



Applying Racial Equity to U.S. Federal Nutrition Assistance Programs: SNAP, WIC and Child Nutrition

A BREAD FOR THE WORLD INSTITUTE SPECIAL REPORT



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KEY TERMS

Please see the glossary for more detailed definitions of these terms and additional terms used throughout this paper.

Equity. Equity is a state in which all people in a given society share equal rights, access, opportunities, and outcomes, which are not predicted or influenced by one’s identity characteristics, including race, gender, and class.¹ Equity is achieved by providing targeted investments to “meet people where they are” to create equitable opportunities. Equity creates equality.

“Equity
creates
equality.”

Racial Equity. Racial equity is one type of equity. Racial equity is achieved when targeted investments enable people of color to overcome the structural discrimination they encounter—thereby eliminating racial divides between communities of color and their white counterparts, and allowing communities of color to reach optimal outcomes, including in nutrition and food security.

Equality. Equality has traditionally been defined as providing equal investments to people. Under this definition, actions to promote equality usually do not lead to equal outcomes since they do not account for discrimination, circumstances, and needs. Equality, as Bread for the World Institute envisions it, would enable all communities to achieve optimal outcomes on an equal basis. This requires equity—individuals are protected from discrimination and provided with the targeted support and access they need to succeed given the barriers they encounter.

Foreword

Ending hunger in a lasting, sustainable way requires addressing its root causes (see Appendix 29). While hunger and poverty rates have declined nationwide, people of color remain at consistently higher risk of hunger and poverty than their white peers. This is due, in large part, to structural racism. Applying a racial equity lens—a concept and practice that focuses on achieving equality for people of color—can help the United States reduce the impacts of structural racism (for more on racial equity, see the Key Terms, the glossary, and the Appendix, Tool 2).

To end hunger and food insecurity in the United States, the nation must apply a racial equity lens to causes and solutions. In this context, achieving racial equity means that people of color are no longer more likely to be food insecure than whites and can reach optimal nutritional outcomes. Putting the needs of communities of color at the center has the wider effect of lowering barriers for everyone. Ultimately, the impact of applying a racial equity lens to federal nutrition programs is that all participants, regardless of race, are able to improve their nutritional status.² See “Understanding the Curb-Cut Effect,” page 12, for more on how this happens.

While there are many factors that contribute to food security and freedom from hunger, this report focuses on one—nutrition. Since racial equity has not been consistently and comprehensively applied to the larger ecosystem of hunger causes and solutions, a good first step is to apply a racial equity lens to key U.S. federal nutrition assistance programs. The research scope of this report is limited to the main nutrition programs that act as the first line of defense against hunger for millions of people: the Supplemental Nutrition Assistance Program (SNAP); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and Child Nutrition programs (which include school meals, after-school meals, summer meals, Summer Electronic Benefits Transfer or EBT, and the Fresh Fruit and Vegetable Program (FFVP). The Food Distribution Program on Indian Reservations (FDPIR)³ for Indigenous communities and the Nutrition Assistance Program (NAP)⁴ that operates in Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands are also referenced in the SNAP section.

“...Nutrition programs reduce hunger, and they already apply equity principles in some ways. This paper explores ways these efforts can be strengthened.”

among advocates and researchers that equity matters. The good news is that nutrition programs reduce hunger, and they already apply equity principles in some ways. This paper explores ways these efforts can be strengthened.

Organizations that are advocating for racial equity to be applied in anti-hunger and anti-poverty policies and practices must also be equipped to apply this lens on a daily basis. This lens should inform organizational internal practices, including hiring, office culture, decision making, policy and program design, advocacy strategies, and retention/promotion. To learn more, see the chart in Appendix, Tool 1 on pages 73-75.

RACIAL EQUITY VS. RACIAL EQUALITY

The two concepts are different. By practicing racial equity, racial equality is achieved. In other words, providing targeted support based on need, circumstance, and historical context creates an environment where all communities can attain equal, and later optimal, outcomes regardless of race.

For more, see Key Terms and the Glossary.

The goal of the analysis is to identify additional ways these programs can apply racial equity principles in order to move the country closer to the time when people of color are no longer disproportionately food insecure and no longer disproportionately at risk of food insecurity.

This report (1) discusses what it means to end hunger and malnutrition; (2) makes the case that the United States cannot end hunger without applying a racial equity lens; (3) analyzes how each program has reduced food insecurity by adopting equity principles related to class, gender, and race; and (4) offers recommendations on how each program can accelerate progress against food insecurity and hunger by more deeply applying a racial equity lens.

The analysis in this paper was informed by organizations in the anti-hunger and anti-poverty community, including practitioners and researchers of color, who are committed to ending hunger in the United States. There is a growing consensus

Executive Summary

In 2015, 193 countries, including the United States, committed to a series of global human development goals, the Sustainable Development Goals (SDGs). They include ending **hunger**, as well as **malnutrition (see glossary)** in all its forms, by 2030.⁵ All the goals are interconnected and emphasize the need to look holistically at the systems that affect a person's or family's ability to survive and thrive. They call for increased attention to communities that have historically been left behind, some of whom have high rates of hunger and malnutrition (see Appendix 29 for more on the global goals).

Communities of color in every U.S. region are at higher risk of food insecurity and hunger, largely because of structural and institutional **racism (see glossary)**. Efforts to reduce food insecurity and hunger have not yet put the needs of communities of color at the **center (see glossary)** of their analysis, policies, and programs.

This report develops a framework to reduce the **racial nutrition divide (see glossary)** by applying a racial equity lens to federal nutrition programs. People of color will only benefit from **racial equality** and reach optimal nutritional levels when the United States attains **racial equity (see glossary)**. As the Institute sees it, the country and its systems must attain racial equity before communities of color can enjoy the fruits of racial equality, including benefiting from optimal nutrition. (For more on racial equity, see Appendix, Tool 2).

The programs analyzed in this report include the Supplemental Nutrition Assistance Program (SNAP) as well as its alternatives on reservations and in U.S. territories; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and Child Nutrition programs (CNP). They are part of a larger continuum of federal programs for people at risk of food insecurity and poor nutrition.

The methodology designed and used for this report (see page 9) can also be applied in fields outside both the nutrition and anti-hunger communities. Improving nutrition is only one piece of the larger task of ending hunger. The findings of this report can be used to extend the approach to other policies and programs that do not yet apply a **racial equity lens** but are critical to responding to hunger holistically (e.g., jobs, housing, asset building, transportation).

“This report develops a framework that applies racial equity principles to reduce nutritional divides.”



Zach Blum for Bread for the World

Federal nutrition programs can apply a racial equity lens by:



Putting the needs of communities of color at the center. Focusing on the needs of communities of color, including those related to **historical trauma** (see glossary), nutritional deficiencies, and resource segregation, will strengthen program outcomes and benefit recipients of all races.



Expanding inclusivity. Some programs have eligibility restrictions on individuals or on institutions such as schools and nonprofits. Many of these restrictions disproportionately hurt communities of color, so reducing them would contribute to more racially equitable outcomes.



Implementing equity-centered approaches to make it easier for participants to receive support. Implementing **equity-centered approaches** (see glossary) puts the needs of recipients of color at the **center** (see glossary), which can reduce participation barriers. Currently, some program requirements create constraints for many recipients, disproportionately people of color, when they try to **access** (see glossary) services. Two of these constraints are remote or inaccessible physical locations of services, and the requirement that participants apply for or access services in person. The latter is a barrier for many parents who work in one of the **10 lowest-paying jobs** (see glossary)—particularly those with unpredictable work schedules⁶ and/or lack of access to reliable transportation. Taking into account potential constraints when programs are designed and implemented will make it easier for recipients to access the services they need in an equitable way.



Increasing support for and accountability of program staff. Racial equity is not always practiced in program implementation—there can be a lack of **cultural competence** and **cultural humility** (see glossary) among some implementing staff. Some recipients reported in interviews that they confronted interpersonal racism, **stereotypes** (see glossary), and other forms of discrimination when trying to access program services. All staff who interact with program beneficiaries, including administrators, school officials, and grocery store cashiers, should be supported and held accountable for applying a racial equity lens in the way they provide services to the community. Support could include training; accountability could include putting in place procedures for filing complaints. Employing a staff that is racially representative of the community and establishing a pathway for program beneficiaries to become staff will also help promote equity, reduce bias, and improve program outcomes.



Creating a mechanism that allows recipients, particularly recipients of color, to participate in program design, implementation, and evaluation. Program participants should have a mechanism to provide feedback that informs program improvements. As the end users, recipients are uniquely qualified to offer their perspectives. It is important to note that participation should be equitable—meaning that participants have real power to influence the outcomes. For more on the role of equitable engagement in the report's methodology, see page 73. Creating such a mechanism affirms the value of experiential expertise and helps establish an environment that supports consistent growth in applying racial equity principles.



Strengthening the collection and disaggregation of data. Glaring gaps exist in the data, particularly disaggregated racial and ethnicity data on the impact of programs on reducing poor health or improving nutritional outcomes. Collecting this data and making it accessible to researchers is key to ensuring that programs reach all communities and that the United States is making progress toward racial equity and food security.

Methodology

How a racial equity lens was applied

The methodology for applying a **racial equity lens** was founded on the goal of **centering** the needs of **communities of color** (see glossary). Given the current racial nutrition divides that exist, this process was divided into two thought processes. The first part of the thinking was on closing the current **racial nutrition divide** (see glossary), whereby the programs would need to achieve equal outcomes for recipients of color relative to their white counterparts. The second part of the thinking was on ensuring that communities of color benefited from reaching optimal nutrition. As explained in the Foreword, policies that are centered on those who have been traditionally left behind will automatically benefit all who receive those policies, including white recipients. Both stages of thinking are integral to achieving comprehensive equity for all communities.

For Child Nutrition Programs, this meant providing targeted support that addressed the inequitable conditions children of color living in lower-income households face to ensure optimal nutrition. For women, infants, and young children participating in WIC, this meant achieving equitable breastfeeding outcomes. At the same time, this meant being sensitive to the inequitable structures that impact breastfeeding rates for women of color, as well as the inequitable circumstances that disadvantage formula-fed children, such as the unsafe drinking water in many communities. These sensitivities were important to consider as researchers thought through what it would take to achieve equitable nutritional outcomes for infants of color and their mothers. For individuals and families participating in SNAP, this meant equalizing food security outcomes between recipients of color and their white counterparts. Within each program, there are additional caveats to be addressed to help close the current racial nutritional divide and propel the United States towards optimal nutrition for communities of color.

For a more detailed understanding of what racial equity is, see the Glossary and Appendix, Tool 2. For a more detailed understanding of the research approach, please see the stages below, and also see page 73, to review detailed research questions used within each stage:

Stage 1: Do not assume that the program or policy did not already apply an equity lens. Many anti-hunger programs already include an equity lens or efforts to promote equity in their program design—for example, gender or class equity. Programs serve lower-income communities, so their overall goal is to help people with fewer resources achieve equal outcomes. But for many reasons, some within the program’s purview and some outside its control, equal outcomes are not always the result. Using additional equity lenses, including a racial equity lens, can move the program closer to its goal.

Stage 2: Analyze the outcomes for each racial and ethnic group. If outcomes are not equal across participants of all races, then there is room to use a strengthened racial equity lens to adjust the inputs to achieve equal outcomes. The way to do this is to put the needs of communities of color at the center of the analysis in order to identify whether or how barriers to equal outcomes are addressed and how these program or policy elements can be improved.

Stage 3: Analyze why and how the outcomes of each racial and ethnic group were different. Once racial and ethnic disparities are identified, it is important to respond to the history and other factors that created these divides. Understanding the “why” and “how” behind the data is critical, especially when determining which recommendations are the most culturally sensitive and appropriate in addressing the historical trauma associated with the disparity.

Stage 4: Use a racial equity approach to ensure that experts of color are equitably engaged in leading this project and shaping the narrative. To see what it means to equitably engage people of color, please see text box on page 73. Any racially equitable approach enables and empowers people of color to make decisions about how their narrative is portrayed. It is critical to racial equity that people of color be empowered to exercise true leadership. This project, for example, empowered authors and researchers of color who are experts to lead the development of the methodology. During consultations, they met with program participants who are people and

WHAT DOES IT MEAN TO “CENTER” THE NEEDS OF COMMUNITIES OF COLOR?

“Centering” means simply focusing attention. All decisions are informed by the barriers facing communities of color and solutions aimed at overcoming those barriers. Barriers and solutions are at the center of our thinking and discussions.

For more, please see the glossary.

experts of color. Participants in programs are experts on the strengths and weaknesses of the programs. Feedback from people who receive or have received nutrition benefits should guide research areas and topics. Some of the topics were identified solely by listening to the perspectives of recipient experts of color. Engaging with participants directly is an integral part of using a strengthened racial equity lens in order to empower the agency of participants, even when qualitative or quantitative research has not yet caught up.

Stage 5: Consult with people doing this work. Often, policy recommendations are inadvertently made in siloes. Initial consultations with experts on the issues should be made, but additional meetings with people who work with communities that receive nutritional support, including staff who help implement nutritional programs, are critical. When possible, learn about the racial equity work that nonprofit staff, intermediaries, and program implementers are already doing, and look for opportunities for the anti-hunger field to apply a racial equity lens.

The Institute's hope is to build on this method for future projects, and offer this practice as a possible pathway for other organizations, as well as policy makers and implementers, to use as they think through how to apply a racial equity lens for future work inside and outside of the nutrition field. For more information on how a particular organization can apply a racial equity lens, both internally and through decision making on policy, advocacy, and implementation, please use the [Racial Equity Assessment Tool](#), created by the Alliance to End Hunger.⁷

Please review page 73 for a more detailed outline of questions that organizations can use to apply a racial equity lens in their policies.

Research Tools

In concert with the racial equity methodology described above, a variety of quantitative and qualitative research tools were used to develop this report:

- Racial Equity Lens Methodology Questions Guide (see page 73)
- Raw and computed data from the Economic Research Service (ERS), the U.S. Census Bureau (including the American Community Survey), and the U.S. Department of Agriculture (USDA). This data was helpful in understanding the scope and trends of each program.
- Multiple scholarly research studies on each program, which helped identify and understand data gaps and the impact of SNAP, WIC, and Child Nutrition programs.
- An initial brainstorming session with anti-hunger service providers, advocacy and research organizations, and field experts. This helped narrow the scope of research early in the process as well as flag areas where in-depth research was needed.
- A series of meetings with service providers, researchers, community members, and program implementers, including one group interview with an Indigenous service provider team. This qualitative data collection was helpful in understanding each program's implementation, constraints, and opportunities for growth, and in identifying what support might be needed to implement the report's recommendations.
- Six individual interviews and one focus group with African American and Indigenous nutrition program participants, located in states and tribal lands across the nation. This qualitative data collection took place both before writing and researching, and before finalizing the recommendations. The conversations highlighted the points of equity and inequity in each program in order to better formulate recommendations. Interviewees were given a copy of the recommendations for comment.
- Research, feedback, and one-on-one conversations with Latino/a, Indigenous, and African American experts in the nutrition field, including individuals associated with the National First Food Racial Equity Cohort, Health Connect One, the Oregon Inter-Tribal Breastfeeding Coalition, the Native American Nutrition Conference, and the Race Forward Conference. This was helpful in strengthening the initial recommendations and framing additional recommendations, ensuring that both were informed by existing work on racial equity and nutrition.
- Two site visits were conducted. The first was at Mary's Center (a multi-service provider in Washington, DC, that administers WIC and supports SNAP recipients). The second was at a grocery store, where researchers walked through a typical shopping experience for WIC and SNAP participants. These two visits provided a quick glimpse of how WIC and SNAP operate on the ground for recipients. For more on Mary's Center, see Appendix 20.
- A formal consultation with anti-hunger service providers, advocacy and research organizations, and field experts. This helped strengthen the initial research and recommendations. This group provided follow-up support as recommendations were finalized.

The Case for Racial Equity in Nutrition Programs

The goal of this report is to provide guidance on how to apply a racial equity lens to one specific aspect of hunger—nutrition. Nutrition is a topic that is often ignored, yet the science is clear: the country cannot afford to do so. Lack of a nutrient-rich diet disrupts children’s development⁸ and leads to chronic illnesses in adulthood,⁹ including cardiovascular disease, high blood pressure, and diabetes.¹⁰ The damage caused by nutritional deficiencies and inadequate diets exacerbates the impact of **hunger** (see glossary), particularly within communities of color where people are affected at higher rates.

“The country cannot afford to ignore nutrition.”

Context

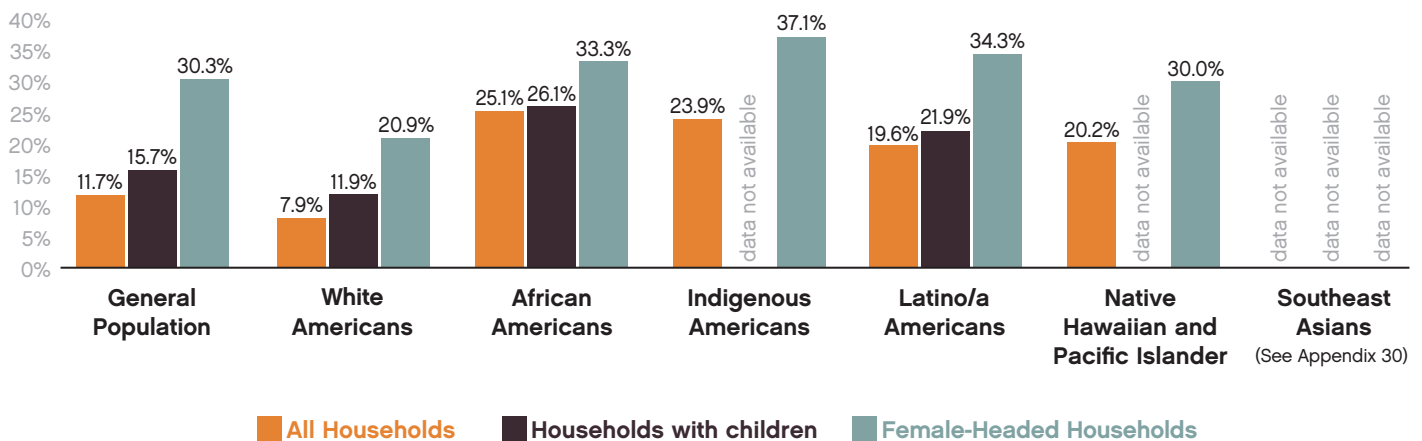
Over the last seven years, the overall U.S. food insecurity rate has fallen from 14.9 percent to 11.8 percent.^{11 12} By some measures, food security rates have bounced back from the Great Recession, while in other ways, much more work needs to be done to return to pre-recession levels of food insecurity and then improve.¹³ Much of the decrease in food insecurity since the Great Recession is due to federal nutrition programs.^{14 15 16} Without these critical lines of defense, food insecurity and rates of nutritional deficiencies would have been higher during the Great Recession,¹⁷ and they would also be higher today.

Whether the national level of food insecurity is higher, lower, or similar to its “typical” level, the food insecurity rate of people of color is consistently *at least twice, and in some states up to six times*,¹⁸ that of whites.

People of color (see glossary) face a multitude of barriers to nutrition and food security that must be addressed to achieve racial equity. Many of these barriers are in large part a product of racially biased public policies (both past and present), structures, institutions, practices, and cultural beliefs and attitudes that systematically discriminate against people of color. Some have been in place since the arrival of European settlers in North America.¹⁹ Many continued after the slavery era, and many persist today.²⁰ The figure below shows that many factors that contribute to higher rates of food insecurity and poor nutrition among people of color have been created by discriminatory policies and practices.

As shown, barriers to becoming food secure and attaining equitable nutritional outcomes range from the systemic racial wealth divide, to job segregation, to living in areas of **concentrated poverty** (see glossary) that lack full-service groceries and transportation options (“food deserts” and “transit deserts”). These and other barriers limit financial and geographical **access** (see glossary) to healthy food options for people of color, which in turn prevents or hinders progress against hunger and poor nutrition.

Figure 1: Food Insecurity in 2017 by Race²¹ and Other Characteristics²²
(most current data available)²³



NOTES: This report uses single-race data. Food insecurity rates for Indigenous households include only those who qualify for SNAP. This data does not include people who qualify for both FDIPIR and SNAP but use FDIPIR, nor does it include people who qualify only for FDIPIR and not for SNAP.

Food insecurity rates are not available for Southeast Asians as a group and are not reported by household type.²⁴ However, food insecurity by ethnicity data is available on the aggregate level for Hmong, Vietnamese, Laotian, Cambodians, Thai, Burmese, Malaysians, Indonesians, and Filipinos. For a detailed chart, see Appendix 30.

See Appendix 24 for percentage breakdowns by household type and race, review estimations, and sources.

