from 500 to over 900 cases per worker in local Department of Transitional Assistance (DTA) offices. Though requested internally and by a variety of state advocates, state appropriations were not made available to increase DTA resources to manage the surge, and so caseworkers had trouble processing SNAP renewal applications in the required timely way. Appropriately concerned about the nutrition of Massachusetts families, when a renewing household had provided all the necessary information, DTA continued SNAP benefits for these households until they had time to more thoroughly review the case. USDA subsequently informed the state that this protocol, designed to protect families and elders from hunger, was not acceptable and benefits for these families awaiting review must stop. The USDA deemed as overpayments the benefits received in this period, though it found no fault or fraud on the part of the SNAP recipients.⁶⁰ State lawmakers can ask USDA to show forbearance in tough economic times, as well as provide sufficient funding to increase staffing and help DTA modernize its eligibility processing to remove bureaucratic barriers so that families who have played by the rules are not penalized by going hungry because of overburdened state agencies' inability to keep up with processing paperwork. There is a precedent for such action. In July 2012, in recognition of the huge demand for health care among low-income households coupled with the difficulty the state had in keeping up with health care renewals, the Massachusetts General Court directed the Office of Medicaid to not terminate coverage to recipients who sent in renewal forms in a timely manner.⁶¹

It is important to recognize the toll the recession has taken on all state agencies and ensure that the health of low-income households that play by the rules are not jeopardized by overburdened state agencies.

Streamline and Update MassHealth Processes for Special Situations State regulatory changes alone could mitigate the development of malnutrition among some particularly vulnerable populations, such as premature and malnourished infants and children with special health care needs. Current Massachusetts law mandates that specialized formulas and supplements for publicly insured premature and sick infants and older children with special health care needs requires approval as durable medical equipment, subject to the lengthy prior authorization process.⁶² Because it is classified as durable medical equipment, a patient must obtain prior approval from MassHealth to obtain this formula, a process that because it takes several weeks and involves an astounding amount of paperwork is ripe for administrative error and delay. At this moment, the risk of delay by administrative error is borne particularly by these vulnerable sick infants because MassHealth makes no provision for the infant to receive an emergency supply while the approval process is pending, though some formula may be obtainable from WIC for only a month. Clinical experience shows infant patients of Dr. Frank (co-author of this article) and colleagues, after discharge from lengthy and expensive neonatal intensive care stays, had to be rehospitalized for malnutrition while this process ground on.

In 2012, the Medical Legal Partnership, a national organization that delivers health care for vulnerable populations by addressing unmet legal needs and removing legal barriers that impede health, in conjunction with pediatricians from area hospitals suggested the following changes to prevent morbidity associated with inadequate nutrition in these particularly vulnerable children:

- Categorize enteral formulas and similar nutritional supplements as pharmaceutical items, not as durable medical equipment.
- Create a special category of prior approval for special nutritional supplements requiring a 3-day window instead of the current 15-day period in which prior authorization must be processed.
- Provide mechanisms to secure an emergency supply of formula pending authorization and appeals processes.

Improve Participation in CACFP CACFP provides children in child-care and after-school programs with nutritious snacks and meals. The program is administered at the state level through reimbursements that come from the federal government. In Massachusetts, the Department of Elementary and Secondary Education is the designated CACFP administrator and the Department of Early Education and Care is the licensing agency for all child-care centers in the state. CACFP helps to meet the nutritional needs of about fifty thousand Massachusetts children from low-income families in child care each day. While participation has been increasing overall, less than half of family day-care homes participate nationwide; in Massachusetts, 70% of family day-care homes participate, leaving many children without the benefits of the program.⁶³

These gaps are overwhelmingly due to onerous program requirements and confusing processes for enrollment, which are aggravated by inconsistent agency enforcement of state and federal regulations. This situation leaves current participant providers frustrated and discourages new providers from joining.⁶⁴

The following changes would improve participation and retention in CACFP:

- Increase CACFP funding at the federal or state level or both to (a) raise the meal reimbursement rate, (b) reimburse providers for one additional meal or snack a day, and (c) reimburse providers for meals that are prepared but not served by accident or because of unexpected child absences.
- Streamline program paperwork by (a) putting more forms and requirements online and (b) not requiring handwritten attendance records. These steps would reduce frustration among providers and sponsors, allowing them to focus on their most important task, caring for children.⁶⁵