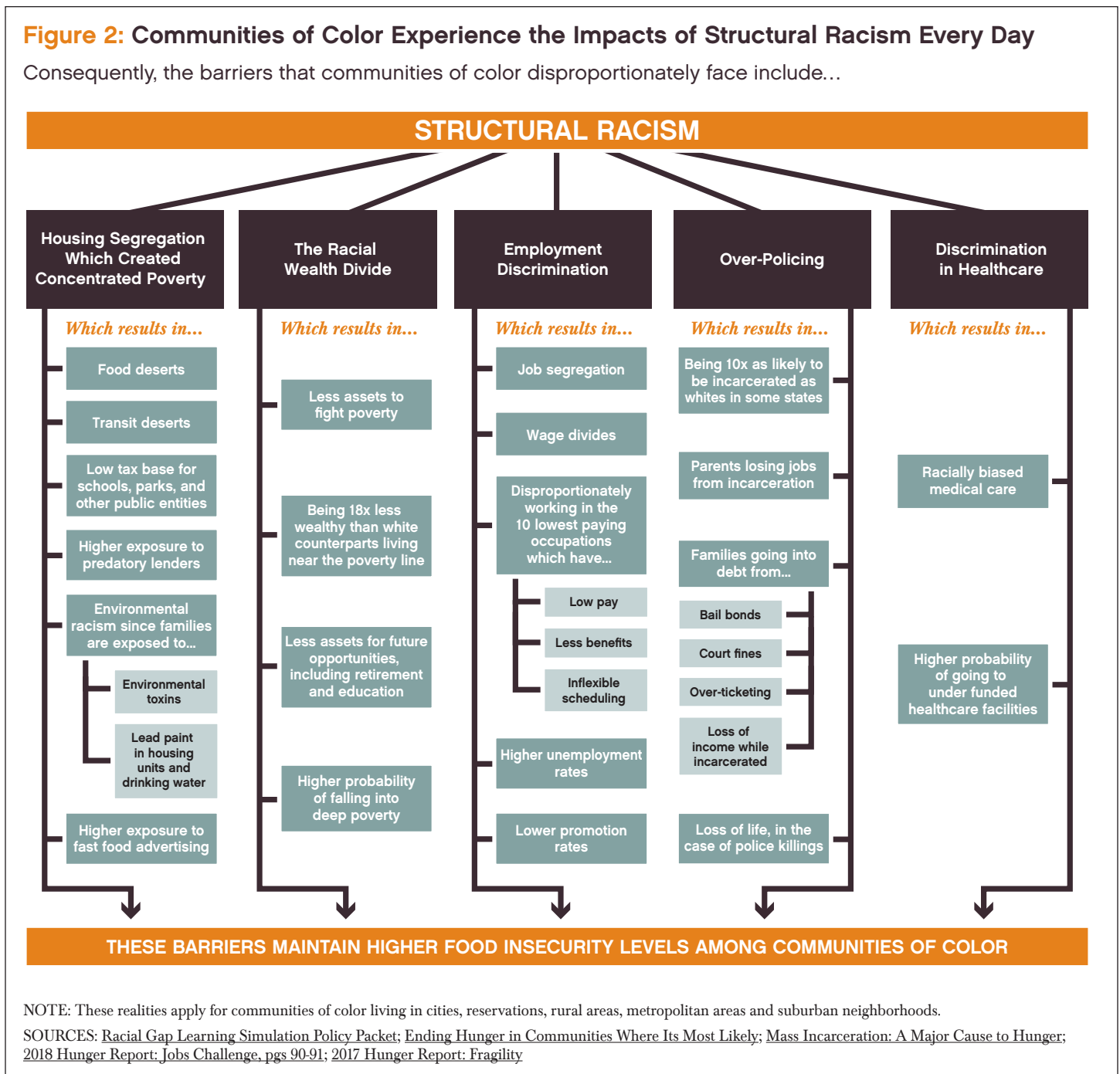
Ending hunger: applying a racial equity lens

As explained in greater detail in an earlier [Institute resource](#),²⁵ ending hunger is not just about ensuring access to food. It means addressing the underlying conditions that lead to hunger. This is why looking beyond food security measures to the root causes of hunger is so important.

Reducing vulnerability to hunger includes ensuring that everyone (1) has access to *enough* food; (2) has access to *essential nutrients*; (3) is *financially capable* of buying enough nutrient-rich food, and (4) is able to choose foods that are *culturally appropriate*. In other words, ensuring that individuals and households have the income and assets necessary to survive, thrive, and save for the future is essential to ending their vulnerability to hunger. Merely ensuring that everyone is fed, without regard to whether the food is nutrient-rich and/or without ending the cycle of living paycheck to paycheck, is not “ending hunger” as Bread for the World Institute defines it.

Figure 2: Communities of Color Experience the Impacts of Structural Racism Every Day

Consequently, the barriers that communities of color disproportionately face include...



Existing programs that have already been proven to work, such as SNAP, WIC, and Child Nutrition programs, can become a larger part of the solution by applying a racial equity lens. This would be a first step toward closing the persistent racial divide in food insecurity rates. It would also contribute to recipients of all races reaching an optimal nutritional status. (It is important to note that there are other programs, part of a larger continuum of nutrition services, that are not discussed in this report).

Moreover, nutrition programs alone will not end racial disparities in nutrition or hunger, as shown in Figure 2. Other non-nutrition policies and practices that impact hunger (as outlined in Figure 2) should also apply a racial equity lens. Strengthening racial equity in these particular federal nutrition programs is a key step toward gradually eliminating inequities.

There are also costs associated with failing to address racial disparities—disparities are likely to worsen, pushing the United States further from its food security and nutrition goals.

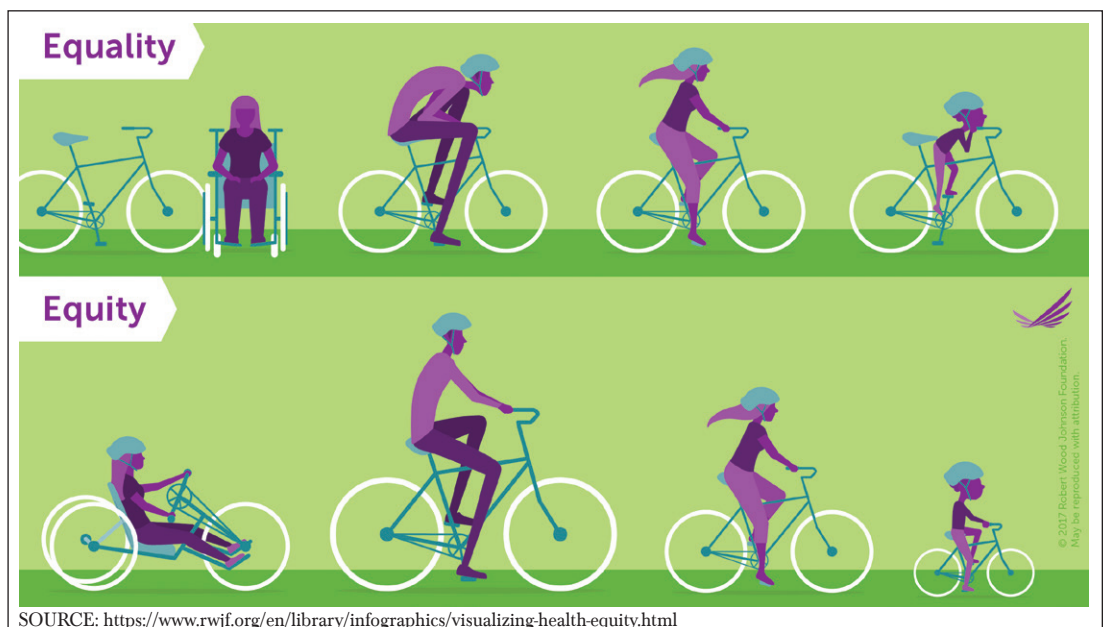
Understanding the Curb-Cut Effect

As mentioned earlier, SNAP, WIC, and Child Nutrition programs have been effective in meeting families’ immediate needs. Applying a racial equity lens to these programs will not only reduce hunger in communities of color more quickly, but will also help food-insecure people of all races.

“Equality means that everyone has the opportunity to take the bus. Equity supplies the “curb cut” to help ensure that everyone can get on the bus.”

Curb cuts were the result of a conscious decision followed by implementation. They did not materialize on their own when people who use wheelchairs faced barriers to travel. This is why applying a racial equity lens is critical: deliberate steps are needed to reverse structural and institutional discrimination. While this report focuses on racial equity, it reflects a pattern of thinking that can be applied to other forms of equity, such as class or gender equity.

To learn more about the wider economic benefits of achieving racial equity, please see the W.K. Kellogg Foundation’s report on [the business case for racial equity](#).²⁷



WHAT ABOUT FOOD INSECURITY RATES AMONG SOUTHEAST ASIANS?

The U.S. Census does not report food insecurity rates broken down by ethnicity and household type. Also, not all Southeast Asian communities are included in the current U.S. Census database on food insecurity.

For a chart on food insecurity among specific Southeast Asian communities, not disaggregated by household type, see Appendix 30.

Trends of Equity in Nutrition Programs

SNAP, WIC, and Child Nutrition programs were selected as focus programs because they serve millions of people in the United States and have similar scopes and scales of operations. Their approaches to implementing racial equity principles are not identical, but they share some key features:

“Ending hunger means ensuring that people have the income and assets necessary to survive, thrive, and save for the future. It is essential to end vulnerability to hunger.”

- **Each program has elements of an inclusive eligibility model.** Each program is open to people of any racial or ethnic group. Generally, meeting the income eligibility criteria is the only requirement. Being inclusive is essential to achieving equity.
- **Each program provides targeted support to individuals and families with the greatest needs.** Equity, as explained earlier, means receiving the support needed to achieve equal outcomes. Providing targeted support is the best way to produce equal outcomes. SNAP, WIC, and Child Nutrition programs prioritize support to individuals and families with the lowest incomes and greatest need for nutritional support.
- **Each program seeks to use equity-centered approaches (see glossary) to make it easier for people to participate.** Promoting equity requires an

understanding of the constraints and needs of the community being served. For example, transportation and time constraints frequently limit individuals’ ability to apply for nutrition programs in person. They may live in transit deserts, be without affordable, reliable transportation, and/or have unpredictable work hours.²⁸ Nutrition programs are beginning to be more flexible about options for participants to qualify for or renew benefits. In some states, SNAP and WIC now allow interviews by phone and/or online applications, thus working to “meet clients where they are.”

More detailed analysis is included in the individual sections on SNAP, WIC, and Child Nutrition programs.

Reducing the Racial Divides in Nutrition and Food Security

The similarities in the efforts of nutrition programs to apply an equity lens also allowed for the development of recommendations that can apply to all.

These include:

- **Put the needs of communities of color at the center (see glossary).** Focusing on the needs of communities of color, including those related to **historical trauma (see glossary)**, nutritional deficiencies, resource segregation,²⁹ and others, is a practice too seldom employed. Doing so will address the needs of people of color rather than leaving them out of the narrative and, as explained earlier, will benefit other people as well because of the “curb cut effect.”
Transportation is a central need in many **communities of color (see glossary)** due to housing segregation. Identifying this need and taking steps to address it using a racial equity approach will not only help people in these communities, but also other hard-to-reach populations whose lack of transportation options may have other primary causes—for example, people who live in remote parts of a state.
- **Expand inclusivity.** Some programs have eligibility restrictions on people or on institutions such as schools and nonprofits. A few examples of how programs might become more inclusive are given below.

In some states, people who have criminal records are barred from SNAP participation. Individuals returning from incarceration, also referred to as **returning citizens (see glossary)**, have high levels of food insecurity.³⁰ Excluding them

WHO ARE PEOPLE OF COLOR?

For the purposes of this report, people of color are all people who are not white. Although the U.S. Census problematically categorizes some groups of people of color as white (for example, Arabs and non-Black Latino/as), the report considers these groups to be communities of color.

This report’s concern is communities of color that consistently have the highest food insecurity rates: Indigenous, African American and Pan African, Latino/a, Native Hawaiian, Pacific Islander, and specified Southeast Asian ethnicities.

See **people of color** in the glossary for more.

from SNAP harms their children and other family members as well. These bans disproportionately affect families of color³¹ since communities of color are over-policed³² and subject to discrimination in other parts of the criminal justice system.³³ Latino/as and African Americans are three and six times as likely as whites, respectively, to be incarcerated. There are stark disparities in the likelihood of incarceration for a man of color and a white man convicted of the same crime.

WIC could expand its inclusivity by revising policies that cut off WIC eligibility six months sooner for women who are not breastfeeding, often disproportionately women of color, than for those who are. Child Nutrition programs could foster inclusivity by expanding programs that now make fresh fruit and vegetables available to some elementary students via an application process³⁴ to all low-income students in elementary, middle, and high schools. Becoming more inclusive enables programs to reach even more of the people most in need.

- **Strengthen equity-centered approaches to make it easier for participants to access nutritional support.** Developing practices that center around the needs of the recipients is key to promoting **equity-centered approaches (see glossary)** that make it easier for program participants to receive support.

Each program can strengthen its current approaches by revisiting program features that do not take the constraints that confront many recipients when they try to access support into consideration. Two such constraints are inaccessible program office locations, and the requirement that participants apply for or access services in person (instead of providing optional online or phone service).

Resources and services must be accessible and co-located services should be closer to communities with the highest **concentrations of poverty (see glossary)** and the largest number of transportation deserts, to help participants avoid making multiple trips. Technology can also help make it easier to access benefits. Many low-income people still lack regular, reliable access to Wi-Fi, so technological options should always be “in addition to” and not “instead of.” This will avoid exacerbating inequity for people of color.

- **Increase the cultural humility, competence, and accountability of frontline staff.** The goal of applying a racial equity lens is to achieve equal outcomes, which are in part contingent on participants receiving support from staff and feeling comfortable doing so. Both **linguistic and cultural competence** and **cultural humility (see glossary)** are essential to this process.³⁵ Interpersonal racism, whether unconscious and subtle or conscious and overt, remains a problem in some program implementation settings. It could be staff in offices who subconsciously judge their clients using **stereotypes (see glossary)**. It could be staff in grocery stores who are condescending and act as though people who participate in WIC or SNAP should be ashamed. In other cases, it is wider practices that lead to a racist impact, whether this is intentional or not. One example concerns office staff who either did not speak, or refused to speak, clients’ preferred languages. It could be, however, that offices lack the resources needed to support speakers of other languages. There must be accountability both for instances of interpersonal discrimination and for policies or behavior that lead to a racist impact. Just as each situation is unique, solutions and measures of accountability will also differ.
- **Create mechanisms that enable recipients, particularly recipients of color, to equitably participate in designing, implementing, and evaluating programs.** Achieving the goal of racial equity is a process, one that is strengthened by ongoing evaluation. Creating opportunities for program recipients to have regular, meaningful input into how programs can adapt to better serve their needs and address barriers will enable each program to continue applying an equity lens.

Programs should have a deliberate approach to engagement, perhaps consulting with nutrition program participants of color and recognizing them as experiential experts. It is important to be conscious of the potential for programs to be paternalistic and/or viewed as paternalistic.

- **Strengthen data collection and disaggregation.** Achieving racial equity requires researchers to track outcomes for each racial group. Data is available on health conditions, as well as nutritional status, food security, and nutrition program participation rates, within groups. However, there are glaring differences in the availability and quality of data as well as a great deal of missing information. Neither information across all populations on the impact of nutrition programs on reducing poor health or improving nutrition outcomes, nor similar information disaggregated by race and ethnicity, are currently collected. Collecting this data and making it accessible to researchers will allow implementers, policy makers, and program designers to gauge the impact of targeted investments and assess ongoing efforts to strengthen racial equity.

Collecting data is far from a straightforward process and raises questions that an agency or research team may not be able to answer on its own. For example, for Indigenous communities, “blood quantum” laws³⁶ combined with restrictive federal government policies on which groups are recognized as tribes³⁷ complicate the task of accurately identifying and classifying individuals and families.



Supplemental Nutrition Assistance Program (SNAP)

Supplemental Nutrition Assistance Program (SNAP)³⁸

Overview: Policy, Scope, and Impact

Each month, the Supplemental Nutrition Assistance Program (SNAP) helps an average of 40 million people living in households that struggle to put food on the table.³⁹ The Urban Institute analyzed U.S. Census data over a 10-year period and found that SNAP reduced **food insecurity** by roughly 30 percent and **very low food security** by 20 percent.⁴⁰ (See glossary for terms in bold).

SNAP benefits are based on household size. The program targets individuals and families most in need of support, and 92 percent of SNAP benefits go to households with incomes at or below the poverty line (which, in 2018, was \$20,780 for a family of three).⁴¹ Almost 60 percent of benefits go to households in deep poverty (with incomes of *half* or less of the poverty level, or \$10,390 or less for a family of three in 2018).⁴² USDA reports that SNAP participation is associated with a lower risk of being food insecure,^{43 44} and it contributes to reducing the severity of hardship for millions of people in the United States.⁴⁵

Although SNAP is technically a “supplemental” support, many recipient households rely on SNAP benefits for most or all of their monthly grocery budget. This is due in part to wage stagnation for many U.S. workers over the past 40 years.⁴⁶ Stagnant wages affect lower-paid workers more than others. The federal minimum wage has remained \$7.25 an hour, despite inflation, for the past decade. Millions of people, disproportionately people of color and women of all races, work in the **10 lowest-paying jobs in the United States**⁴⁷ (see glossary).

The next two sections grapple with equity issues associated with SNAP, as well as block grant nutrition programs for U.S. territories and a commodities program for Indigenous communities.

“Over a 10-year period, SNAP reduced food insecurity by roughly 30 percent.”

Figure 3: Percentage of Households Receiving SNAP by Poverty Threshold



SOURCE: <https://www.cbpp.org/research/policy-basics-the-supplemental-nutrition-assistance-program-snap>

Racial Equity in SNAP

SNAP applies an equity lens in several ways. First, it is an entitlement program—meaning that people who qualify based on income and other eligibility criteria are entitled to benefits. Entitlement status expands the program’s reach in communities with high food insecurity rates and enables it to respond to increased need during economic downturns. This and other equitable aspects of SNAP are summarized below:

Table 1: How SNAP Promotes Equity

Policy Aspects	How This Promotes Equity
1. It is available to those who need it	SNAP’s entitlement structure provides money to income-eligible households to purchase food. Communities of color are disproportionately represented among both food insecure households and households that have, in the words of the U.S. government, very low food security. ⁴⁸ This structure is vital to ensuring that everyone who needs SNAP is able to access it (see glossary).
2. Benefits expand with family size	This policy helps provide food security for each member of the household. SNAP policies do not penalize households based on parents’ marital status, as some earlier anti-hunger and anti-poverty policies did. Such policies disproportionately hurt households of color. ⁴⁹
3. Participants select their own food	Recipients can choose what to eat, although their ability to choose a healthy diet also assumes that they have access to a grocery store that carries a variety of fresh foods. Requiring participants to choose from a predetermined list of foods is paternalistic. SNAP excludes only pre-made foods such as items from hot bars.
4. SNAP benefits are accessed through Electronic Benefits Transfer (EBT) cards	Researchers report that accessing benefits through EBT cards has reduced the stigma of using SNAP benefits, which has contributed in the past to lower participation rates. ⁵⁰ The previous “food stamp” vouchers were not as widely accepted.

Table 2: How the SNAP Alternative—the Food Distribution Program on Indian Reservations (FDPIR)—Promotes Equity

Policy Aspects	How This Promotes Equity
The Food Distribution Program on Indian Reservations (FDPIR) addresses some barriers reported by Indigenous communities.	USDA established an alternative to SNAP, the Food Distribution Program on Indian Reservations (FDPIR), because of the long distances that some residents of reservations must travel to reach a fully stocked grocery store. ⁵¹ FDPIR provides a monthly package of commodities. Families who are eligible for both programs must choose one in any given month. About 85 percent of Indigenous people who qualify for SNAP also qualify for FDPIR. FDPIR requires less documentation from applicants, making the application process easier. Administrative offices are located on the reservation and staffed by Indigenous people. FDPIR also offers home delivery services for elderly beneficiaries. These accommodations are the result of USDA’s efforts to take into account the needs of the communities being served.

Recommendations: Reducing Racial Inequities in SNAP

As just shown, SNAP promotes equity in various ways. But there are additional opportunities to strengthen nutrition outcomes among households of color, because recipients of color still face disparities in food security. Seven ways SNAP can apply a racial equity lens include:



Recommendation 1

Increase the monthly benefit amount



Recommendation 2

Increase access to and consumption of healthier food options



Recommendation 3

Eliminate practices that exclude or hurt people of color



Recommendation 4

Support SNAP-related measures that promote equity



Recommendation 5

Strengthen hiring, training and accountability of caseworkers



Recommendation 6

Establish a mechanism for SNAP beneficiaries to equitably participate in program design, planning, and evaluation



Recommendation 7

Strengthen the collection and disaggregation of data within SNAP



Recommendation 1

Increase the monthly benefit amount

Context

Congress should pass legislation to increase SNAP benefits for the following reasons: (1) benefits routinely run out before the end of the month; (2) healthier food is more expensive; and (3) the program assumes that participants have more time to cook than is actually the case.

Very few SNAP households can make their benefits stretch for the entire month. Some studies have shown that many families consume significantly fewer calories toward the end of the month.⁵² SNAP benefits are based on USDA's "Thrifty Food Plan," but this practice should be discontinued. The Thrifty Food Plan was derived from the reported spending of people who were food insecure and could not afford a nutritionally adequate diet. In other words, it is a nutritionally inadequate plan *because it is modeled on a nutritionally inadequate plan.*⁵³

Running out of grocery money leads to health problems. For example, the National Institutes of Health found that the rate of hospital visits for low blood sugar was higher in the last week of the month among lower-income patients, but not among other patients—suggesting that running out of food contributes to an increased risk of hospitalization.^{54 55}

Since people of color are far more likely to be food insecure, they are also disproportionately harmed by an inadequate benefit. One in four African American children and one in five Latino/a children are food insecure, compared with one in eight white children.⁵⁶ The Institute would expect similar disparities for households with Indigenous, Native Hawaiian, and Pacific Islander children, but does not have disaggregated data for them.

Increasing the benefit can also help increase people’s consumption of healthier foods, notably vegetables and sources of protein, since healthier foods are more expensive.⁵⁷

On or near reservations, which are more likely to be **areas of concentrated poverty (see glossary)**, food prices are typically quite high, due primarily to the cost of transporting food to rural areas. A study conducted by First Nations found that on average, Indigenous communities spend significantly more to purchase food in every category, including dairy, bread, meat, and fruit.⁵⁸ Read more about this in Appendix 9. This finding was confirmed through interviews with Indigenous communities, during which some people reported prices such as \$14 for a pound of apples at the nearest grocery store, an hour away from the reservation.

Current SNAP benefit amounts are based on the Thrifty Food Plan, which assumes that SNAP recipients have 1.5-2.5 hours daily (roughly 9 to 17 hours every week) to prepare meals—plus the time needed to shop for food.⁵⁹ Using the reference *Recipes and Tips for Healthy, Thrifty Meals*,⁶⁰ it took a USDA researcher 2.5 hours a day, or more than 17 hours a week, to prepare the suggested menus.⁶¹ In another study, a researcher needed about 80 minutes a day or just over 9 hours a week.⁶² It is unrealistic to use either time estimate; SNAP participants, like people in other U.S. households, have about 40 minutes a day available to

cook.⁶³ Increased monthly SNAP benefits would allow families to purchase healthier foods, foods that require less time to prepare, and, most importantly, additional food so that both children and adults have enough to eat the last week of the month.

Amending SNAP rules to permit the purchase of some prepared foods at grocery stores, such as rotisserie chicken and pre-made salads, could help ease participants’ time constraints and improve healthy eating options, with more fresh foods included. It could also help manage costs—for example, reducing the need to buy salad ingredients, condiments, or other foods in larger quantities that may be difficult to incorporate into later meals while they are still fresh.

According to the Center on Budget and Policy Priorities, a \$30 per person increase in monthly SNAP benefits would raise food purchases by \$19 a month per person, improve consumption of nutritious foods such as vegetables and protein sources, and increase the time households spend shopping and preparing food.⁶⁴ It is unclear whether this would be a large enough increase for families to buy enough healthy food to last the entire month. In the same study, food insecure families reported that they need an additional \$50 to \$85 per person per month to purchase enough healthy food.⁶⁵

Recommendation

- **Increase the monthly benefit per person to reflect needs.**

USDA should conduct research to determine the benefit levels that the poorest households (especially by asset amount and race), need in order to buy nutritious food throughout the month. The benefit level should also take into account the time limitations and realities explained above. To these points, USDA should increase SNAP benefits from the cost of the Thrifty Food Plan to the cost of the Moderate Food Plan.⁶⁶ Based on the research findings and moderate food plan, food insecure households should receive a larger allotment per meal (including when school-age children are home, such as on the weekends and during school breaks), in order to help improve the quality of meals and ensure that households do not routinely run out of grocery money. Since households of color have the fewest assets to fall back on to avoid facing deeper levels of hunger due to the racial wealth divide, Congress should authorize changing the SNAP benefits formula to provide additional support to households with the lowest levels of assets. This targeted approach will ensure that households of color receive the support they need.

Food prices are generally higher for SNAP participants who live in or near reservations or in rural or urban food deserts. SNAP benefit formulas should take into account the fact that many families must rely on corner stores or travel long distances to the nearest grocery store, both of which are likely to have higher prices and fewer options. As shown in Figure 2, communities of color are more likely to live in high poverty areas that include food deserts.

DID YOU KNOW THAT...

Alaskan Natives could spend up to \$25 for a gallon of milk, compared to the national average of \$3.25?

DID YOU KNOW THAT...

Households of color have significantly less savings to turn to when monthly benefits run out, because of the racial wealth divide? To learn more about this, see Appendix 21 or visit bread.org/simulation to go through the Racial Wealth Gap Learning Simulation.



Recommendation 2

Increase access to and consumption of healthier food options

Context

As earlier mentioned, **communities of color (see glossary)** are at higher risk of consuming fewer nutritious foods since they have less **access (see glossary)** to full-service grocery stores.

Recommendation

- **Expand SNAP Matching Programs.** Over the years, USDA has introduced pilot programs that match SNAP benefits to give participants additional benefits to spend on nutritious foods. Expanding the Food Insecurity Nutrition Incentive (FINI) Grant Program (recently renamed the Gus Schumacher Nutrition Incentive Program),⁶⁷ as well as the Healthy Incentive Program (HIP), would complement an increase in monthly SNAP benefits.

DID YOU KNOW THAT...

90 percent of Hawaii's food is imported? The majority of stores that sell healthy foods are located in higher income neighborhoods, leaving many Native Hawaiians (who are disproportionately lower income) in food deserts with limited access to healthy food.

SOURCE: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3419825/>

In both programs, the extra resources can be spent on fruits and vegetables. For example, by participating in the Gus Schumacher Nutrition Incentive Program (GSNIP), also known as Double Up Food Bucks, a mobile farmer's market in Pittsburgh was able to provide a \$2 physical coupon for every \$5 in SNAP benefits spent on fruits and vegetables, with no cap.⁶⁸ In a HIP pilot, recipients received an additional \$3.65 per month on average, which led to their spending an additional \$1 on fresh fruits and vegetables in participating stores and an additional \$6 on total fruit and vegetable purchases.⁶⁹

The 2018 Farm Bill made GSNIP a permanent program, which is an encouraging step forward.⁷⁰

USDA should work with farmer's market networks to remove barriers and increase participation in matching programs. Some farmer's markets,

particularly in Hawaii,⁷¹ do not yet have the technology to accept EBT cards and/or do not participate for unspecified reasons.

In addition to determining how best to expand matching programs, USDA should consider how HIP could better reflect the MyPlate recommendations, which encourage Americans to fill half their plates with fresh fruits and vegetables.

Local governments should also consider creating or expanding matching programs for fruits and vegetables. Indianapolis, Seattle, and Washington, DC, offer programs that double the amount of SNAP benefits spent on vegetables and fruits at participating grocery stores and farmer's markets. Each participant can access extra benefits up to a daily cap (which ranges from \$20 to \$50). Matching programs make it more realistic for SNAP participants to buy healthy foods. For more information, see Appendix 14.

Local governments should also consider creating or expanding matching programs for fruits and vegetables. Indianapolis, Seattle, and Washington, DC, offer programs that double the amount of SNAP benefits spent on vegetables and fruits at participating grocery stores and farmer's markets. Each participant can access extra benefits up to a daily cap (which ranges from \$20 to \$50). Matching programs make it more realistic for SNAP participants to buy healthy foods. For more information, see Appendix 14.

- **Increase funding for the Healthy Food Finance Initiative (HFFI).** While this recommendation is not directly under SNAP, it directly impacts SNAP's ability to achieve its objective of strengthening nutritional outcomes among low-income households. Like SNAP (and FINI), HFFI receives its authorization and funding from the farm bill. For nearly a decade, HFFI has demonstrated that it is an effective public-private approach that builds an equitable food system, which benefits farmers, business owners,, and consumers.⁷²



Joseph Moheri for Bread for the World

HFFI expands the supply of healthy food options in many urban, suburban, rural, and tribal areas that are classified as food deserts. Congressional action to increase funding to expand HFFI in communities with the highest levels of poverty will make it easier for families to participate in SNAP and increase their ability to use SNAP benefits on fresh food options to improve nutritional outcomes. In conjunction with increased federal funding, states should consider creating statewide HFFIs to provide additional support (as recommended by several state stakeholders).⁷³ For a more detailed understanding of HFFI and its role in addressing food deserts and improving nutrition, see Appendix 12.

- **Encourage healthcare providers to ask patients about food insecurity.** Another means of increasing access to healthier food is to ensure that all people who are food insecure receive the benefits for which they are eligible. Healthcare providers, including hospital staff, pediatricians, and other doctors, should systemically screen patients for food insecurity.⁷⁴ They should use this information to connect patients with local SNAP offices, or community organizations that help connect residents with SNAP, to apply for benefits. Healthcare providers should also use this in their community health needs assessments. For more on the questions to ask and how to use the information, see Appendix 22.
- **Make FDPIR foods healthier.** Currently, FDPIR food options vary by reservation. Some interviewees reported that food options on certain reservations are fresher (fresh fruits and vegetables and foods not past their expiration date). Other distribution centers do not have fresh fruits and vegetables, and food options have sometimes expired. The standard should be that all reservations, regardless of location, receive at least five options for fresh fruits and at least five options for fresh vegetables. Canned options contribute to diabetes and obesity, which affect Indigenous communities disproportionately. See Appendix 19 for more on canned foods and the history of obesity among Indigenous communities.



iStock photo



Recommendation 3

Eliminate practices that exclude or hurt people of color

Context

Not everyone who needs SNAP qualifies. This is because of practices that exclude or hurt some groups of food insecure people. Those affected are disproportionately people of color and include some of the most financially vulnerable individuals. They include many **prime-aged adults (see glossary)** without dependents, who lose SNAP benefits after three months if they are not working or participating in a qualifying work program. Depending on the state, people who have been convicted of certain drug felonies are denied benefits, particularly those recently released and/or considered out of compliance with their parole or probation conditions.

These groups have high levels of poverty and food insecurity. Between 36 percent and 37 percent of prime-aged adults⁷⁵ without dependents are estimated to live in poverty,⁷⁶ and in a study by the National Institutes of Health, 91 percent of people returning from incarceration reported being food insecure.⁷⁷ People in these groups also face employment barriers. See Appendix 25 for more on the barriers that contribute to food insecurity for both groups.

Residents of Puerto Rico, American Samoa, and the Commonwealth of Northern Mariana Islands, all of whom are U.S. citizens, do not qualify for SNAP. Before 1982, residents of Puerto Rico qualified for SNAP. At this time, the SNAP participation rate was 60 percent.⁷⁸ In 1982, SNAP was converted into a separate nutrition assistance program called NAP

“Some of the most financially vulnerable individuals do not qualify for SNAP or have restrictions.”

(the Nutrition Assistance Program). Participation rates were cut in half when NAP became the only option for residents of Puerto Rico, because NAP is a block grant, meaning that it had a fixed amount of funding regardless of recipient needs. It was no longer an entitlement program that expanded when more people became eligible, so many fewer people qualified.⁷⁹ Although presumably 60 percent of residents were still struggling to put food on the table, only 30 percent of households received assistance under NAP.⁸⁰

Similarly, American Samoa and the Commonwealth of the Northern Mariana Islands also do not administer SNAP.⁸¹ Nearly half of people in Puerto Rico,⁸² nearly 70 percent of people in the Commonwealth of the Northern Mariana Islands,⁸³ and nearly 80 percent of people in American Samoa⁸⁴ live below the federal poverty line. The majority of residents are people of color. They are at far higher risk of hunger than their fellow U.S. citizens who live in states, the District of Columbia, or even the two other U.S. territories (Guam and the Virgin Islands).

Recommendation

- **Congress should extend the SNAP program to all U.S. territories.** The three territories discussed above have very high poverty rates, and a block grant structure cuts many food insecure people off from nutrition assistance.
- **Congress should identify changes to SNAP that states are permitted to make, but that result in fewer people being eligible than under federal law, and prohibit states from making such changes.** These changes include, but are not limited to, adopting asset limits criteria, making eligibility contingent on child support payments, declaring people with certain criminal records ineligible, and mandating additional or stricter work requirements than under federal law.
- **Congress should increase funding for the Food Distribution Program on Indian Reservations (FDPIR).** This would both help food insecure people and enable USDA to better support the concept of self-determination, or recognizing the capacity of Indigenous communities and equitably engaging with them to plan and implement programs, within FDPIR⁸⁵ (see page 73 for definition of equitable engagement).

“When Indian Country lost its ability to feed itself, through whatever means, we lost that part of ourselves that supports our ability to thrive. It is only by regaining our foods will we be able to restore our health...”

—Janie Hipp, Director, Indigenous Food & Agriculture Initiative, University of Arkansas School of Law. Member of Chickasaw Nation of Oklahoma.

SOURCE: http://www.heart.org/idc/groups/heart-public/@wcm1/@adv/documents/downloadable/ucm_475567.pdf

Recipients interviewed for this paper said that the benefit amount is insufficient; the value of the food package is \$72, compared to an average \$125 in SNAP benefits.⁸⁶ The Institute recommends increasing the FDPIR benefit to that of SNAP.

Recipients reported experiences that differed from the information in program literature. On paper, the program offers four traditional foods, but interviewees expressed the need for foods that are specific to certain regions and also made the point that recipients and direct service providers should be more involved in decisions about traditional foods. The Institute recommends that USDA continue working with its current group of tribal representatives and also include additional recipients and nonprofit staff from all regions.

This expanded group could also help develop other strategies to strengthen how the principle of self-determination is applied in practice.⁸⁷ One suggestion made in interviews was that USDA could enable and equip Indigenous farmers to grow and distribute traditional foods. This would require USDA to change its contracting practices to support farming and distribution. The 2018 farm bill allocated \$5 million for a demonstration project that allows tribes to use “638” tribal self-determination contracts to purchase FDPIR food.⁸⁸ Once this pilot is completed, the data should be evaluated for information on the funding needed to enable other tribes to follow suit. Also, simply adding the phrase “regionally grown” to the wording of FDPIR’s traditional foods provision would mean more support for Indigenous farmers in producing traditional foods.



U.S. Army National Guard photo by Spc. Hamiel Inzary

For more on the impact of food insecurity in Puerto Rico post-hurricanes, see Appendix 23.

To see a detailed chart of racially inequitable state laws, please see Appendix 8.



Recommendation 4

Support SNAP-related measures that promote equity

Context

A significant barrier for SNAP families seeking better nutrition is that, as explained earlier, SNAP benefits rarely last the entire month,⁸⁹ and they run out even faster if participants buy healthier foods. Less expensive foods are, on the whole, less nutritious.⁹⁰ This simply exacerbates nutrition and health disparities.

Barriers to participation in SNAP also work against efforts to improve nutrition. Some of these are limited amounts of time, transportation, and/or Internet and phone access, or a combination. These may prevent people from keeping appointments, calling, or emailing to reapply, report problems, or seek nutrition information. Such barriers are highest in states that no longer offer in-person SNAP office visits at all.

Many interviewees reported that lack of time and transportation prevented them from shopping to eat many fresh foods. If someone can only get to the store every two or three weeks or once a month, he/she generally must choose items with long shelf lives. SNAP rules against purchasing prepared foods can also hinder efforts to improve family nutrition. As mentioned earlier, the Thrifty Food Plan assumes that recipients have between 1.5 hours and 2.5 hours a day to prepare meals,⁹¹ when the average SNAP recipient only has about 40 minutes per day, similar to other U.S. households.⁹²

Another barrier is discrimination on the part of SNAP caseworkers and other frontline staff (e.g., grocery store clerks). This likely stems from unconscious bias and lack of training. Racist attitudes may dictate whether an eligible applicant is in fact approved for SNAP benefits, or whether a recipient feels comfortable using benefits at the grocery store.

Recommendation

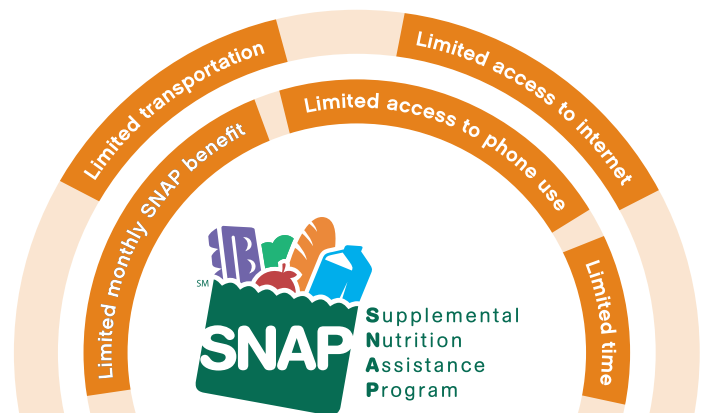
Using electronic benefit cards (EBT) for SNAP cards makes it easier for people to access their benefits and, since they are far less conspicuous in grocery store checkout lines, reduces the stigma of using SNAP. Congress and state governments (whether in the absence of federal legislation or while waiting for changes to take effect) should continue or take action to enact other policies that encourage participation.

These include:

- **Offer options to people who plan to apply for SNAP.** Applicants and recipients should have options to apply online and interview by phone. States are allowed to develop an online process⁹³ and many have done so. All states should have infrastructure in place for online and phone contacts with SNAP offices. This will ensure equity among participants regardless of location. All SNAP offices, caseworkers, and online and print materials should advertise the options. They should also inform recipients of the commitment made by AT&T to provide low-cost wireline home Internet to households with at least one SNAP participant.⁹⁴ States should also maintain regular business hours at offices for people who do not have reliable access to the Internet or a phone.
- **Mandate that USDA or state agencies explore the possibility of forming partnerships with grocery delivery services.** This would help address some of the barriers just discussed, including working long and odd hours and not having reliable transportation. It could also increase recipients' access to fresh foods and contribute to improved nutrition.

Figure 4: SNAP Barriers for Optimal Nutrition

There are several barriers that make it difficult for SNAP recipients of color to use their benefits for optimal nutrition...



These barriers reinforce existing racial nutrition and health disparities.

In 2017, USDA announced that its Food and Nutrition Service (FNS) would begin a SNAP Online Purchasing Pilot, working with seven food retailers in eight states.⁹⁵ Congress included the pilot in the 2018 Farm Bill.

Questions remain about specific policies that might or might not ensure that all recipients can participate equitably in such services. The pilot program does not increase SNAP benefits to accommodate higher prices and/or delivery fees. The program needs to ensure that the extra costs are not deducted from a recipient's SNAP benefits or require her to use household financial resources. Another issue is the need to develop relationships with additional vendors to ensure that EBT payments are accepted online, and with smaller regional or local retailers to ensure that all communities have access to this option. This may also require authorization for extra fees charged to reservations or other communities that retailers consider remote. To avoid reproducing inequity, reservations, other remote areas, and individual SNAP recipients should not be charged. Instead, USDA should assume the responsibility for such charges.

- **Consider reforming SNAP policies on acceptable food items.** The proposed change would allow a percentage of a household's SNAP benefit to be used for hot or store-prepared foods, like a rotisserie chicken, for example. This revision could help reduce the significant time commitment for food preparation that SNAP's continued use of the Thrifty Food Plan requires.
- **Maintain or transition to co-located services.** Co-locating services in or near the administrative offices for other federal benefits that SNAP recipients may receive, such as WIC, can help save time and transportation money. Other potential locations for limited-hours services might be local libraries or community centers, such as the YMCA, that are closer to recipients' homes. A good example of program co-location is Mary's Center in Washington, DC, which offers a number of services under one roof—including SNAP, WIC, a farmer's market presence, a doctor's office, and other community supports for recipients' nutrition and health needs.
- **Create additional community-based partnerships aimed at increasing participation among those who are eligible.** Although SNAP had an 85 percent participation rate in 2016, up from 72 percent in 2010, 7 million people who are eligible to participate in the program do not participate.⁹⁶ Their reasons may include lack of awareness that they are eligible, concern that the application process will be too difficult or time-consuming or that they will be stigmatized for participating, distrust of government programs, or something else altogether.

Many of these barriers can be addressed with outreach conducted by trusted members of the community who already participate in events along with potential recipients. Local SNAP offices could consider partnering with existing community groups such as those based on school, faith, or community service. These groups could conduct basic screening for food insecurity and connect potential recipients with SNAP. Hiring local office staff who reflect the racial/ethnic background of their neighborhoods and/or are themselves current or former SNAP participants is another effective strategy for increasing participation.

- **Expand transportation subsidies for low-income residents.** These subsidies are not under SNAP's jurisdiction, but they directly promote better access to grocery stores for participants. Local governments should work to provide transportation subsidies to low-income residents that cover at least half, preferably the full amount, of transit costs. See Appendix 13 for information about cities that have adopted this approach or are on the verge of doing so.
- **Create formal support systems to bolster the food production efforts of people living on reservations.** On some reservations, Indigenous people are producing traditional foods using ancestral practices. These farmers are often SNAP participants as well. The long distances to the nearest grocery store for many residents of reservations may make either growing food themselves, or buying it from others on the reservation, a more realistic option. However, many people who might be interested may not have the training and equipment to be successful.

Local farm and garden initiatives keep money in the local economy and ensure that people have access to preferred, often much healthier, foods. In Wyoming, one reservation is piloting an effort to scale up a formal indoor farmer's market. For more information, see Appendix 10.

USDA should work with other agencies and with tribal communities to help make funds available to support entrepreneurial start-ups with equipment and culturally competent agricultural training. This would enable more Indigenous people who would like to farm and distribute food on the reservation to do so.

DID YOU KNOW THAT...

Enabling families of color to purchase fresh vegetables and fruit options by increasing the benefit amount can reduce the purchase of less expensive canned goods, which often contain high levels of high-fructose corn syrup. This exacerbates conditions such as diabetes and obesity—both already at higher rates among communities of color.

- **Improve equity-centered practices within FDPIR to encourage eligible Indigenous people to participate.**

Distribution centers should be upgraded in order to operate using a grocery store model. While some centers do offer a shopping type of experience, others simply distribute boxes of food, with clients given little or no choice as to what foods they receive. The latter group of distributors need resources and funding to establish and manage spaces where clients select from items on view. FDPIR policies have not kept pace with technological advances or with the growth of the program.⁹⁷

FDPIR should also ensure that written policies allow each geographical area to have its own traditional food options. Currently, there is only one traditional food for an entire region of the country. This means, for example, that blue corn mill, indigenous to the southwest, is also the only “traditional” food option for people in the northern plains, even though it is not traditional there and few people are familiar with cooking with it. FDPIR should explore ways to support local communities in implementing their own ideas for continuing regional food traditions.



Recommendation 5

Strengthen hiring, training and accountability of caseworkers

Context

People of color experience racial discrimination in virtually every aspect of life. This is due to **structural racism (see glossary)**, which is embedded in all of our societal systems. It is sometimes very subtle and can go unnoticed and unchecked. This is not to assign blame, but instead, to assign responsibility to us all. Applying a racial equity lens means not only countering structural racism at the policy design level, but also at the implementation stage.

SNAP recipients report incidents of racial discrimination from SNAP caseworkers as well as from grocery clerks and other frontline staff. Instances include racist comments during interviews with caseworkers and discriminatory treatment in grocery stores. Such experiences indicate a need to strengthen **linguistic and cultural competence** and **cultural humility (see glossary)**.

Experiences with discrimination exacerbate the shame that people who are eligible for nutrition program benefits often already feel. Racist incidents may deter eligible people from applying for SNAP, or current participants from returning to stores to use their benefits. Discrimination could even be a factor in applicants of color being turned down when they are in fact eligible. Quantitative data on this is not collected, so there is a need for further investigation, since any such instances immediately affect children and families.

Recommendation

USDA should:

- **Require SNAP caseworkers to have both anti-racism and implicit bias training.** Anti-racism training will enable people to relate to SNAP participants without being judgmental or subscribing to **stereotypes (see glossary)**, but it is just a first step. People who work with recipients need ongoing training in implicit bias. These requirements should apply to every SNAP employee.
- **Build in accountability.** Training is not enough to break down institutional and interpersonal racism. Accountability mechanisms must hold staff, including caseworkers, accountable. Each office and grocery store should be required to publicize its formal complaint process. It should be clear to participants that these complaints will be taken seriously and answered by more senior staff. Doing so will help counter **historical trauma (see glossary)** from systems that have failed to be responsive to communities of color, in addition to fostering trust and encouraging participation. All complaints should be investigated and staff appropriately counseled and disciplined.

Applicants who are discriminated against should have some form of immediate recourse without fear of retaliation—particularly in the form of being turned away from the program in the future. Interviewees reported that applicants who are denied must often wait a long time before they are allowed to reapply. In the meantime, their families run out of grocery money.

- **Take steps to ensure that current and/or former recipients are equitably represented among caseworkers.** Proportional representation among staff of those who have faced hunger and food insecurity is critical to equitable

implementation. People with personal experience may be more likely to understand and empathize with participation barriers and less likely to pass judgement. Moreover, SNAP's goal is to help people who face hunger, and hiring staff with direct knowledge helps ensure that the voices of food insecure people are heard and can influence office culture and practices to be of greater service.

- **Take steps to ensure that the overall caseworker racial and ethnic makeup reflects the racial and ethnic demographics of the community.** Caseworkers should reflect the community in which they work. This is particularly important in eliminating or reducing language barriers.



Recommendation 6

Establish a mechanism for SNAP beneficiaries to equitably participate in program design, planning, and evaluation

Context

Currently, SNAP does not have a formal process that allows recipients to equitably participate in designing, implementing, and evaluating the program. This has led to many recommendations being made and implemented without consulting people with lived experience; participants are also rarely asked for their suggestions or their reactions to proposals.