Eliminate Stigmatization of the School Breakfast Program Schools across the Commonwealth recognize the importance of starting the day with a nutritious meal by providing breakfast on standardized testing days, recognizing that empty stomachs impair the concentration necessary to succeed on tests. But breakfast on a testing day cannot provide students with information they missed because they were hungry the preceding week or month. School meal programs need regular, sustained support to effectively reach all students who need them. Since participation is voluntary on the part of the student, ensuring that the program is student-friendly is almost as important as the quality of the food. In other words, school-age children (elementary through high school) must eat the food to receive the benefit, and therefore support for the program must be institutionalized and barriers that stigmatize participants by singling them out as participants in reduced-price or free meals must be removed. A recent School Breakfast Program Scorecard found that for the 2011–12 school year, for the first time nationally, more than half of all low-income students who participated in school lunch also participated in school breakfast, and more than 90% of schools that operate the National School Lunch Program also offered the School Breakfast Program.⁶⁶ The goal is to have as many children as possible who eat school lunch also eat school breakfast, thereby yielding only a small discrepancy between the two percentages. States that ranked high in this report had institutionalized school breakfast in the classroom at the state level. Unfortunately, in this report, as a state Massachusetts ranked 42nd. Boston, however, in comparison with about fifty-five other urban districts, was 8th in participation. Much can be learned from Boston, which introduced Universal Breakfast and breakfast in the classroom across the district in the 2012–13 school year. In comparison with about fifty-five other urban districts, it was 8th in participation.⁶⁷

Existing laws dealing with school-based nutrition programs in Massachusetts are a strong foundation on which to build.⁶⁸ To improve participation, however, Massachusetts must eliminate the stigmatization of the breakfast program. The following strategies are recommended:

- Allow classroom feeding to be counted as instructional time. For example, breakfast provides opportunities to practice measuring skills and to discuss biology, nutrition, ecology, and other domains related to the real world components of the meal.
- Make school breakfast universal in low-income districts. (In qualifying areas, all meals at the school are designated as free, drawing a higher reimbursement for the school and removing stigma for the children because all are able to eat free.)
- Remove barriers to accessing the program by offering breakfast after the bell and inside the classroom and including second-chance breakfast in the form of “grab and go” bags at a later hour for schools that start very early in the morning.

Improve the Quality of School Meals The USDA provides a significant number of the items used to prepare school meals through the Schools/Child Nutrition USDA Foods Programs.⁶⁹ Also, a variety of foods are accessible to states on the federal level, such as Fresh produce, whole grains, and low-sodium frozen vegetables, and other healthful foods. Unfortunately, not all of these items are available in Massachusetts at this time. But the Commonwealth can improve the quality of the food served by bringing in the best possible selection of fresh, commodity foods.

Sustain Funding for MEFAP The Massachusetts Emergency Food Assistance Program (MEFAP) is a state-funded program that agencies, such as the Greater Boston Food Bank, use to purchase foods that are distributed free to all eligible emergency food providers, to sponsor nutrition education initiatives, and to help food banks with funding to distribute food to those in need. MEFAP is a supplementary food assistance program and is integral to the mission of the Commonwealth's emergency food providers to address immediate food needs in their communities. In FY2012, the four Massachusetts regional food banks (the Food Bank of Western Massachusetts, the Greater Boston Food Bank, Merrimack Valley Food Bank, and Worcester County Food Bank) distributed more than 16 million pounds of MEFAP food (representing over 12.5 million meals) to those in need throughout the state.⁷⁰

With commodity prices continuing to rise and cuts in federal emergency food funding, food banks rely even more on MEFAP funding as they strive to provide all those in need in the Commonwealth with three meals a day. While not a structural solution, MEFAP is an important emergency response to fighting food insecurity in households in Massachusetts.

Consider an Income Tax Credit for Persons Engaged in Commercial Agricultural Production for Donations of Food To support local food production and local food banks address food insecurity. Massachusetts lawmakers should consider a tax provision similar to Maine's Act to Support Maine Farms and Alleviate Hunger (Sec. 1. 36 MRSA §5219-FF). The law provides an income tax credit of up to \$5,000 to persons engaged in commercial agricultural production for donations of food to incorporated nonprofit organizations that provide free food to low-income individuals for the purpose of alleviating hunger.

Children who lack food now cannot eat it later and receive the benefits retroactively. Thus, ensuring that all children in the Commonwealth of Massachusetts have adequate, nutritious food to help them sustain good health, succeed in school, and someday reach their full potential is a matter of extreme urgency.

Notes

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⁴ Coleman-Jensen, Nord, and Singh, *Household Food Security*.

⁵ Ibid.

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