Equity, as emphasized throughout this report, includes putting the needs of the people most affected by the problem at the **center (see glossary)**. Racial equity in SNAP requires making the needs of communities of color the center of planning, which in turn requires the equitable participation of SNAP recipients of color, informing planning on a regular basis, to ensure that what will work best for them and their communities remains at the forefront.

Recommendation

USDA should:

- **Create a formal mechanism to solicit feedback from SNAP participants.** Each recipient should receive a survey via text and/or email asking about the quality of services. Survey questions should be created in partnership with current recipients to ensure that the questions reflect community concerns. The survey should also include space for respondents to add their own comments and ideas. In addition, the public comment period should be extended.

Both of these suggestions increase opportunities to offer feedback but do not build equitable participation in the process. A SNAP ambassador program made up of current participants from different parts of the country would introduce equitable participation. The ambassadors could provide detailed information on their experiences and those of people in their community. They would continue to be involved throughout the entire process (including decision making) and be compensated for their time at a living wage rate.



Recommendation 7

Strengthen the collection and disaggregation of data within SNAP

Context

Currently, data on food insecurity is disaggregated by race, but it is not fully inclusive. For example, there is no data on black Latino/as; rather, data is only captured on Latino/as in general.

Data is not collected on the nutritional status of people in each racial group, nor on the general quality of the food eaten by people. The frequency and extent to which households run out of food is also not tracked.

Having this information could help tailor policies to the needs of the community. It would also help create sub-benchmarks that could ultimately make it possible to determine the impact of specific policy changes on each group's nutritional status.

Currently, data is available on how many people SNAP lifted above the poverty line, disaggregated by race (with the exception of Indigenous people and Native Hawaiians). But researchers do not know how many people improved their diets and nutritional status as a result of SNAP.

Strengthening the collection and disaggregation of data can also help (1) identify people who are food insecure but are not being captured by current data collection methods, (2) identify households that need additional support, and (3) understand to what extent SNAP is making a difference in the nutritional health of participating households.

One key population that is largely unrepresented in food security data is people who are returning from jail or prison. The research and data available show that they are disproportionately people of color and have very high levels of food insecurity. But there is no way to ensure that they receive the support they need to transition back into their communities.

“One key population that is largely unrepresented in food security data is people who are returning from jail or prison.”

Recommendation

Some of the additional data could be gathered by expanding the U.S. census data included in the USDA food insecurity report and the American Community Survey.

- **The U.S. Census should include additional questions in data collection surveys:**
 - Do you have a criminal record? If so, are you currently on parole or probation, or has the sentence been completed?
 - Are you the head of household?
 - How many children are in this household?
 - Do you have a household member who is currently incarcerated, on parole, or on probation? If yes, clarify which one.
 - Do you have a household member who is not incarcerated, on parole, or on probation, but has an existing arrest or conviction record?
 - What was the level of food insecurity before arrest, conviction, or parole hearing?
 - What was the level of food insecurity post release or post-parole?
 - What is the employment status of you or the family member with an arrest, conviction or parole record?
 - What is the income level of you or the family member with an arrest, conviction, or parole record?
- **The U.S. Census should collect and report additional data, including:**
 - Food insecurity disaggregated by both race and household type (e.g., female-headed households). Currently, there is publicly available food insecurity data that is disaggregated by race *or* by household type, but there is no information on how they relate to each other. There is also no data as yet that shows the intersection of race with ethnicity, or race with criminal record status.
 - Nutrition level by household type, disaggregated by race, ethnicity, gender, and conviction status, before enrollment in SNAP. Currently this data is not collected.
 - Nutrition level by household type, disaggregated by race, ethnicity, gender, and conviction status after enrollment in SNAP. Currently this data is not collected.
 - Average food quality consumed by each currently participating household, disaggregated by race, ethnicity, gender, and conviction status. Currently this data is not collected.
 - On average, the date each month when a household runs out of food, disaggregated by race, ethnicity, gender, and conviction status. Currently this data is not collected.
 - Nutrition level by household type, disaggregated by race, ethnicity, gender, and conviction status post-SNAP. Currently this data is not collected.

A photograph of a woman smiling and holding a baby in a sling. The image is overlaid with a large orange diagonal graphic. In the background, a faint WIC logo is visible.

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

Photo by Leah Stern © 2015

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

Overview: Policy, Scope, and Impact

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the third-largest nutrition assistance program,⁹⁸ is designed to improve the health and well-being of pregnant women, mothers, infants, and children up to the age of 5 who are at nutritional risk.⁹⁹ All participants are income eligible or participating in another means-tested program such as Medicaid, SNAP, or TANF.^{100 101 102} WIC works to ensure that its clients have **access (see glossary)** to breastfeeding support, nutritious food options, nutrition education, and referrals to health care and other social services.¹⁰³

WIC is not an entitlement program, but since 1997, its budget has been sufficient to serve all eligible applicants—about 7.3 million people in 2017,¹⁰⁴ of whom 1.7 million were women, 1.8 million were infants, and 3.8 million were children under the age of 5.¹⁰⁵ In 2018, 53 percent of all U.S.-born infants¹⁰⁶ and a quarter of all pregnant women received WIC benefits.¹⁰⁷ WIC serves a racially and ethnically diverse population. See graph at right.

Among all racial groups identified, 41.8 percent identified as Latino/a.¹⁰⁹ Table 3 on page 30 highlights WIC participation by race and ethnicity.

WIC operates in all 50 states, the District of Columbia, Puerto Rico, Guam, American Samoa, the American Virgin Islands, the Northern Mariana Islands, and through 34 Native American Tribal Organizations.¹¹⁰

WIC is seen as one of the most effective nutrition programs. The evidence shows, for example, that the program improves birth outcomes, increases participants' intake of vitamins and other nutrients, and reduces anemia in children.^{111 112 113 114}

Figure 5: WIC Serves More Than 8 Million Low-Income Women, Infants, and Children

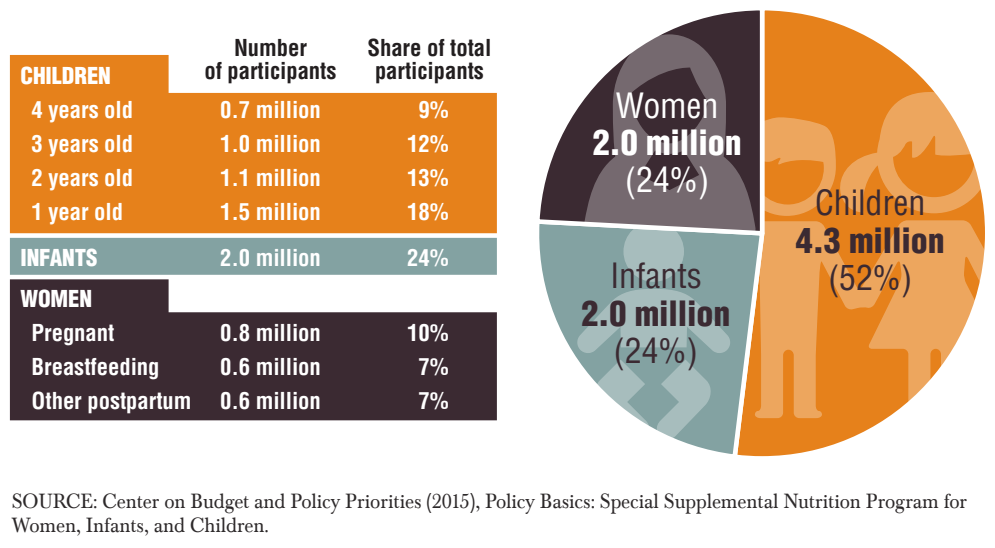


Figure 6: WIC Participation by Race¹⁰⁸

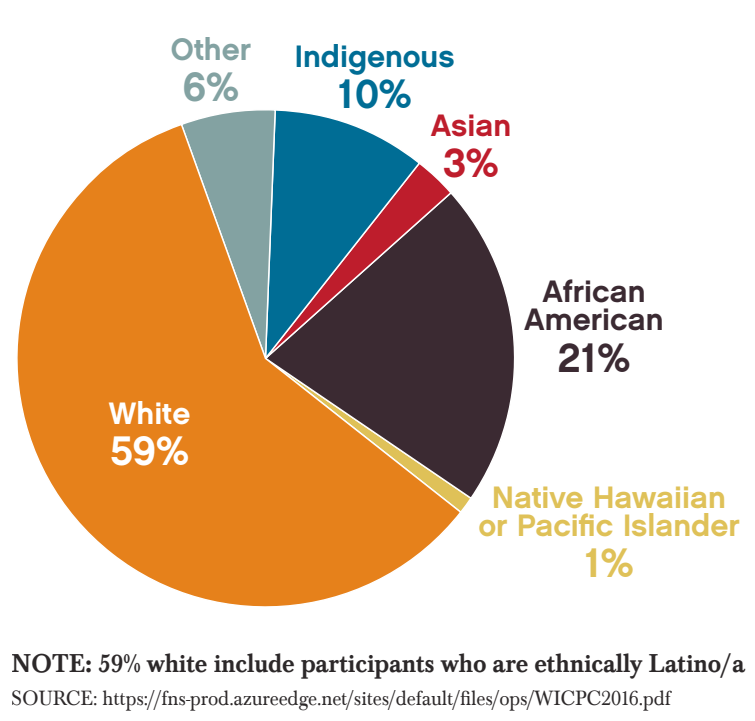


Table 3: Percentage of Participants by Race and Ethnicity

Race	Hispanic/Latino	Non-Hispanic/Latino	Ethnicity Not Reported
Total Participants (N)	3,685,729	5,125,133	4,610
American Indian or Alaska Native only	21.9	2.0	0.0
Asian only	0.4	5.9	0.0
Black or African American only	2.9	33.6	0.4
Native Hawaiian or Other Pacific Islander only	0.6	0.9	< 0.1
White only	69.1	51.2	0.3
Two or more races	5.0	6.3	0.1
Race not reported	0.2	0.1	99.2
Total	100.0	100.0	100.0

NOTE: Percentages may not add to 100.0, and subtotals may not add to totals, because of rounding.

SOURCE: <https://fns-prod.azureedge.net/sites/default/files/ops/WICPC2016.pdf>

Equity in WIC

Promoting equity is inherent in WIC’s purpose, which is to improve the nutrition of pregnant and postpartum women, infants, and children who have low incomes. Evidence of its success is seen in improved health outcomes among millions of women and children.¹¹⁵ Unfortunately, data is not disaggregated by race and ethnicity, so it is not possible to assess to what extent the improvements are equitable across all demographic groups.

There is evidence from some communities that WIC has narrowed the divide between the infant mortality rates for African Americans and whites. There is potential to improve state level and eventually national level statistics by replicating these successes. In Hamilton County, Ohio, among non-WIC participants with incomes similar to WIC participants, 21 of every 1,000 African American babies born alive died before their first birthday (2.1 percent), compared with a rate of just under 8 white babies (0.78 percent).¹¹⁶

Participating in WIC reduced the risk of death among babies of both races, but the risks were reduced disproportionately for African American babies. The WIC participants’ mortality rates over the same time period were 9.6 deaths per 1,000 live births among African Americans and 6.7 deaths among whites.¹¹⁷ Though not yet equal, these death rates are far closer to racially equitable than those of non-participants.

This is a summary of equitable aspects of WIC’s design:

- 1. WIC provides free health screenings that are tailored to individual participants.** Information is collected based on physical exams (e.g., height and weight), a hematology assessment¹¹⁸ to determine whether the person has iron deficiency, and health histories that assess risks of complications such as premature birth. Screenings establish whether applicants are at nutritional risk, as required for eligibility. Identifying actual and potential nutritional problems also makes it possible to treat or prevent them. Conducting these screenings is an example of a racially equitable practice¹¹⁹ because the screenings prioritize conditions that disproportionately affect people of color (examples include premature birth, low birth weight, and anemia¹²⁰).



53%

In 2018, **53 percent** of all U.S.-born infants and a **quarter** of all pregnant women received WIC benefits.

25%



2. **WIC provides specialized support.** WIC services are designed to meet each participant's unique nutritional needs, including both micronutrients and macronutrients, based on her or his screening. For example, applicants with moderate iron deficiencies may be asked to return in a month to check their progress. Those with dangerously low iron levels will be referred to a healthcare provider. These approaches are designed to address nutritional conditions, many of which disproportionately hurt women and children of color.

3. **All women who are eligible based on income and nutritional risk may participate.** WIC does not deny benefits to children whose mother is incarcerated, for example, nor to women returning from jail or prison and their children, who are at very high risk of poverty and food insecurity.^{121 122 123}

4. **WIC allows tribal governments to administer the program in culturally competent (see glossary) and sensitive ways.** The majority of Indigenous WIC participants live in communities governed by tribal government, whether on or off a reservation.¹²⁴ Respecting tribal self-determination and culture is important in providing appropriate services and boosting nutrition among Indigenous participants.

5. **WIC works to improve the options available in its approved food packages.** In 2009, USDA revised WIC food packages¹²⁵ according to the Dietary Guidelines for Americans and the American Academy of Pediatrics' infant feeding practices guidelines. In addition to an increased focus on healthier foods, the changes included expanding the list of foods within each category to be more suitable for people from different racial and cultural backgrounds with different nutritional needs. Two examples are allowing soymilk and tofu in addition to dairy milk, and corn tortillas in addition to whole wheat bread. The 2009 changes have resulted in healthier diets among participants.^{126 127}

In 2017, after a three-year review, experts from the National Academies of Sciences, Engineering, and Medicine (NASEM), recommended additional changes to USDA.¹²⁸ If implemented, these recommendations could also improve the nutritional status of WIC participants.

6. **WIC offers peer counseling breastfeeding support.** Breastfeeding is the optimal source of nutrition for babies. Breastfeeding lowers their risk of health conditions such as infections and lower respiratory tract illnesses—as well as their risk of SIDS (Sudden Infant Death Syndrome). Indigenous and African American infants are at highest risk of both SIDS¹²⁹ and mortality from all causes.¹³⁰ Breastfeeding also has benefits for mothers—for example, it reduces their risk of breast¹³¹ and ovarian cancer,^{132 133} which affect women of color disproportionately. It reduces overall maternal and infant mortality.¹³⁴

For all these reasons, WIC works to increase breastfeeding rates for all clients and to reduce the disparities between white mothers' breastfeeding rates and those of African American and Indigenous mothers. Whenever possible, mothers who are unfamiliar with breastfeeding are paired with peer counselors who share their language, race/ethnicity, and other aspects of identity. This helps ensure that counselors are able to work in ways that are **culturally and linguistically competent (see glossary)**—for example, supporting mothers in overcoming barriers to breastfeeding that are exacerbated by racism. Some local WIC agencies have supported efforts to create peer counseling programs by and for women of color, such as CinnaMoms in Los Angeles (see spotlight box above).¹³⁵ These services can also provide part time, and sometimes full time, employment options for mothers with experience breastfeeding who are or have been WIC participants.

WIC participants' **breastfeeding initiation and duration rates (see glossary)** have continued to increase over the past 20 years,¹³⁶ although there is limited disaggregated data.¹³⁷

SPOTLIGHT



Courtesy of CinnaMoms

CinnaMoms is a program based in Los Angeles that connects African American women to culturally sensitive, targeted breastfeeding support both before and after their babies are born. The founders are two African American lactation educators who previously worked at WIC. WIC can advance racial equity by supporting such initiatives and empowering women of color to use their leadership skills and expertise to benefit their communities.

www.cinnamoms.org

Recommendations: Strengthening Racial Equity in WIC

In addition to offering recommendations to improve racial equity that can be implemented immediately, the Institute also suggests a longer-term approach that will help in advocating the adoption of these and future recommendations and in monitoring their implementation. This is to initiate a WIC Racial Equity Team, composed of representatives from the National WIC Association, USDA, local and state WIC offices, WIC participants, and nutrition research and policy experts of color (some of whom informed the analysis of this report). Equitable engagement (see page 73) of all members of the team is essential.

The recommendations include:



Recommendation 1

Provide targeted support based on health disparities within communities of color



Recommendation 2

Strengthen breastfeeding support for recipients of color



Recommendation 3

Support the implementation of the report of the National Academies of Sciences, Engineering, and Medicine (NASEM) as well as other recommendations that promote flexibility and cultural sensitivity in food packages



Recommendation 4

Reduce maternal and infant mortality and strengthen maternal and infant health



Recommendation 5

Strengthen hiring, training, and accountability of caseworkers



Recommendation 6

Establish a mechanism for SNAP beneficiaries to equitably participate in program design, planning, and evaluation



Recommendation 7

Strengthen data collection and disaggregation within WIC



Recommendation 1

Provide targeted support based on health disparities within communities of color

Context

Infants and children of color are more likely to experience underlying health conditions, such as anemia. In order to progress to equal racial outcomes, data should be disaggregated by race and specific health conditions. Table 4 on page 33 shows that African American women participating in WIC have anemia rates twice those of whites, and the highest anemia rates of any racial group during pregnancy, breastfeeding, and postpartum.¹³⁸

Other examples of race-based health disparities include:¹³⁹

- Indigenous, Latino, and Native Hawaiian and other Pacific Islander women, as well as Indigenous children, are at higher risk of weight gain.
- Asian women are the only group at higher risk of being underweight.
- African American infants are more likely than other infants to be born prematurely and/or at a low birth weight (less than 5.5 pounds).

Table 4: Distribution of Race of Women Participants by Anemia Level

Anemia Level	American Indian or Alaska Native Only		Asian Only		Black or African American Only		Native Hawaiian or Pacific Islander	
	Number	%	Number	%	Number	%	Number	%
Total Women	203,005	–	78,365	–	432,494	–	17,031	–
Below FNS-issued nutritional risk criteria	39,066	19.2	19,720	25.2	170,848	39.5	4,469	26.2
Not reported*	22,834	11.2	6,256	8.0	24,043	5.6	1,155	6.8
Pregnant Women	83,909	–	29,203	–	161,859	–	6,217	–
Below FNS-issued nutritional risk criteria	4,664	5.6	2,447	8.4	33,072	20.4	664	10.7
Not reported*	13,349	15.9	2,940	10.1	8,663	5.4	483	7.8
Breastfeeding Women	72,623	–	31,751	–	124,781	–	6,384	–
Below FNS-issued nutritional risk criteria	20,520	28.3	10,771	33.9	58,694	47.0	2,148	33.6
Not reported*	5,610	7.7	2,207	7.0	7,076	5.7	411	6.4
Postpartum Women	46,473	–	17,411	–	145,854	–	4,430	–
Below FNS-issued nutritional risk criteria	13,882	29.9	6,502	37.3	79,082	54.2	1,657	37.4
Not reported*	3,875	8.3	1,109	6.4	8,304	5.7	261	5.9

Table continued...

Anemia Level	White Only		Two or More Races		Race Not Reported		Total Women	
	Number	%	Number	%	Number	%	Number	%
Total Women	1,259,211	–	64,660	–	3,663	–	2,058,429	–
Below FNS-issued nutritional risk criteria	278,898	22.1	14,845	23.0	458	12.5	528,304	25.7
Not reported*	66,286	5.3	5,877	9.1	1,829	49.9	128,280	6.2
Pregnant Women	492,947	–	25,186	–	1,344	–	800,665	–
Below FNS-issued nutritional risk criteria	35,678	7.2	2,163	8.6	83	6.2	78,771	9.8
Not reported*	27,959	5.7	2,759	11.0	525	39.1	56,678	7.1
Breastfeeding Women	426,158	–	22,184	–	1,166	–	685,047	–
Below FNS-issued nutritional risk criteria	127,623	29.9	6,628	29.9	211	18.1	226,595	33.1
Not reported*	21,055	4.9	1,814	8.2	550	47.2	38,723	5.7
Postpartum Women	340,106	–	17,290	–	1,153	–	572,717	–
Below FNS-issued nutritional risk criteria	115,597	34.0	6,054	35.0	164	14.2	222,938	38.9
Not reported*	17,272	5.1	1,304	7.5	754	65.4	32,879	5.7

NOTES: For the percentage of women with hematologic test results that fell below FNS nutritional risk criteria, the calculation denominators included women for whom no data were reported, so the percentages reported here represent lower bounds. Values reported here are additive; hemoglobin and hematocrit are mutually exclusive categories. FNS-issued nutritional risk criteria for hemoglobin and hematocrit values are based on CDC recommendations (CDC, 1998). Participants with blood measures below the cutoff values are considered to be at risk.

* “Not reported” indicates the number and percentage of participants by participant category for whom data were not reported on blood measures. For pregnant women, the category also includes participants missing data on expected date of delivery or weeks gestation. For breastfeeding and postpartum women, the category includes participants missing data on age.

SOURCE: <https://fns-prod.azureedge.net/sites/default/files/ops/WICPC2016.pdf>

Recommendation

Congress, USDA, local and state WIC agencies, and the National WIC Association should tailor the program to prioritize the needs of recipients who face disproportionate health and nutritional risks.

- **Reduce anemia among WIC participants, particularly during pregnancy and postpartum periods and particularly among African American women.** To reduce anemia, local WIC agencies should provide additional iron supplementation for participants with low iron levels and increase WIC benefits so that participants can purchase specified iron-rich foods, including fruits and vegetables.
- **Reduce overweight and obesity rates, particularly among Indigenous, Latina, Native Hawaiian, and other Pacific Islander mothers.** These women are more likely to gain excessive weight during pregnancy,¹⁴⁰ primarily due to pre-existing obesity^{141 142 143} and diabetes.^{144 145 146} WIC-supported strategies for weight management, measurement, and evaluation should carefully consider the criteria that are used to determine appropriate body weight. Some of the women interviewed for this report reported that the criteria for determining that a person is overweight or at risk of developing diabetes seem to be racially biased because they do not consider body frames that are common among some women of color to be within normal weight ranges.

For a brief history of obesity among Indigenous communities, please see Appendix 19.

For more on the historical trauma of government relations with Indigenous communities, which led to mistrust of government, see Appendix 27.

- **Improve data on Indigenous mothers' health.** Lack of information compromises the ability to assess Indigenous health needs and how WIC can meet their specific needs. USDA should work with WIC Tribal Agencies to identify the reasons for low reporting rates and develop culturally appropriate solutions. Mistrust of the federal government will need to be addressed, since it is part of the historical trauma suffered by Indigenous women and their families.

- **Tailor WIC food packages to better respond to health and nutrition needs common among people of color.** WIC agencies should work with local experts of

color to determine the most common health and nutrition needs in their local communities. WIC food packages should be tailored to respond to those local needs. Currently, WIC participants who are iron-deficient receive more frequent monitoring and may be referred to a healthcare provider. To improve racial equity, participants should be given additional options for iron-fortified foods within their WIC food packages.



Recommendation 2

Strengthen breastfeeding support for recipients of color

Context

There are many benefits of exclusive breastfeeding, including some that reduce disproportionate risks among infants of color (for example, higher rates of SIDS) and among their mothers (for example, breast cancer, ovarian cancer, and type 2 diabetes).¹⁴⁷

However, WIC does not collect or report data on **breastfeeding initiation, duration, and exclusivity (see glossary)**, nor does it provide breastfeeding rates by race.¹⁴⁸ As a result, little information is available. The U.S. Department of Health and Human Services has reported that African Americans have lower breastfeeding rates than whites and Latinas.

The Centers for Disease Control and Prevention observed breastfeeding rates among women income-eligible to receive WIC. Among African Americans, the breastfeeding rate was 37 percent, compared to 57 percent for whites and 74 percent for Latinas.

Some WIC offices offer peer counseling support for breastfeeding, which has been shown to correlate with higher rates of women planning to breastfeed. Evidence suggests that actual breastfeeding rates increased among African American and Indigenous mothers when they received prenatal support and peer counseling, although the increases were modest.¹⁴⁹ The largest positive impact was among Pacific Islanders, with a 10 percent increase.¹⁵⁰ See Appendix 16 for the complete results.

The research also found that African American mothers who sought post-natal care in WIC offices with peer counseling support had significantly *lower* breastfeeding rates than white participants. This was the only racial group with such results. More

research to understand the impact of peer counseling on African American breastfeeding rates and what might improve their experiences should be undertaken.

Further research is needed on how the programs are implemented, how and by whom the programs are managed, whether peer support is accurately tailored to the needs of the target community, and peer counseling caseloads. See the CinnaMoms program model for breastfeeding support for African American women on page 31.

Women who are breastfeeding are eligible for WIC benefits for a longer time period than women who are not—up to one year after the baby is born for breastfeeding mothers, but only six months for non-breastfeeding mothers. The policy was meant to encourage women to breastfeed, but due to the absence of data, the policy’s impact is unknown. It may be working at cross purposes with the racial equity goals of the program. Since women of color have lower breastfeeding rates overall, they are eligible for WIC benefits for a shorter time.

All women should be empowered to give their babies the best nutritional start in life.

Communities of color have a long history of honoring relationship and community. Programs have the potential to improve breastfeeding rates when they are committed to **cultural humility (see glossary)**, seek to overcome the mistrust associated with the historical trauma of being denied the ability to breastfeed and nurture their children, acknowledge the barriers and stress that living in a racist society presents, and improve the treatment provided by healthcare professionals.

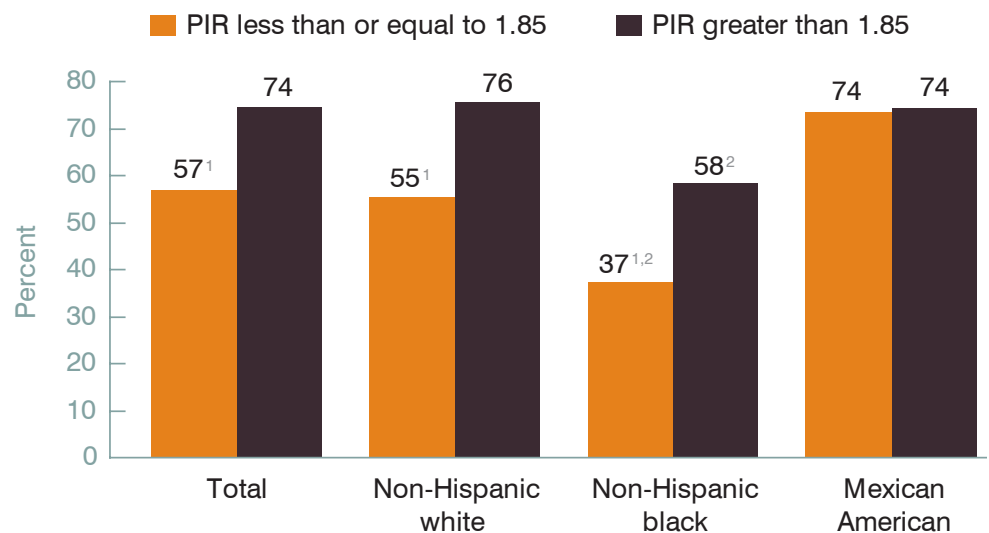
DID YOU KNOW THAT...

Indigenous, Native Hawaiian, and African American mothers are less likely to breastfeed?

African American women have the lowest rate of exclusive breastfeeding—nearly 20 percentage points less than white women? The breastfeeding divide is even wider at the one-year mark than earlier.

SOURCES: <https://www.cdc.gov/breastfeeding/resources/us-breastfeeding-rates.html>
https://www.cdc.gov/mmwr/volumes/66/wr/mm6627a3.htm#T1_down

Figure 7: Percentage of Infants Who Were Ever Breastfed by Poverty Income Ratio (PIR) and Race-ethnicity: United States, 1999-2006



NOTES: Income status was defined using the poverty income ratio (PIR), an index calculated by dividing family income by a poverty threshold specific for family size. Low income was defined as PIR less than or equal to 1.85, and high income was defined as PIR greater than 1.85.

¹ Significant differences between the two income groups.

² Significantly different from non-Hispanic white and Mexican-American infants within income groups.

SOURCE: <https://www.cdc.gov/nchs/data/databriefs/db05.pdf>

Recommendation

- **Take further steps to understand the historical, structural, and societal barriers that confront women, specifically racism and trauma.** WIC agency staff can use their training on **historical trauma** and **structural racism (see glossary)** to help strengthen their relationships with WIC participants. Training at both the national and state and local levels is needed. WIC should adopt a strengths-based approach to create and implement programs that equip mothers to overcome barriers to breastfeeding. As explained in the Spotlight box on page 37, this involves honoring the traditions of particular communities of color.

WIC should hire and consult with individuals and organizations that have experience with this type of programming, such as the Oregon Inter-Tribal Breastfeeding Coalition. Local community health organizations and leaders of color should co-design program content and implementation methods that honor community tradition and provide optimal breastfeeding support to women of color. See Recommendation 5 for more on the racial demographics of local and state WIC offices.

- **Targeted support to help women of color overcome barriers to breastfeeding should be offered at all WIC agencies.** Local communities should design their own programs using programs such as CinnaMoms in Los Angeles as models. The African American Breastfeeding Network¹⁵¹ or the Black Mother’s Breastfeeding Association should also be consulted¹⁵² to develop relevant programs that complement existing efforts.
- **WIC policies should seek to reduce the impacts of racism and strengthen the agency’s relationships with women of color and their families.** According to the National Institutes of Health, racism in “both its institutional and individual forms” is the largest contributing factor to lower **breastfeeding initiation and duration rates (see glossary)** among African American, Indigenous, and Native Hawaiian women,¹⁵³ Racism also undermines the ability of WIC participants to trust WIC staff and benefit from services. The following actions would help counter racism affecting WIC participants:
 - **Reevaluate the qualifications required to become a peer counselor and a licensed lactation consultant.** Until the mid-20th century, many babies born in the south, both African American and white, were delivered by African American women health providers known as “granny midwives.”¹⁵⁴ Toward the end of the 19th century, childbirth began to become medicalized in some cities, and African American midwife practices were made illegal or forced to comply with strict requirements for medical training and expensive licensing. Many African American midwives could not afford this training

BRIEF HISTORY

Low breastfeeding rates among African Americans date back to slavery, when African American mothers suffered the historical trauma of being forced to breastfeed their master’s children instead of their own children.

Similar to enslaved African women, Indigenous women had a strong tradition of breastfeeding their children this first food. But disruption of family ties and culture under U.S. government policies such as forced relocation and removal of children to boarding schools significantly weakened this tradition.

Later, both corporations² and early WIC offices exerted significant pressure on African American and Indigenous communities to purchase and use formula.

In addition to the historical trauma from racism, racism is also embedded in the structure of the daily lives of women of color, from the neighborhood or reservation in which she lives, to the low-wage job that she works, to the water she drinks and the environment she lives in, all being shaped by racially unjust policies. These are examples of racism women of color experience today—conditions that cause chronic stress and affect lactation.³ Oxytocin is a chemical in the body that causes milk to flow freely from the breast.⁴ However, when a person is stressed or scared, adrenaline is released. That adrenaline then inhibits the oxytocin, causing low lactation or milk flow.⁵

Many women of color do not have the resources to seek lactation support. Those who do sometimes report receiving poor care or being discouraged from breastfeeding because of racist attitudes in the medical and allied health fields.⁶ ⁷ Such incidents deepen mistrust of healthcare professionals and contribute to a lower likelihood of initiating breastfeeding among mothers of color.⁸

For more historical context and information on historical trauma, see Appendix 1 and the glossary. For more on the impact of pervasive racism, see Appendix 2.

¹ West, E. and Knight, R. J. “Mothers’ milk: slavery, wetnursing, and black and white women in the Antebellum South.” University of Reading. 2017. <http://centaur.reading.ac.uk/66788/7/article%20%281%29%20%281%29.pdf>

² Corporations aggressively marketing formula to African American mothers in the early to mid-1900s. *Ibid* <http://centaur.reading.ac.uk/66788/7/article%20%281%29%20%281%29.pdf>

³ “Miles to Go Before We Sleep: Racial Inequities in Health.” National Center for Biotechnology Information, US National Library of Medicine, National Institutes of Health. September 2012. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3712789/>

⁴ “Stress and Breastfeeding: How to Protect Your Milk Supply.” Rachel Obrien. <https://www.rachelobrienibcl.com/blog/stress-and-breastfeeding-protect-milk-supply/>

⁵ *Ibid*⁶ According to a recent study of 36 International Board Certified Lactation Consultants who assist mothers with breastfeeding, there were reports of instances of patients of color receiving unequal care and of healthcare providers making racist remarks to patients. <https://www.ncbi.nlm.nih.gov/pubmed/29557297>

⁷ Some women of color, particularly African American women, have even encountered healthcare providers who completely discourage breastfeeding. “Enhancing Breastfeeding through Healthcare Support: Results from a Focus Group Study of African American Mothers.” National Center for Biotechnology Information, US National Library of Medicine, National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5290044/>

⁸ *Ibid*.

and licensing and were forced out of the profession. African Americans and other people of color still have far less access to the resources needed to obtain certificates and licensing and to recertify at prescribed intervals—due in large part to the racial wealth divide.

Given the racially inequitable history of licensing in the healthcare field, WIC should thoroughly reexamine the assumptions behind its credential requirements for positions such as peer counselor and lactation consultant. Policies should be revised to reflect the education, skills, and experience shown to be essential to the positions. WIC should develop strategies to expand access to the necessary education and training among interested WIC participants and others for whom lack of resources are a barrier.

These measures will preserve high standards for the services that WIC offers while also making access to career opportunities for peer counselors and others more racially equitable. In turn, increasing the representation of people of color in these positions will enable WIC to connect more closely with its clients and provide support that is more relevant to participating mothers' experience. For further detailed recommendations on what the larger public health field and WIC policies can do to ensure racial equity, see Appendix 15.

- **Ensure that WIC participants of color have access to peer support from other women of color.** This should include hiring proportional numbers of women of color as community health workers. In addition, Congress should dedicate funding to train more African American and Indigenous lactation consultants and community health workers. In addition to paying for their training, WIC agencies should also be funded to pay trainees for their time, at a living wage, to reduce barriers to participation.

DID YOU KNOW THAT...

Breastfeeding rates among Latinas tend to decrease the longer they have lived in the United States?

This suggests that an overall cultural shift in our country is needed to ensure that policies, practices, and advertisements encourage breastfeeding among all mothers, regardless of race or income status.

SOURCE: Gibson-Davis CM, Brooks-Gunn J. Couples' immigration status and ethnicity as determinants of breastfeeding. *Am J Public Health.* 2006;96:641–646

SPOTLIGHT



Courtesy of OITBC

The Oregon Inter-Tribal Breastfeeding Coalition (OITBC) provides culturally sensitive prenatal and postnatal support for Indigenous women and their families. The coalition has a strengths-based framework that teaches breastfeeding as an ancestral practice and reinforces this concept using other traditional practices.

“The whole family is involved to fortify the ongoing support a mother has post labor, and to honor the strength present in each family unit, as well as the strength from our ancestors.”

—*Roberta Ortiz, LE, CD, CHW, Oglala Sioux/Yomba Shoshone, Founder of the Oregon Inter-Tribal Breastfeeding Coalition*

Lactation consultants and community health workers of color can provide culturally relevant support that takes into account **historical trauma** and **structural racism (see glossary)**, which impact the breastfeeding rates of WIC participants of color. See Appendix 5 for additional recommendations on improving equity in credential requirements and Appendix 28 for more on empowering women of color to serve other women of color.

- **Increase funding for targeted peer-to-peer breastfeeding support for African American, Indigenous, and Native Hawaiian women, and for research on the design and impact of these programs.** Tribal centers should have the resources they need to provide breastfeeding support, but many tribal WIC offices are underfunded, reducing the opportunity for breastfeeding support via classes. In some cases, respondents reported that non-tribal WIC agencies required Indigenous participants to drive long distances to receive support instead of allowing the tribal office to teach classes—despite the fact that tribal offices had established trust, honored cultural traditions, and were located near participants.

Research funding is needed to understand which breastfeeding support strategies work for each racial and ethnic group. Improvements in programs based on this research can help raise breastfeeding rates among women of color, with the understanding that resolving the root causes of low breastfeeding rates will require more support from the larger public health field as well as from other sectors.

Additional funding for breastfeeding support is needed; 30 percent of local WIC agencies do not receive funding to provide it.¹⁵⁵ Other offices receive some support but could offer stronger programs if they had additional funding.^{156 157} Additional funding should be allocated to ensure that peer counselors are paid a living wage and to address barriers to participation (e.g., lack of transportation or child care)

- **Ensure that programs are flexible.** Women of color disproportionately work long hours at **ten lowest-wage jobs** (see **glossary**)¹⁵⁸ that lack flexibility.¹⁵⁹ Flexibility in scheduling breastfeeding support programs is needed.
- **WIC data should be centralized so that the impact of its initiatives on racial equity can be assessed.** Data collection should include assessments of many facets of WIC, including the impact of breastfeeding peer counseling on closing the racial divide in breastfeeding rates, and the impact of offering six additional months of WIC benefits as an incentive to breastfeed.

DID YOU KNOW THAT...

Licensing in the healthcare community historically excluded, and to a significant extent continues to exclude, people of color? To learn more about this, see Appendix 5.

WHAT CAN THE LARGER PUBLIC HEALTH COMMUNITY DO TO INCREASE RACIAL EQUITY FOR WIC PARTICIPANTS?

The larger public health community should make a concerted effort to apply a racial equity lens in its current policies and practices, including providing targeted support to communities of color to reduce the impacts of racism. The public health community should also advocate for policies that equip women of color to provide for their families. One example is paid family leave. A study published by the National Institutes of Health of WIC participants in Hawaii found that most Native Hawaiian women stopped exclusively breastfeeding once their babies were a week old, primarily because of work obligations. For more, see the 10 lowest-paying jobs in the glossary.

In addition, appropriate officials should meet with the National Association of Professional and Peer Lactation Supporters of Color and the CSI National First Food Racial Equity Cohort to develop a plan to strengthen racial equity in the professions of lactation educator and doula. These efforts will strengthen maternal health and breastfeeding among women of color. For details on how this can be done, see Appendix 15.

SOURCES: "Breast-feeding practices among WIC participants in Hawaii." National Center for Biotechnology Information, US National Library of Medicine National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pubmed/11209586>



Recommendation 3

Support the implementation of the report of the National Academics of Sciences, Engineering, and Medicine (NASEM) as well as other recommendations that promote flexibility and cultural sensitivity in food packages

Context

The list of WIC-approved foods includes items that meet WIC eligible food federal requirements. But state agencies do not always authorize all items on the list, and some foods that are culturally important are not on the list. For example, a family from Peru or Bolivia cannot use WIC benefits to purchase quinoa, a traditional food that contains more protein and dietary fiber than brown rice. In some states, families cannot buy brown jasmine rice or brown basmati rice.

In 2017, experts from NASEM recommended improvements to the WIC food packages.¹⁶⁰ The NASEM report recognizes the importance of allowing more culturally sensitive food options.

Recommendation

- **USDA should implement NASEM’s recommendations, including those on making specific culturally sensitive dairy items, grains, and vegetables more available.** Within each WIC food group (dairy, grains, etc.), choices should be nutritious, meet federal requirements, and reflect sensitivity to the cultural food needs of mothers and children from various communities of color. In addition, state WIC agencies should authorize all NASEM-endorsed foods rather than being allowed to delete individual items. USDA should amend the rules to allow state and local agencies to tailor food packages for participants with identified nutritional deficiencies and to request additional support to address nutrition-related conditions.

WHY IS PROVIDING CULTURALLY APPROPRIATE FOOD IMPORTANT?

1. Food is a source of nourishment and identity.
2. People prefer to cook and eat familiar foods.

For more, see Appendix 4.



Recommendation 4

Reduce maternal and infant mortality and strengthen maternal and infant health

Context

Women and babies of color have higher maternal/ infant mortality rates.¹⁶¹ The rates of infant mortality (defined as babies born alive who die before their first birthday) for African American, Indigenous,¹⁶² and Native Hawaiian¹⁶³ babies are twice as high as for white babies. African Americans have the highest mortality rate.¹⁶⁴

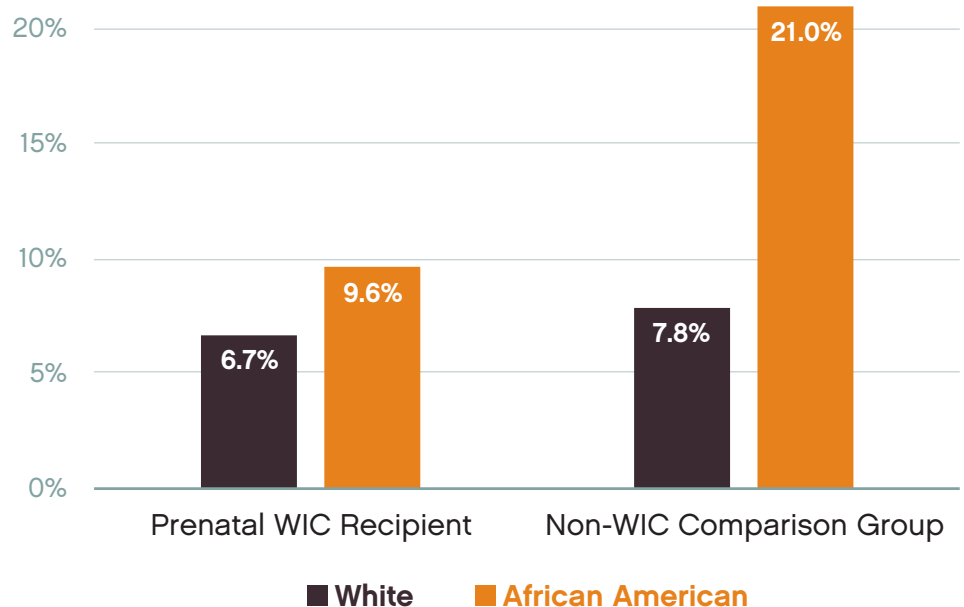
As described earlier, one of WIC’s major accomplishments (as documented in a county in Ohio) has been to significantly lower the death rate of participating African American infants. Their mortality rate approached that of white infants in this community. For more complete data on infant mortality, see Appendix 17.

Data on the impact of participating in WIC on maternal mortality is not centrally collected.

The U.S. population has stark racial disparities in maternal mortality, as shown in the table on page 40. Indigenous women are nearly four times as likely as white women to die from complications of pregnancy or childbirth. Note that disaggregated data for Latinas is not available.

Historical racism directly contributes to higher maternal mortality rates. Prenatal care has been proven to reduce maternal mortality, but one in three African American women and one in two Indigenous women have fewer than the recommended number of prenatal care visits.¹⁶⁵ A study of Native Hawaiian mothers found that they are twice as likely to receive no prenatal care until their third trimester.¹⁶⁶ Other factors that contribute to maternal mortality are undernutrition and iron-deficiency anemia. As discussed earlier, expectant mothers who are African American or Indigenous have higher rates of anemia and other micronutrient deficiencies than whites.¹⁶⁷ See Appendix 3 for more information about historical racism and its impacts on maternal mortality.

Figure 8: Infant Mortality Rates of African Americans and Whites



SOURCES: The Impact of Prenatal WIC Participation on Infant Mortality and Racial Disparities. National Center for Biotechnology Information, US National Library of Medicine, National Institutes of Health. April 2010. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837444/>

Table 5: Maternal Mortality by Race

Maternal Mortality	White Women	African American Women	Indigenous Women	Native Hawaiian Women
Number of Deaths (per 100,000 live births)	12.4 deaths per 100,000 live births	40.0 deaths per 100,000 live births	46.2 deaths per 100,000 live births	20.7 deaths per 100,000 live births ¹⁶⁸

SOURCE: Pregnancy Mortality Surveillance System. Center for Disease Control and Prevention. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>

Recommendation

- WIC should expand postpartum care for breastfeeding and non-breastfeeding mothers.** WIC’s postpartum services include food packages, health monitoring, and breastfeeding support. Studies show that improving health care and other social support services for mothers during pregnancy and between pregnancies leads to improved health outcomes for mothers and infants.¹⁶⁹ This would disproportionately benefit African American and Indigenous mothers on WIC, who are at highest risk of maternal mortality, have the lowest breastfeeding initiation and duration rates, and lose WIC benefits earlier.

The Centers for Disease Control and Prevention report that extending postpartum care¹⁷⁰ could reduce maternal mortality, with women of color benefiting disproportionately. As mentioned earlier, communities of color place a high value on community and relationships. Studies have found that strategies that include primarily face-to-face support have higher breastfeeding success rates than other strategies (see Appendix 28).^{171 172} A 2015 FNS study found that many state agencies recommend that local WIC agencies have peer counselors contact program participants within their first week at home.¹⁷³ Research has also found that postpartum care is especially helpful until the baby is three months old.¹⁷⁴

WIC agencies should assign a community health worker or peer counselor to provide face-to-face support for new mothers who participate in WIC at least within the first three weeks of childbirth. Ongoing postpartum face-to-face support fosters relationships and trust, which can encourage women of color to breastfeed and increase the chances that potential health complications will be noticed early.

- WIC agencies should work with local stakeholders in a comprehensive effort to reduce mortality and improve infant and maternal health.** A citywide initiative in Baltimore that identified and named as top priorities neighborhoods most in need of supportive services could be used as a model. Headed by the City Health Department, the initiative provided families with medical and social support before pregnancy, during pregnancy, and postpartum. The city’s infant mortality rate fell by nearly 40 percent.¹⁷⁵

WIC already provides many of these services in some areas, but their impact could be magnified by forging partnerships with community organizations. Local breastfeeding or nutrition networks led by women of color serving women of color, such as the African American Breastfeeding Network¹⁷⁶ and the Oregon Inter-Tribal Breastfeeding Network,¹⁷⁷ are critically important partners where they exist. Local WIC agencies should empower these networks to play a leading role in this comprehensive effort. For more on how Baltimore designed and implemented its strategy, see Appendix 18.

SPOTLIGHT



Courtesy of HealthConnect One

“As people of color, we come from traditions where relationships, community, and trust are important. So any action aimed at increasing breastfeeding or addressing inequities needs to dedicate time toward building relationships, community, and trust with women of color and their family at the center (see glossary). Some of the best breastfeeding rates among women of color have been in places where they had strong pre- and post-natal in-person support from other women of color.”

See recommendation 2 and Appendix 28 for more on the importance of trust and relationships for programmatic impact.

—Brenda Reyes, from *HealthConnect One* and the *Racial Equity Breastfeeding Cohort*

- **WIC offices should target outreach to African American and Indigenous communities to boost enrollment among eligible women.** WIC participation has positive impacts on birth weight and survival for African American infants. The Institute believes that participating Indigenous infants benefit in a similar way. Boosting support for increasing enrollment of eligible African Americans and Indigenous women will improve health and reduce mortality among infants of color.
- **USDA should conduct and publish more research on the impact of WIC on reducing maternal mortality among African American, Indigenous, and Native Hawaiian mothers.** Both experts and community members of color should be equitably engaged and empowered to lead these efforts. For more on equitable engagement, see page 73.



Recommendation 5

Strengthen hiring, training, and accountability of caseworkers

Context

In interviews, Bread for the World Institute learned that recipients encounter racism from WIC frontline staff, whether through interpersonal behavior or office processes. Many interviewees reported being racially stereotyped by staff. One interviewee reported an instance of cultural insensitivity where, as earlier mentioned, administrators insisted that Indigenous women attend breastfeeding classes at the general WIC office rather than at the local Tribal WIC office, although the former was further away with staff who were not culturally competent in inter-tribal traditions, and this plan did not address barriers such as lack of transportation and child care.

Beyond the multiple complaints of racial discrimination, it appears that staff have little to no accountability for adhering to changes made to improve racial equity, or for prioritizing the needs of recipients of color.

Recommendation

USDA and the National WIC Association should:

- **Require WIC staff to have both anti-racism and implicit bias training.** Anti-racism training will enable people to relate to WIC participants without being judgmental or subscribing to **stereotypes (see glossary)**, but it is just a first step. People who work with recipients need ongoing training in implicit bias. These requirements should apply to every WIC employee.
- **Build in accountability.** Training is not enough to break down institutional and interpersonal racism. Accountability mechanisms must hold staff, including caseworkers, accountable. Each office should be required to publicize its formal complaint process. It should be clear to participants that these complaints will be taken seriously and answered by more senior staff. Doing so will help counter **historical trauma (see glossary)** from systems that have failed to be responsive to communities of color, in addition to fostering trust and encouraging participation. All complaints should be investigated and staff appropriately counseled and disciplined.
Applicants who are discriminated against should have some form of immediate recourse without fear of retaliation—particularly retaliation in the form of being turned away from the program in the future.
- **Take steps to ensure that current and/or former recipients are equitably represented among staff.** Proportional representation among staff of people who have faced hunger and food insecurity is critical to equitable implementation. People with personal experience may be more likely to understand and empathize with participation barriers and less likely to be judgmental. Moreover, WIC’s goal is to help people who face hunger, and hiring people with direct knowledge helps ensure that the voices of food insecure people are heard and influences office culture and practices to be of greater service.
- **Take steps to ensure that the overall staff racial and ethnic makeup reflects the racial and ethnic demographics of the community.** Staff should reflect the community in which they work—this is important in eliminating or reducing language barriers, for example. Changing hiring practices to reflect racial equity should increase racial and ethnic diversity at all levels of the program. The program can do this with the support of outside racial equity consultants.

BENEFITS OF A RACIALLY AND ETHNIC DIVERSE WORKPLACE

Staff members who come from the communities WIC serves help the office better understand the community’s needs, culture, and sensitivities—allowing WIC to strengthen its impact. For more on how racial and ethnic diversity at all staff levels strengthens WIC, see Appendix 26.

Information that each local and state agency should collect to help achieve this includes (1) how it currently tracks WIC staff positions by race and ethnicity (2) equitable systemic approaches now in place to ensure that staff composition mirrors the communities they serve and (3) the racial and ethnic diversity at each agency by position compared with community racial and ethnic makeup. This information should be made publicly available.

A straightforward approach would be for local and state WIC offices to consider hiring community health workers and other local staff and training them to respond to the needs of their own community and the needs of the local office. Changing recruiting practices and job requirements will help identify candidates in an equitable way. The goal should be for each office to have office demographics that mirror those of their communities by 2030. Racial and ethnic diversity should be present at all levels of seniority, not only in entry-level positions. The National WIC Association can help monitor these transitions, perhaps through a national campaign.

For more on recommendations for WIC hiring practices, please contact the National Association of Professional and Peer Lactation Supporters of Color (NAPPLSC) and HealthConnect One.

- **The National WIC Association should oversee a baseline assessment of each WIC office. It was difficult for Bread researchers to make a comprehensive assessment of local WIC offices' levels of understanding and activity to promote racial equity.** An equitably designed baseline assessment, completed by staff, community representatives of color, and recipients of color, would capture the strengths and weaknesses of the local office and enable all stakeholders to formulate an action plan to ensure that all policies and practices reflect the principles of racial equity.
- **The National WIC Association and the USDA should increase accountability of frontline staff in each office.** Due to **historical trauma (see glossary)**, trust in government programs among people of color has been lost. Some people do not feel comfortable reporting offenses, and others do not have faith in the systems to hold staff accountable for their actions.

We recommend hiring organizations of color on the ground as well as WIC recipients of color to conduct a study to research and brainstorm equitable ways of holding frontline staff accountable. The reason for this is because filing a complaint (which is the current process now) does not take into account existing power dynamics both with race and class that lower income recipients of color confront, nor does it consider previous historical trauma between communities of color and U.S. government programs.

- **The National WIC Association should support the National Grocers Association's efforts to apply a racial equity lens to policies and practices in its member stores.** This could be in the form of training on applying a racial equity lens during the National Grocers Association's¹⁷⁸ annual conference.



Recommendation 6

Establish a mechanism for SNAP beneficiaries to equitably participate in program design, planning, and evaluation

Context

Currently, WIC does not have a formal process for honoring the lived experience of experts of color who receive benefits from their program. Part of achieving racial equity means that the voices of people impacted by WIC are actively sought out and included in the decision-making process.

Recommendation

USDA and the National WIC Association should:

- **Encourage clinics to host racially representative focus groups to gather community feedback.** Potential topics include what is working well, what could be improved, and what are the remaining barriers preventing women and their children from fully participating. Some centers encourage participation in these discussions by offering giveaways of needed items such as diapers, wipes, and other toiletries (see Appendix 20). Other organizations have offered honoraria in recognition of the time and the first-person insights into program effectiveness that beneficiaries offer. Respondents should not be asked for their names or other identifying information because of the historical trauma of government's collecting the names of people of color, only to use them later for actions unrelated to the stated purpose.



Recommendation 7

Strengthen data collection and disaggregation within WIC

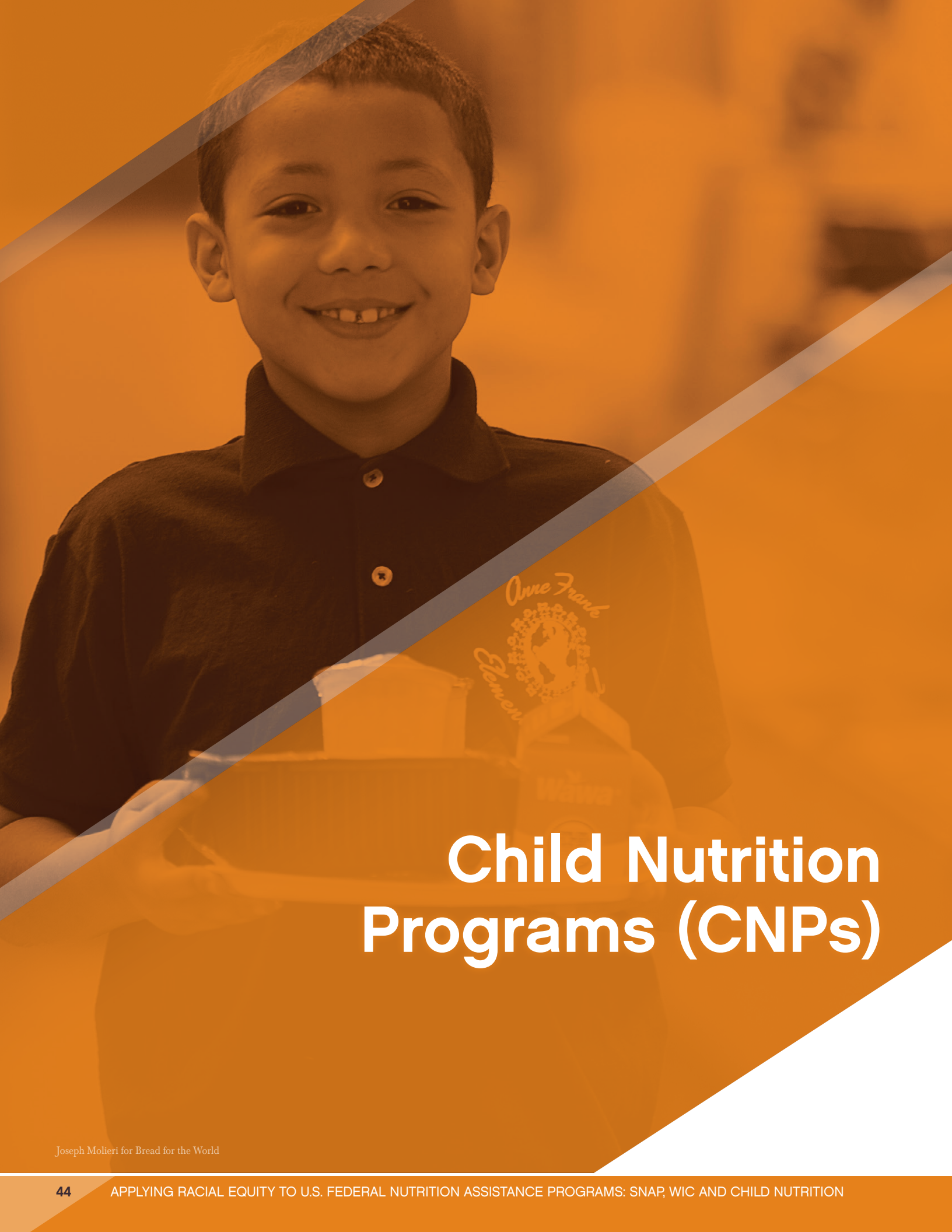
Context

As mentioned earlier, gaps in research and data prevent researchers from analyzing the impact of WIC on women, infants, and children of various races and ethnicities. WIC would benefit from strengthening data collection and disaggregation within the program.

Recommendation

WIC could begin this process with these actions:

- **Create a mechanism for collecting and reporting data in a centralized way.** It is difficult to find national data on the impact of WIC on recipients that is broken down by race and ethnicity. Some state-level studies provide this data, but collecting and reporting it is not required and there is no way of centralizing it.
- **Collect and report more detailed and nuanced data on race and ethnicity.** WIC reporting does not include enough options for race and ethnicity to capture all the information needed to create an effective plan to strengthen racial equity. For example, there is no separate category for people who identify as Latino/a, so the majority are counted as part of the white demographic. Another example is that there is no disaggregated data on Asian ethnicities (e.g., Thai, Burmese, Japanese), yet there are wide variations in food insecurity rates among people of Asian descent. Recent data on Native Hawaiians was difficult to find, perhaps because of the small population size.
- **Collect and report disaggregated data on a larger number of indicators.** The Office of Management and Budget, which sets federal data collection policy, should require WIC to provide data that is disaggregated by race and ethnicity for all the main categories of indicators tracked, such as birth outcomes, infant health, weight at birth, and so forth. Top priority should be given to detailed data on breastfeeding initiation rates and breastfeeding duration rates, since breastfeeding is a very important intervention with a short window of opportunity for any given newborn.
- **Conduct additional research.** Topics where additional research will help WIC apply a racial equity lens throughout its work include:
 - Impact of culturally sensitive breastfeeding supports in eliminating racial breastfeeding divides
 - Impact of Breastfeeding Food Package Incentive on breastfeeding rates
 - Peer-to-Peer Breastfeeding Program Impact on breastfeeding rates
 - Impact of WIC food packages on improved nutrition rates (anemia, obesity, etc.)
 - Impact of WIC on maternal and infant mortality racial divides



Child Nutrition Programs (CNP)

Joseph Molieri for Bread for the World

Child Nutrition Programs (CNP)

Overview: Policies, Scope, and Impact

Federal Child Nutrition programs (CNPs) are essential to the physical and cognitive development and overall well-being of children from low-income families. Children who have nutritional deficiencies or live in food-insecure households are less likely to succeed academically and more likely to develop long-term health problems. Both academic achievement and good health are key factors that enable children of color to achieve equity.

CNPs include the following programs. See Appendix 6 for a chart with a description of each program and related information such as eligibility criteria.

- **National School Lunch Program (NSLP)**
- **School Breakfast Program (SBP)**
- **Fresh Fruit and Vegetable Program (FFVP)**
- **Special Milk Program (SMP)**
- **Summer Food Service Program (SFSP)**
- **Seamless Summer Option (SSO)**
- **Child and Adult Care Food Program (CACFP)**
- **Summer EBT Pilot**

NOTE: The Community Eligibility Provision (CEP) is not a program, but a policy option within the National School Lunch Program (NSLP) and School Breakfast Program (SBP). For more information, see Appendix 6.

NOTE: The After-School Snack Program is part of the National School Lunch Program, and the At-Risk After-School Meals Program is part of the Child and Adult Care Food Program (CACFP). For more information, see Appendix 6.

Overall, CNPs have done much to improve the nutritional well-being of children across the country. Participation in school lunch programs has decreased childhood obesity rates by at least 17 percent and poor health among children by 29 percent.¹⁷⁹ These programs benefit children of color disproportionately; the majority of students who attend schools where 75 percent or more of the students qualify for free or reduced-price lunch (often called the FARMS rate) are children of color.¹⁸⁰ Data that is disaggregated by race and ethnicity for each program is not readily available, however, so it is not possible to analyze whether children from different racial and ethnic groups are benefiting in different ways.

Equity in Federally-Funded Child Nutrition Programs

Child Nutrition programs address racial equity because they generally target areas of **concentrated poverty** (see glossary), which are areas with dense populations of people living near, at, or below the federal poverty line. Research shows that the harms caused by poverty are exacerbated in neighborhoods whose poverty rates exceed certain thresholds—particularly when poverty rises above 20 percent, and again when it reaches 40 percent.

One in four African Americans, one in six Latino/as, and one in two Indigenous people in counties with a high proportion of Indigenous residents¹⁸¹ live in areas of concentrated poverty, compared to one in 13 whites.¹⁸² At least one in five Native Hawaiian and Pacific Islander students enrolled in public schools attend schools in high-poverty neighborhoods.¹⁸³ Focusing on areas of concentrated poverty is focusing on children of color, simply because the children living and attending school in these neighborhoods are disproportionately children of color.



One in four African Americans, one in six Latino/as, and one in two Indigenous people in counties with a high proportion of Indigenous residents live in areas of concentrated poverty, compared to one in 13 whites.

Two federal provisions allow meals and snacks to be distributed based on the eligibility of an entire district or area rather than that of individual students. The Community Eligibility Provision (CEP) allows schools to provide free lunch and breakfast to all students without requiring individual household applications.¹⁸⁴ The Fresh Fruit and Vegetable Program (FFVP) allows schools to distribute free fruits and vegetables on a similar basis. The required thresholds are different: CEP requires that two-thirds of the students served live in low-income households, while FFVP requires a student poverty rate of at least 50 percent. These thresholds ensure that the beneficiaries are students who live in areas of concentrated poverty.

The following are other equitable aspects of Child Nutrition programs:



Income Eligibility. No matter where children live, if they are from a low-income household, they may apply for free or reduced-price school meals. This is true whether they live in a wealthy area, a neighborhood of concentrated poverty, or a middle-class suburb. It also applies regardless of race, gender, religion, or other demographic factor.



Group Eligibility. This approach certifies and enrolls children for free or reduced-price school meals automatically based on their membership in certain groups, in an effort to ensure that students with the greatest needs receive the benefits for which they qualify. There are two types of group eligibility:

- **Categorical Eligibility.** In this type, children who are part of specific categories are eligible for benefits. Parents do not need to fill out individual applications because children are considered “categorically” eligible for FARMS. Currently, categorical eligibility is granted to children who live in households that participate in SNAP, FDPIR, Temporary Assistance for Needy Families (TANF), and/or Head Start, as well as children who are homeless, part of a migrant family, or in foster care.
- **Community Eligibility Provision (CEP).** CEP provides services to students as members of a group. CEP provides universal free lunch and breakfast to all students who attend schools where many or most families have low incomes. Schools who serve these students are not required to use their time and resources to collect and process individual household applications.¹⁸⁵ CEP streamlines the process of serving school meals to all children in low-income schools and reduces the stigma associated with receiving free or reduced-price school meals, thereby increasing student participation. By providing increased reimbursement, Community Eligibility also helps reduce the financial burden on low-income schools seeking to serve quality meals.¹⁸⁶ The implementation of CEP applies a racial equity lens, since most schools that qualify for the program are in concentrated areas of poverty with high percentages of students of color.



Additional fresh fruits and vegetables are targeted to children in greatest need. The Fresh Fruit and Vegetable Program (FFVP) is also based on community eligibility. It provides additional funding of \$50 to \$75 per student per year so that elementary schools with FARMS eligibility rates of 50 percent or more can distribute free fruits and vegetables to all students.¹⁸⁷ The program promotes nutrition education alongside the introduction of new fruits and vegetables. In addition to increasing children’s consumption of fresh fruits and vegetables,¹⁸⁸ FFVP helps counteract the damage done by the widespread advertising of unhealthy foods in lower-income neighborhoods.



Targeted support is provided to children after school and during the summer. Children in areas of concentrated poverty may also receive support as a group when not in school, whether that is over the summer or after school each day. The Summer Food Service Program offers reimbursement to providers for all meals that are either served at sites in areas where at least 50 percent of the children in the community live in low-income households, or at sites where at least 50 percent of students served are low-income. The Seamless Summer Option has the same eligibility requirements but can be operated only by schools that participated in the NSLP during the previous school year. These eligibility requirements also apply to the At-Risk After-School Meals Program, part of the Child and Adult Care Food Program (CACFP).

Seven out of 10 African American and Latino/a children attend schools that qualify for such targeted support.¹⁸⁹ See Appendix 6 for more on SFSP and SSO.



Kitchen equipment grants are available for low-income schools. Low-income schools may apply for kitchen equipment grants. The National School Lunch Program (NSLP) Equipment Assistance Grants for School Food allocates funding for state agencies¹⁹⁰ to provide financial support to low-income schools to buy new or upgraded kitchen equipment. Recipient schools are selected based on their FARMS rate and on how recently they last received a grant, with priority given to schools with FARMS rates of 50 percent or more. This helps alleviate the financial burden on schools in areas of concentrated poverty to serve a variety of fresh and flavorful meals that meet federal nutrition standards. They are better able to produce meals of comparable quality to those in higher-income schools.



Targeted distribution of summer EBT funds is available to families in different parts of the country, including households on Indigenous reservations. Families that participate in SNAP and have school-age children may receive targeted increases in EBT/SNAP benefits during the summer months. Families who live on Indigenous reservations are also eligible. In summer 2017, USDA awarded grants to several low-income communities, including the Chickasaw and Cherokee Nations, to operate Summer EBT. Both tribes had managed summer EBT demonstration projects in 2016.¹⁹¹ The project evaluation found that food insecurity rates were lower in areas that offered summer EBT and that children who lived in areas with some summer EBT funding ate more nutritious meals than children who qualified for SNAP but did not receive additional summer EBT.¹⁹²

Because Indigenous children currently have higher rates of obesity and diabetes than children of other racial identities, it is especially important to provide targeted interventions that increase their **access (see glossary)** to healthy foods and improve their overall dietary quality. Indigenous children also have particularly high food insecurity rates, so ensuring that Indigenous households have targeted support during the summer months is important to improve equity as well.

Recommendations: Reducing Racial Inequities in Child Nutrition Programs

While there are aspects of child nutrition programs that already support equity, there are also opportunities for CNPs to achieve more racially equitable outcomes among all children. The following recommendations would improve the nutritional divide between children of color and their white peers:



Recommendation 1

Reform nutritional standards and enhance staff education to reduce micronutrient deficiencies



Recommendation 2

Increase financial support for kitchen equipment and food preparation in schools and other meal sites in low-income communities



Recommendation 3

Expand the Fresh Fruit and Vegetable Program (FFVP)



Recommendation 4

Expand the nutritional support children receive when they are not in school



Recommendation 5

Establish a mechanism for CNP beneficiaries to equitably participate in program design, planning, and evaluation



Recommendation 6

Strengthen data collection and disaggregation within Child Nutrition Programs



Recommendation 1

Reform nutritional standards and enhance staff education to reduce micronutrient deficiencies

Context

CNPs should seek to prevent and/or eliminate micronutrient deficiencies among children of color to achieve equitable nutrition outcomes for all children. While Child Nutrition programs focus on children who lack access to nutrient-rich diets, programs will be more effective if the initial program design identifies and plans for nutrient-specific dietary needs based on health issues.

Vitamin D is the most significant micronutrient disparity among children of color. Vitamin D deficiency can be caused by a number of factors, among them lactose intolerance, limited exposure to sunlight, dark skin, and obesity. African American and Indigenous children are more likely than white children to be lactose intolerant^{193 194 195} and obese.^{196 197} Because residents of low-income neighborhoods are disproportionately people of color, African American and Indigenous children in urban and metropolitan areas are less likely to have places to play outdoors and get sufficient exposure to sunlight.¹⁹⁸ The combination of these factors and their darker skin explains why African American children have the highest Vitamin D deficiency rates of all racial groups¹⁹⁹ and Indigenous children also have high rates of Vitamin D deficiency.²⁰⁰

“Many children of color are unable to consume the main source of Vitamin D available at school—milk—because of lactose intolerance. This contributes to high levels of Vitamin D deficiency among children of color.”

Vitamin D plays a key role in child development, and deficiencies have been associated with other health complications that are found disproportionately in communities of color.^{201 202 203} Thus, it is vital that children receive sufficient Vitamin D as part of their daily diets. Currently, milk is the main reliable source of Vitamin D provided in schools under USDA nutrition standards, but as just mentioned, many children of color are lactose intolerant, putting them at higher risk of Vitamin D deficiency.

Children of color are also more vulnerable than white children to iron deficiency. One study showed that the iron deficiency levels of Latino/a children were far higher than those of non-Latino/a children.²⁰⁴ Iron is vitally important; the human body needs it to produce healthy new red blood cells. Children with low iron levels are at higher risk of iron-deficiency anemia.

Child Nutrition programs should recognize and respond to disparities in nutritional risks among different racial/ethnic groups. Programs should offer food options that are more nutritious, **culturally competent**, and **culturally humble (see glossary)**, and should educate front line staff such as cafeteria workers on nutritional inequities.

Recommendation

Adopting these reforms concurrently, so that they work in concert and do not stand in isolation, will be the most effective way of making Child Nutrition programs more racially equitable.

- **USDA should make a concerted effort to eliminate nutritional deficiencies.** Since children of color are disproportionately at risk of deficiencies in two main nutrients, iron and Vitamin D, Child Nutrition programs should provide appropriate amounts of both in readily absorbable forms by:
 - **Working collaboratively to ensure that students of color receive enough iron each day to eliminate current deficiencies.** CNPs are responsible for providing a third of Recommended Dietary Allowances (RDA) through the National School Lunch Program, which serves 22 million students. Increasing the serving size so that it provides half, rather than one-third, of the daily requirement²⁰⁵ would be a good option.
 - **Launch a USDA team, led by nutritionists of color, to determine how both CNPs and the larger public health community can contribute to eliminating nutritional deficiencies, particularly iron.** Such a team should include people from diverse backgrounds, such as school administrators, school kitchen staff, healthcare practitioners, public health specialists, anti-hunger researchers, and parents and students representing various geographical areas, racial identities, and ages. The team’s recommendations should then be piloted under a strong evaluation protocol to identify the practices that show the most promise of reducing key nutritional deficiencies.

- **Expand the list of products approved as meeting the “milk” requirement in school meals, with the goal of increasing Vitamin D intake among children of color.** USAID should offer dairy milk alternatives, including lactose-free milk and plant-based milk options, as well as foods that are either rich in or fortified with Vitamin D, such as orange juice, lactose free or plant-based yogurt, tuna, salmon, egg yolks, and cheese. USDA should increase its reimbursement rates to offset any increased costs related to dairy milk alternatives, particularly for schools approved to provide universal free meals under Community Eligibility policies.
- **Ensure that all eligible children benefit from Child Nutrition programs at school.** Researchers, practitioners, and program designers cannot assume that all eligible students are already participating in nutrition programs. The enrollment and verification process can pose a variety of barriers to children who are in fact eligible. One USDA study found that upfront verification²⁰⁶ and graduated verification²⁰⁷ posed barriers to enrollment for eligible children.²⁰⁸ One way to accurately identify eligible children and boost participation is through the Healthy, Hunger Free Kids Act of 2010, which allows states to use Medicaid data to directly certify children in low-income households as eligible for Child Nutrition programs.²⁰⁹
- **Identify schools that do not offer one or both school meals, prioritizing schools in areas of concentrated poverty.** Some schools offer school lunch but not school breakfast. USDA should work with schools, prioritizing schools located in areas with poverty rates of 20 percent or higher, to expand the meal options available to students.
- **USDA should strengthen efforts to ensure that school officials and staff do not pressure children to consume dairy products.** Training for the staff of schools that offer or are planning to offer the National School Lunch Program, for example, should discuss not only the benefits of dairy milk, but the health risks associated with it, including its impact on lactose-sensitive individuals. Some children of color have been forced to consume milk despite being lactose intolerant. The emphasis should be on providing food options that meet the needs of various groups of students. Training should also emphasize the evidence-based recommendations not to pressure or force children to eat, and how to avoid doing this in real-life scenarios.



Recommendation 2

Increase financial support for kitchen equipment and food preparation in schools and other meal sites in low-income communities

Context

Inequitable financial resources among schools—the result of making property taxes the source of funding—exacerbate disparities in child nutrition. Three of the most significant financial investments to serve school meals are kitchen equipment, staffing, and the initial start-up costs to add a summer feeding program. Schools, churches, and community organizations interested in offering meals for children in areas of concentrated poverty during summer vacation are often discouraged by high start-up costs and complex health and safety regulations.

Recommendation

- **Ensure that school meal sites have access to kitchen equipment and staff funding.** Congress should increase the reimbursement rates for schools, increase the funding available to states through the NSLP Equipment Assistance Grant Program, or both. Increasing the reimbursement rate is more equitable in the sense that obtaining an equipment assistance grant requires an application process that requires staff time and resources, but less equitable in requiring that schools purchase items up front and wait to be reimbursed. State administrators should consider prioritizing schools that also offer the Seamless Summer Option (SSO).
- **Make congregate (group) feeding programs more financially feasible by increasing financial support for meals served during extended school breaks.** The financial burden and regulatory considerations associated with starting a summer/winter break meal site can be overwhelming for community organizations. The financial burden could be reduced by allowing states to grant sponsors initial start-up funding to purchase equipment needed to prepare basic meals and meet state health codes. Increased federal funding would reimburse states.

All eligible SFSP sites are already located in areas in which 50 percent or more of enrolled students qualify for free meals. When allocating grants, states should prioritize sites that have few nearby sites.



Recommendation 3

Expand the Fresh Fruit and Vegetable Program (FFVP)

Context

According to a 2018 Tufts University report, children who are exposed to fresh fruits and vegetables show a 17 percent increase in habitual consumption of healthier foods, compared with children who have not been familiarized with these foods.²¹⁰ Making fresh fruits and vegetables available to children of color is key to improving some of the social determinants of health²¹¹ that harm communities of color, and to countering the barrage of fast food advertising in these communities.

The gap between the ad exposure of African American and white children is widening. In 2013, African American children and teens viewed 70 percent more food ads on TV channels geared to them than their white peers. By 2017, African American children saw 90 percent more ads and teens saw 113 percent more ads than white children in these age ranges.²¹²

The Fresh Fruit and Vegetable Program (FFVP) encourages healthy eating habits. Expanding this program beyond elementary schools is a way to reach more students in high-poverty areas.

Recommendation

- **USDA should automatically certify schools in high-poverty areas as eligible for the FFVP.** These schools already qualify under Community Eligibility policies to serve free school lunch and breakfast to all students; automatically allowing them to participate in the FFVP is a logical extension with similar objectives. Schools that are not located in areas of concentrated poverty, but serve many Indigenous children, should also be eligible to participate in FFVP. Increasing the consumption of fruits and vegetables among Indigenous children can reduce their likelihood of developing diabetes—a serious health condition that affects Indigenous communities at a higher rate than any other racial/ethnic group.²¹³
- **USDA should promote farmers' participation in FFVP and should purchase locally grown food for the program.** This is especially important for schools located on or near reservations, to ensure that Indigenous farmers can work with schools to provide traditional fruits and vegetables. It is also particularly important for schools located in Hawaii. While there has been a push to support locally grown fruits and vegetables through the FFVP, Hawaiian farmers face barriers to growing enough produce to meet the needs of the statewide school system. For example, FFVP requires farmers to carry farm liability insurance, which is very expensive in Hawaii. Many local farms also lack food safety certification.²¹⁴ Lack of sufficient capital is a problem faced by many farmers of color, Indigenous and Native Hawaiian alike. USDA should work with farmers to enable them to expand their capacity to grow produce for the FFVP—for example, through training, inputs, and financial support.
- **USDA should restore and preserve the integrity of the “Fresh” Fruit and Vegetable Program.** The proportion of USDA Fruit and Vegetable commodity purchases that is actually fresh is decreasing. The addition of canned, frozen, and dried fruits and vegetables has led to 25 percent fewer fresh items being served,^{215 216} even though highly processed canned or dried products have less nutritional value. Congress should require USDA to ensure that 80 percent of the program's commodities are fresh. At a minimum, no further expansion of canned or dried products should be approved.
- **Congress should require USDA to improve its nutrition education programs and materials.** Children who are exposed to healthy foods, along with age-appropriate information about why choosing them is important, are much better equipped to make longer-term nutritional improvements to protect their health. One effective program for young children is called the Child Health Initiative for Lifelong Eating and Exercise (CHILE Plus), also referred to as Chile New Mexico.²¹⁷ It is a hands-on nutrition education curriculum for Head Start children in urban and rural areas throughout New Mexico, including many Indigenous and Latino/a students. A program such as this one can be adapted and scaled up to include elementary, middle, and high school students as well.

DID YOU KNOW THAT...

Children of color are more likely than white children to see ads for unhealthy foods in their neighborhoods? The far denser concentration of such ads sends a message that the health and well-being of residents of color is less important—reinforcing racial inequity in nutrition.

SOURCE: <http://uconnruddcenter.org/files/Pdfs/TargetedMarketingReport2019.pdf>



Recommendation 4

Expand the nutritional support children receive when they are not in school

Context

The current network of summer feeding sites has many shortcomings. There are far too few sites to meet the need. In fact, of more than 20 million children who participate in FARMS during the school year, only about three million benefit from summer nutrition programs.²¹⁸ In addition, most summer meal sites do not offer transportation, nor do they reimburse families for transportation costs and time.

Summer meal sites are particularly scarce in areas of concentrated poverty, which are far more likely to be home to food insecure children of color. Community organizations in these areas often qualify to be reimbursed for the meals they serve children over the summer, but they can rarely afford to register with SFSP. In rural areas, particularly on reservations, lack of transportation options may make it either impossible or cost-prohibitive for children to access “free” meals.

Family food insecurity worsens during summer and winter breaks since children are home without access to school meals or after-school snack programs. For most families, SNAP benefits run out in the third week of the month. It is even more difficult to stretch SNAP benefits when, for example, a family’s two teenagers are home for summer vacation, each needing the 10 meals a week they usually eat at school. Families whose children are eligible for free school meals have little if any money saved for emergencies. This is particularly true for families of color because of the racial wealth divide.

Therefore, it is essential to expand Child Nutrition programs to provide children with more nutritional support during extended school breaks.

Recommendation

- **Appropriate funds to expand the summer EBT (Electronic Benefit Transfer) Program**, which provides additional SNAP benefits to families with children on summer break. This support should also be available during winter vacation and, for year-round schools, to vacation periods.²¹⁹ Expanding the program will help ensure that families can make up the “missing meals” children get at school when it is not in session.

According to a 2016 Food and Nutrition Service (FNS) report,²²⁰ an increase in summer EBT of \$60 a month reduced the most severe forms of food insecurity by one-third and generally showed positive change in nutrition outcomes, as seen in the results of the Summer EBT demonstration project.^{221 222}

- **Make non-congregate feeding programs more accessible by increasing financial support for hard-to-reach areas.** About 3 million children are reached at summer meal sites through the Summer Meals Program (in policy terminology, these sites are a type of “congregate feeding,” meaning that meals are served to groups). The evidence shows that summer EBT is more effective in reaching children, so this should be the choice in most situations. However, some congregate feeding sites combine providing nutritious meals with other goals, such as helping to prevent summer learning loss.²²³

In other cases, such as in hard-to-reach areas with no consistent meal site sponsor, the best option might be to use mobile meal sites, learning from demonstration projects in Georgia²²⁴ and Montana,²²⁵ as recommended by a 2018 Government Accountability Office (GAO) report, “Summer Meals: Actions Needed to Improve Participation Estimates and Address Program Challenges.” The report outlined transportation barriers and the need for more flexibility in rural areas.²²⁶ For a chart summarizing the barriers identified by GAO and details on the No Kid Hungry food truck initiative, see Appendix 11.



Recommendation 5

Establish a mechanism for CNP beneficiaries to equitably participate in program design, planning, and evaluation

Context

Part of racial equity is ensuring that the needs of communities of color are being placed at the center of how policies and programs are designed, implemented, and evaluated. In order to do this, CNPs need processes in place to enable communities to participate and tell their own stories. Currently, the only infrastructure available to receive feedback from the general public

is for agencies to request comments. This has no formal means of ensuring that the experiences of communities of color are captured and is not a proactive way of equitably involving participants of color in all three stages.

Recommendation

- **USDA should develop additional ways for recipients to participate in the design, implementation and evaluation of Child Nutrition programs.** This requires USDA to literally meet recipients where they are, gathering feedback from children, parents, and school staff to better gauge (1) the effectiveness of the program(s), (2) to what extent the program is improving nutrition outcomes for students, (3) areas for improvement, (4) suggestions on how to eliminate the racial nutrition divide, and (5) recommendations as to how to equitably empower children, parents, and staff in decision making processes. Listening tours and focus groups can yield important feedback.

USDA should have a formal way of tracking the racial demographics of schools to ensure that feedback is received from all racial and ethnic groups in a wide range of geographic settings. Whether everyone is represented should be assessed at all three stages: design, implementation, and evaluation. USDA might consider establishing a working group of students, parents, and school administrators of color to help manage the collection and incorporation of feedback, and/or holding group sessions at school for people to offer comments. Participants should be compensated for their time at a living wage rate.



Recommendation 6

Strengthen data collection and disaggregation within Child Nutrition Programs

Context

Currently, there is little publicly available disaggregated data on nutrition levels among children who participate in CNPs. While data is available on indicators such as anemia, vitamin D, and iron, it is not broken down by whether or not children benefit from CNPs. Improving program policies requires accurate information on trends among the recipients—particularly baseline indicators. Without this information, researchers cannot assess the impact of CNPs on nutrition among children of different races, incomes, ease of access to fully funded programs, or other distinctions. There are no conclusions as to how programs are performing, either on nutrition in general or the racial nutrition divide.

Recommendation

- **Collect and report race and ethnicity data.** Child Nutrition programs should collect and publish disaggregated data on race and ethnicity in each program.
- **Collect and report nutritional data for children who participate in Child Nutrition Programs.** Researchers for this report were unable to find data on
 - Iron and Vitamin D deficiencies among African American and Indigenous children benefiting from CNPs
 - Other deficiencies among children benefitting from CNPs, by race and ethnicity
 - Average consumption of iron, vitamin D, and other nutrients for child by race and ethnicity
 - Variations in the quantities of iron, vitamin D, and other nutrients in school meals, by school racial and ethnic demographics and location
- **Conduct research to understand the impact of various Child Nutrition programs on the nutritional status of children of color.** Top priority topics include:
 - The impact of receiving school meals on rates of micronutrient deficiency, primarily iron and vitamin D deficits, but others as well, by race and ethnicity
 - The impact of increased funding for school kitchen equipment on food preparation and nutrition
 - The impact of several factors on participation rates in different Child Nutrition programs, disaggregated at a minimum by race, ethnicity, and grade in school
 - The impact on program participation of applying a cultural sensitivity lens to the promotion of Child Nutrition programs, disaggregated at a minimum by race, ethnicity, and grade

Conclusion

Ending hunger and poverty is possible, but it requires addressing the root causes. Structural racism is the most significant cause of hunger and poverty in communities of color. Ending hunger by 2030 requires fully committing to and applying a racial equity lens to all policies and programs.

Since many policies and programs currently do not apply a racial equity lens, embedding this lens in anti-hunger policies and programs is a top priority. Racial equity is not just a goal, though—it is also a daily commitment and practice. Advocates, researchers, practitioners, and policymakers must commit to being intentional about racial equity.

As mentioned earlier, to achieve racial equity in any area, it is important that a racial equity lens be comprehensively applied at the legislative, administrative, and implementation levels. It calls for a true multi-layered approach, which is why the report's recommendations reflect this application at all three levels.

A racial equity approach should be applied in all policy areas, including but not limited to nutrition, to end hunger. The methodology of this report can be used to apply a racial equity lens to other nutrition programs in addition to SNAP, WIC, and Child Nutrition programs, as well as to other policy areas, such as jobs, housing, asset-building, transportation, health care, and more.

As a recap, the Institute started this research by not making assumptions about whether or how federal nutrition programs promote various forms of equity. The three most important equitable aspects of the programs were identified as:

1. Elements of inclusivity in eligibility criteria.
2. Policies that target support to individuals and families most in need.
3. Promotion of equity-centered approaches that make it easier for people to participate.

The Institute also identified opportunities for SNAP, WIC, and Child Nutrition programs to strengthen their design by applying a racial equity lens. The top six recommendations are:

1. Center program solutions around the needs of communities of color
2. Expand inclusivity
3. Strengthen practices that make it easier for applicants to access support
4. Increase support and accountability among implementing staff
5. Create structures that empower recipients of color to equitably engage in improving programs
6. Strengthen the collection and reporting of data disaggregated by race and ethnicity

Strengthening racial equity will help communities of color as well as people of all races who benefit from nutrition programs. By definition, it will also begin to narrow the persistent racial disparities in nutrition and food security.

An overarching recommendation that USDA might consider is to create a Special Commission for Racial Equity, which should be led by researchers, practitioners, and program participants of color, to assist in the implementation of the recommendations in this report and to identify additional changes that would promote racial equity. The individuals selected for this effort should have real decision-making power rather than simply being asked to comment. The commission's work should also inform the efforts of other USDA offices and programs to apply a racial equity lens to new areas and issues.

In turn, a transformed internal culture that reflects racial equity makes it easier to create processes, narratives, and analysis that are racially equitable as well. It can inform the efforts of other offices and programs to apply a racial equity lens to new areas and issues. All of this will contribute to shifts in federal policy that will move the country more quickly to the end of hunger and poverty—problems that are completely unnecessary in such a wealthy country.

“Ending hunger is possible, but it requires addressing structural racism with racial equity.”

To learn more about how to apply a racial equity lens in your organization, see **Tool 1 in the Appendix** on page 75 and read this [resource from the Alliance to End Hunger](#).

GLOSSARY

Below are a few vocabulary words for this report

Hunger: Hunger is more than the stomach pains we associate with skipping meals. The U.S. Department of Agriculture measures hunger using the concept of food security,²²⁷ or whether a person or household has regular, reliable access to the food needed for good health. A *food secure* individual or family is able to consistently eat enough nutritious food with no indication of problems with gaining access to food.²²⁸ People with *low food security* may be forced to buy cheaper but less nutritious foods so they can feel full for less money, and they may worry about running out of money for food altogether.²²⁹ The USDA category *very low food security* includes people forced to skip meals or otherwise “reduce their food intake.”²³⁰ The nutrient-poor diets associated with low food security frequently cause or worsen short-term and long-term health problems.²³¹

Equity: Equity is a state in which all people in a given society share equal rights, access, opportunities,²³² and outcomes that are not predicted or influenced by their identity characteristics,²³³ including race, gender, and class. Equity is achieved by providing targeted investments to support people in different circumstances in benefiting equally from opportunities. Such equitable opportunities lead to equal outcomes. There are many types of equity, such as racial equity, gender equity, and class equity.

Equality: Equality has traditionally been defined as “treating everyone the same.” But doing this cannot lead to equal or optimal outcomes because it does not account for different circumstances and needs or the impact of historical discrimination. By accounting for these factors, equality would foster equitable outcomes.

Racial Equity: Racial equity is achieved when communities of color are supported in ways that help compensate for the structural discrimination they encounter. Targeted investments provide equitable opportunities for communities of color that lead to equal outcomes among communities of color and their white counterparts and eventually to optimal outcomes for each community. For more on this, see Appendix, Tool 2.

Racial Equity Lens: Applying a racial equity lens is the *process* through which providing opportunity and access to opportunity become equitable. Applying a racial equity lens provides targeted support to communities of color to create equitable opportunities that eliminate racial disparities and eventually lead to optimal outcomes for communities of color.

Equity-Centered Approaches: Equity-centered approaches are designed to move people toward equality by providing targeted, equitable support based on circumstances or need.

Centering: In general, this means focusing on the needs of marginalized communities. In the context of this paper, it means focusing on the needs and barriers that communities of color face. As a result of focusing on these needs and making informed decisions to address them, programs and policies become more racially equitable.

Access: The ability to attain a particular good, opportunity, or treatment. Individuals do not face geographic, transportation, monetary, linguistic, time, or cultural barriers to “entering,” nor do they face such barriers when receiving or participating in a treatment, opportunity, or good. This definition enables people to see that access is “only fair.” For more, see the section on the curb-cut effect on page 12.

Concentrated Poverty: Concentrated poverty means that 20 percent or more of a community’s households live below the poverty line.²³⁴ Concentrated poverty is associated with a variety of deserts, including food deserts, transit deserts, and asset-building deserts, where neighborhoods with predominately residents of color lack access to full-fledged grocery stores, public transportation, equitable financial institutions, and many other goods. Concentrated poverty can exist in urban, suburban, and rural settings, including reservations.

People of Color: People of color are all people who are not white or of European parentage. The U.S. census problematically categorizes some people of color as white, including non-black Latino/as and people of Arab descent. In this paper, the term includes all people of color but emphasizes communities of color in the United States that have the highest rates of hunger. This includes Indigenous communities (Alaskan Native and American Indian), African American and Pan African communities, which can include black Latino/as; Latino/as (an ethnicity that can encompass black, Indigenous, Asian, and other), Native Hawaiians, Pacific Islanders, and some groups of Southeast Asian descent (Laotians, Cambodians, and Burmese).

Note: Latino/a is used instead of Latino to include both Latinos and Latinas.

Racial Nutrition Divide: The racial nutritional divide refers to a set of nutritional disparities between people of color and their white counterparts. Applying a racial equity lens would result in communities of color having equitable access and opportunity that would eliminate such disparities.

Racism: Racism is a system in which public policies, institutional practices, cultural representations, interpersonal relations, and other norms reinforce the inequality and inequity of people of color.²³⁵ There are four types of racism: structural, institutional, interpersonal, and internalized²³⁶ (see graphic at right):

Structural and institutional racism take place on the systemic level, whereby racial bias takes place within institutions and systems create policies, practices, culture, and ideologies that harm people of color and usually uphold the privilege of white people. Interpersonal and internalized racism take place on the individual level, whereby private beliefs and biases, as well as the way in which individuals interact with one another, is marked by conscious or unconscious bias.

Ten Lowest Paying Jobs: The 10 lowest-paying U.S. occupations are concentrated in the retail, domestic work, and food preparation sectors.²³⁷ Men and women of color, as well as white women, are disproportionately represented in these occupations. Workers of color are consistently paid

less than their white counterparts,²³⁸ and women, regardless of race, consistently are paid less than their male counterparts.²³⁹ Hairdresser/ hair stylist/cosmetologist is ranked as the lowest-paid occupation for women, followed by retail, food preparation, and domestic work. For men, the lowest-paid occupation is retail, followed by food preparation and laboring positions.²⁴⁰

Stereotypes: A stereotype is a thought or belief that people adopt to reflect characteristics and images of individuals within specific identity groups. They usually form outside conscious awareness. These thoughts and beliefs are often over-simplified, rooted in bias, and created and sustained by the dominant culture. Stereotypes generally cause harm when individuals from specific groups interact with the general public and with entities in the public and private sectors. Stereotyping reinforces prejudice against people from specific groups, which causes discrimination against people within these groups, influencing the way people are treated in interpersonal situations and within institutions. Stereotyping is pervasive within mainstream culture; groups can be stereotyped by people who belong to that group as well as by outsiders.

To achieve racial equity, racial stereotyping must be addressed at all levels, but particularly when these stereotypes influence federal, state, and local policy decisions.

Cultural and Linguistic Competency: Cultural and linguistic competency is composed of a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.²⁴¹ Competence implies having the capacity to function effectively as an individual and as an organization

THE FOUR TYPES OF RACISM

Individual-Level Racism

Internalized Racism lies within individuals. These are our private beliefs and biases about race and racism, influenced by our culture. Internalized racism can take many different forms including racial prejudice toward other people of a different race; internalized oppression, the negative beliefs about oneself by people of color; or internalized privilege, beliefs about superiority or entitlement by white people. An example is a belief that you or others are more or less intelligent, or beautiful, because of your race.

Interpersonal Racism occurs between individuals. These are biases that occur when individuals interact with others and their private racial beliefs affect their public interactions. Examples include racial slurs, bigotry, hate crimes, and racial violence.

Systemic-Level Racism

Institutional Racism occurs within institutions and systems of power. It is the unfair policies and discriminatory practices of particular institutions (schools, workplaces, etc.) that routinely produce racially inequitable outcomes for people of color and advantages for white people. Individuals within institutions take on the power of the institution when they reinforce racial inequities. An example is a school system that concentrates people of color in the most overcrowded schools, the least-challenging classes, and the least-qualified teachers, resulting in higher dropout rates and disciplinary rates compared with that of white students.

Structural Racism is racial bias among institutions and across society. It involves the cumulative and compounding effects of an array of societal factors including the history, culture, ideology, and interactions of institutions and policies that systematically privilege white people and disadvantage people of color. An example is the overwhelming number of depictions of people of color as criminals in mainstream media, which can influence how various institutions and individuals treat people of color with suspicion when they are shopping, traveling, or seeking housing and employment—all of which can result in discriminatory treatment and unequal outcomes.

SOURCE: "Four Types of Racism." Oppression Monitor. Jan 2014. <http://oppressionmonitor.us/2014/01/31/four-types-racism/>

within the context of the cultural beliefs, behaviors, and needs, as well as the linguistic needs, of consumers, recipients, and/or participants.²⁴² Achieving racial equity would require honoring cultural and linguistic competency when federal policies are designed and when state and local governments administer them. Tribal sovereignty must also be honored.

For more information on cultural and linguistic competency, [access information from the Department of Health and Human Services](#).

Note: Cultural competency is different than cultural humility. Both should be learned and practiced to ensure that interpersonal racism is addressed.

Cultural Humility: Cultural humility is a practice that is necessary to the process of developing and maintaining mutually respectful and dynamic partnerships with different communities.²⁴³ This practice incorporates a lifelong commitment to self-evaluation and self-critique. In nutrition programs, it includes efforts to redress the power imbalances in the dynamic between staff and recipients. This includes but is not limited to patient-physician relationships and relationships between WIC, SNAP, and CNP caseworkers and front line staff and program beneficiaries. Cultural humility is different than cultural competency since it is an ongoing process and focuses on self-critique and self-awareness of the practitioner or service provider.

Historical Trauma: Historical trauma refers to the violent history that many communities of color, particularly Indigenous and African American communities, have been forced to endure in the United States. Historical trauma may take recognized forms such as ethnocide (destruction of culture, language, etc.) or genocide (the mass killing of individuals in a specific group with the intention of permanently obliterating that group)

Historical trauma started with colonization and the attempted genocide of Indigenous people as a result of European land takeover, violence, and exposure to disease. The transatlantic slave trade was an attempt at genocide of Africans from different parts of the continent. In addition to mass killings, Indigenous and African cultures lost customs and languages. This trauma was compounded by continuing violence, including mass forced migration of Indigenous people and forced chattel slavery and dehumanization of African people.

For Indigenous people, historical trauma continued after forced migration with continuing land takeover, violations of treaties, and forced family separations with children sent to boarding schools. This resulted in the loss of traditions, culture, language, and familial ties among generations of Indigenous people. Similar forms of historical trauma occurred for African Americans, in abuses such as continued economic slavery through sharecropping and other forms of economic bondage, pervasive abuses in an expanded racist criminal justice system, extrajudicial atrocities such as lynching, and legalized school and residential segregation.

Historical trauma impacts economic empowerment, mental health, and nutrition as well as other aspects of life. Applying a racial equity lens to federal nutrition policies requires honoring the impacts of historical trauma and responding to its root causes in order to start a healing process.

Returning Citizens: Returning citizens are individuals who are returning from incarceration, either from jail or prison. Some returning citizens are released and are still under the supervision of the Department of Corrections, and others are released without this stipulation. For more information about the connections between mass incarceration and hunger, and the realities that confront returning citizens and their families, please read “[Mass Incarceration: A Major Driver of Hunger](#).”

Prime-Aged Workers: Disconnected workers are prime-aged workers between the ages of 18 and 49 who are not equitably connected with the workforce, for a variety of reasons, including employment discrimination leading to underemployment and/or long-term unemployment. As a result of employment disparities, many disconnected workers have missed opportunities to establish and build on skills—making them less “employable” in the eyes of many employers. This perception often reinforces yet another cycle of disconnection for people in this group.

Breastfeeding Initiation Rate: The breastfeeding initiation rate is the percentage of new mothers who begin breastfeeding their newborns. Women who do not initiate breastfeeding may be making that decision for a variety of reasons, including having to return to work almost immediately; not having a workspace environment supportive of breastfeeding or pumping breastmilk; having a premature infant not strong enough to breastfeed at first; having difficulty with the baby latching; or as a personal decision.

Breastfeeding Duration Rate: Breastfeeding duration rate is the length of time for which a mother breastfed her infant. Breastfeeding duration is often divided into (1) the period when an infant consumed breastmilk only (exclusive) and (2) the period when an infant consumed breastmilk along with other forms of food (non-exclusive).²⁴⁴ Exclusive breastfeeding durations may be measured at three-month intervals, e.g., “exclusively breastfed through 3 months” and “exclusively breastfed through 6 months.” Non-exclusive breastfeeding durations often include “ever breastfed,” “breastfed through 6 months,” and “breastfed through 12 months.” Each reference in this paper specifies which form, exclusive or non-exclusive, is meant.

APPENDIX

This appendix contains tools, brief historical context, and analysis of issues mentioned in the paper, and various tables and charts.

Appendix, Tool 1: Questions to Ask to Apply a Racial Equity Lens

Please refer to page 73 for the original methodology. This tool has a series of detailed questions that helped shape the process of gathering and evaluating information for the paper. While this is a process that was applied to analyze racial equity in selected federal nutrition programs, it is Bread for the World Institute’s hope that others will find this process helpful in applying a racial equity lens to policies and programs relevant to their work.

Appendix, Tool 2: What is Racial Equity?²⁴⁵

According to Race Forward, a national racial justice organization, racial equity is “the systematic fair treatment of people of all races that results in equitable opportunities and outcomes for everyone.”²⁴⁶ The Center for the Study of Social Policy describes it as the condition that would be achieved if one’s racial identity no longer predicted the opportunities and barriers that one experiences.²⁴⁷ To achieve racial equity, we must apply a racial equity lens (see glossary for definition).

Approaches that are targeted to produce equity for all groups lead to the achievement of a universal goal (see graphic below).



Appendix 1: History of Breastfeeding Among African and Indigenous Americans

Low breastfeeding rates among African Americans date back to slavery. Enslaved black mothers were sometimes forced to stop breastfeeding their own infants to nurse their master’s infants. Sometimes they were permanently separated from their babies.²⁴⁸ In many instances, each time the master’s wife was pregnant, the enslaved woman was expected to get pregnant as well so that she could nurse the master’s infant.²⁴⁹ A black mother’s milk did not sustain and protect her own child—rather, it nourished the babies of the master. White infants received the benefits of breastfeeding, while black infants were left without this nutritional support.

This exploitation of black motherhood and the bodies of black women caused many women of later generations to associate breastfeeding with being an enslaved wet nurse. In some African American communities, rejecting breastfeeding was seen as women asserting control over their own bodies and expressing their freedom.²⁵⁰ This view was reinforced by corporations' aggressive marketing of formula to African American mothers in the early 1900s to mid-1900s. Formula was promoted as a modern alternative to breastfeeding.²⁵¹

The history of indigenous people has also contributed to today's lower breastfeeding rates. Indigenous women from many groups had a strong tradition of breastfeeding their children.²⁵² It was considered a first food for infants. However, the United States has a long history of violence against Indigenous people—including even genocide, as well as forced migration and cultural erasure²⁵³—that disconnected many from their histories.

Later, for two generations, many Indigenous children were forcibly separated from their families and sent to boarding schools, where they were required to learn English and adopt the customs of white people.²⁵⁴ Some children could not travel home for the summer and therefore went as long as six years without seeing their parents.²⁵⁵ This disruption of family life meant that many traditions, including home languages and cultural norms such as breastfeeding, were lost rather than passed down from grandparents and parents to children. Compounding the problem, the family separation era coincided with the arrival of WIC offices on or near tribal lands. Many Indigenous people recall the WIC office as a “formula center” that promoted formula over breastmilk²⁵⁶ and further reduced breastfeeding rates.

Appendix 2: Everyday Occurrences of Racism

In addition to historical trauma from racism, racism remains embedded in the structures under which women of color live. Structurally racist policies such as redlining have segregated the neighborhood where she lives²⁵⁷ and stripped wealth from her neighborhood²⁵⁸ or reservation. She is very often a low-wage worker, due in large part to job segregation by race and gender.²⁵⁹ The environment she lives in²⁶⁰ is at higher risk of air and water pollution because of racially unjust environmental policies and practices, such as disproportionately establishing hazardous waste disposal sites near neighborhoods of color. Other important areas of life have also been shaped by racism. Women of color experience such “ordinary” racism and trauma on a daily basis.

Refer to figure 2 on page 11 for additional context on the impact of racism on communities of color.

Appendix 3: Racism Impacts Maternal Mortality

Research shows that structural racism directly contributes to maternal mortality through factors such as limited access to quality prenatal care, lack of equitable access to a nutritious diet, and preexisting conditions. Women who do not receive prenatal care are three to four times as likely to die as a result of pregnancy and childbirth.²⁶¹ Data indicate that African American and Indigenous women are between 2.2 and 2.5 times as likely to receive late or no prenatal care as white women.²⁶² Native Hawaiian women are twice as likely not to begin prenatal care until the third trimester of pregnancy.²⁶⁴ According to the Centers for Disease Control, African American women are three times as likely as white women to die from complications during pregnancy or childbirth.²⁶⁵ Researchers now know that this is true regardless of a woman's income or level of education, leading to a theory that living in a racist society is an independent risk factor.

The fact that many low-income communities of color are “food deserts,” meaning that they are far from the nearest full-service grocery store, is partly a reflection of racism in neighborhood design.²⁶⁶ Pregnancy is riskier in a food desert since there are higher rates of nutrition-related health problems such as iron-deficiency anemia, which is a significant factor in maternal mortality.²⁶⁷

Lastly, racism leads to lower-quality care during pregnancy and childbirth—part of generally high levels of racial discrimination in medical care. Providers are more likely to underestimate the pain of African American patients,²⁶⁸ ignore symptoms, and dismiss complaints. Studies such as one published in the Proceedings of the National Academy of Sciences have quantified racial bias in the medical treatment of African Americans.²⁶⁹ A study from Emory University found that among patients with similar bone fractures, a hospital in Atlanta prescribed painkillers for 74 percent of the white patients and only 50 percent of the African American patients.²⁷⁰ A third study found that physicians were more likely to underestimate the pain of black patients than of other patients.²⁷¹ Women of color have reported instances of discrimination during prenatal visits, labor and delivery, and postpartum care, all of which contribute to higher maternal mortality rates.

Understanding the devastating consequences of racism in healthcare settings reinforces the importance of applying a racial equity lens and practicing cultural humility.

Appendix 4: Why Culturally Appropriate Foods are Important

Food is an important part of people's lives and identities, and on a more practical level, people usually cook with foods that are familiar to them.

- **Food as a source of identity.** A person's diet can be used to identify him or her as part of one group rather than another. According to studies from anthropologists, food habit researchers, and sociologists, eating is a daily reaffirmation of one's cultural identity.^{272 273} In most cultures, food can be seen as a source of comfort and love. It is used to communicate emotions, affirm community, or begin healing processes. In Indigenous communities, for example, traditional food has long been used during ceremonies, dances, and prayers, and sometimes even to share oral history.²⁷⁴ The foods that we eat are a core part of who we are. Confronting barriers to purchasing foods that are nutritious and culturally familiar discourages people from expressing who they are.
- **People cook and eat familiar foods.** Offering only food options that are outside a person's normal diet can create additional barriers to good nutrition. People who are often already working long hours need to take time to learn to cook the new food and develop an appetite for it. When nutrition programs choose instead to offer a variety of options in food groups with similar nutrient content, it is more equitable and empowers recipients to use ingredients in culturally relevant ways.

Appendix 5: History of Licensing in the Healthcare Field

Racism also marks the history of licensing in the healthcare field.²⁷⁵ Until the mid-20th century, many babies born in the South, both African American and white, were delivered by African American women health providers. Known as "granny midwives," they did the work of today's doctors, midwives, and doulas before hospital birth became the norm. In the era of slavery, such women were of critical importance to slave masters, who depended on their expertise to safely deliver their own babies as well as slave babies. During Jim Crow segregation, midwives were critical to African American health care, and they were trained, respected healers in their communities.

Toward the end of the 19th century, childbirth among urban whites was becoming medicalized, but African American communities, particularly in rural areas, were excluded from this trend. White healthcare providers still refused to treat African American patients, so midwives remained critical to safe childbirth. By the 1970s, births in hospitals attended by doctors (and later nurse midwives) had become the norm, and community midwives were phased out.²⁷⁶

This was made possible by (1) the passage of laws and policies regulating the practice of medicine, (2) the introduction of certificate and degree requirements to work in the healthcare field, and (3) a racialized campaign to discredit African American midwives. Because the new rules required medical training and licensure to provide childbirth services, African American midwives who could not afford to receive training or pay licensing fees were forced out of the field altogether. In addition, there was an organized racist campaign that portrayed midwives as uneducated, unsafe, and dirty. These factors led to today's lack of racial diversity in the healthcare field, which makes it less likely that mothers of color can receive supportive care from other women of color. To see a video recounting this history, [please click here](#).²⁷⁷

More recently, cost remains a barrier to entry into the healthcare field for many women of color. White women from middle-class backgrounds are more likely to be able to meet the educational requirements to become International Board Certified Lactation Consultants (IBCLC).²⁷⁸ Becoming a nurse or a doula, or undergoing a set number of hours of training in addition to passing an exam,²⁷⁹ are sometimes required. Peer counselors often do not have the opportunity to fulfill all the requirements. Jobs that require the IBCLC are often poorly paid unless the woman is also a registered nurse, so women without other sources of income have limited opportunities to work in the industry.²⁸⁰ Licenses are expensive, and there is a history of discouraging if not outright prohibiting black women from qualifying for them. Most recently, the Affordable Health Care Act has limited reimbursement for expensive equipment such as breast pumps, which can cost up to \$300, to only IBCLCs who are in network.²⁸¹

The result of this combination of factors is that lactation consultants are disproportionately white. There is a need for more lactation consultants of color to increase breastfeeding rates among new mothers of color. Expanding the network of providers WIC participants are allowed to see, along with training more women of color as lactation consultants, could help ensure that more African American infants and other infants of color receive the nutritional benefits of breastfeeding. Lactation is an issue where it is important to have culturally competent advice from people with whom one feels comfortable.

Appendix 6: Child Nutrition Programs (CNP)

Program	Description (including where and what food is served)	Eligibility	Setting
National School Lunch Program (NSLP) <i>*includes lunch and after-school snacks</i>	Federal reimbursement to schools that serve school day lunches to all students enrolled in public and non-profit private schools, in exchange for the school (1) offering free or reduced-priced meals to those who qualify and (2) following set nutrition standards.	Children from families with incomes below 130 percent of the federal poverty level are eligible for free lunch, while children from families with incomes between 130 percent and 180 percent of the federal poverty level are eligible for reduced-price lunch.	In school
	<i>The National School Lunch Program also includes the option for students to receive daily snacks.²⁸²</i>	<i>To receive reimbursement for after-school snacks, a school must (1) be currently enrolled in NSLP, (2) serve snacks that meet federal requirements, and (3) offer snacks free or at reduced prices to eligible students.</i>	
	National School Lunch Program Provision: Community Eligibility Provision (CEP): Schools that participate in the National School Lunch Program/School Breakfast Program have the option of using the Community Eligibility Provision. This provision applies to schools where at least 40 percent of enrolled students are categorically eligible for free or reduced-price meals. It allows these schools to provide free lunch and breakfast to all students. A public or nonprofit private school, a full school district, or an area within a district that meets these qualifications can apply for Community Eligibility.		
School Breakfast Program (SBP)	Federal reimbursement to schools that serve school day breakfasts to all students enrolled in public and nonprofit private schools, in exchange for the school (1) offering free or reduced-price meals to those who qualify and (2) following set nutrition standards.	Same as NSLP.	In school
	School Breakfast Program Provision: Community Eligibility Provision (CEP): Same as NSLP.		
Fresh Fruit and Vegetable Program (FFVP)	Program that introduces new fresh fruits and vegetables to children at schools with the highest rates of free meal eligibility. Schools receive additional funding per student annually in order to implement the program, which promotes nutrition education along with serving the fruits and vegetables. Must be offered at a time other than lunch and breakfast.	Elementary schools with the highest rates of free and reduced-price meal eligibility are given priority.	In school

Program	Description (including where and what food is served)	Eligibility	Setting
Summer Food Service Program (SFSP)	Program that reimburses providers who serve meals to low-income children when school is not in session.	Sites in which at least 50 percent of the children enrolled are eligible for free or reduced-price meals may register with the SFSP.	Nonprofits, schools, churches, or other qualifying meal sites
Seamless Summer Option (SSO)	An extension of the NSLP and SBP to the summer months for schools that participate in them	Same as SFSP.	Schools that also administer NSLP during the year
Child and Adult Care Food Program (CACFP)	CAFP sites receive reimbursement for meals and snacks served to low-income children at after-school centers, daycare centers, and childcare centers.	Eligibility varies based on specific site and program, but eligibility guidelines are closely aligned with those for NSLP and NBP.	After-school centers

**NOTE: "In School" programs are offered only at a school and only during the school year.*

Appendix 7: SNAP Alternatives (NAP and FDPIR)

Not all households that qualify for nutrition assistance receive SNAP. There are two programs that act as alternatives to SNAP: FDPIR and Nutrition Assistance Block Grants (NABG).

People living on or near a reservation, as well as all residents of Oklahoma, have the option of applying for FDPIR (the Food Distribution Program on Indian Reservations).²⁸³ It is not available to Indigenous people who live neither on or near a reservation nor in Oklahoma.²⁸⁴ This program provides specialized food packages to low-income Indigenous households, including elderly people who may have mobility limitations, that include traditional food options.²⁸⁵ Households that receive FDPIR may also qualify for SNAP, but cannot participate in the two programs simultaneously. It is important to note that not all households that participate in FDPIR qualify for SNAP. FDPIR food is usually provided at a distribution center, which can differ depending on their location. Some FDPIR distribution centers are set up like grocery stores, with all the food labeled and organized by aisle. At other centers, people need to fill out a request list and wait for a staff member to retrieve and bring them the items.²⁸⁶ Since the distribution centers are on the reservation, program participants do not have to travel long distances to obtain food.

The 2018 farm bill made some changes in FDPIR to increase cultural sensitivity and economic equity. Perhaps the two most significant changes are a new \$5 million demonstration project authorizing tribes to purchase food for the FDPIR under "638" tribal self-determination contracts, and the addition of "regionally grown" to the FDPIR purchase provision for traditional foods.²⁸⁷ Both changes empower Indigenous farmers and respect regional dietary and cultural differences among tribes.

The second nutrition program that falls outside SNAP is a group of block grants for food assistance in Puerto Rico, American Samoa, and the Northern Mariana Islands, known as Nutrition Assistance Block Grants (NABG).²⁸⁸ Through these block grants, each territory administers the Nutrition Assistance Program (NAP). NAP functions slightly differently in each territory. In Puerto Rico, households receive a monthly benefit, composed of 25 percent cash and 75 percent non-cash Electronic Benefit Transfer (EBT) amount, which can be used at grocery stores to purchase food.²⁸⁹ The entire benefit, cash and non-cash, may only be used to purchase eligible food items. In the Commonwealth of Northern Mariana Islands, 30 percent of a household's NAP monthly benefits must be spent on locally grown, raised, caught, or processed food products. Households can decide to spend the remaining 70 percent on local or imported food products, as they choose.²⁹⁰

Appendix 8: State Practices that Create and Widen Inequity

State Practices	How is this practice inequitable?
Asset Limits	Assets can make the difference as to whether or not a family has a buffer against falling deeper into hunger or poverty in the case of a financial emergency, such as an illness or job loss. ²⁹¹ While the goal of establishing asset limits for participation in nutrition programs was to target families most in need, the unintended consequence has been to discourage families from building assets in the hope of remaining eligible for much-needed support. ²⁹² States have the option of using the Broad Based Categorical Eligibility (BBCE) policy to raise the limit on permitted assets and of eliminating asset limits altogether. ²⁹³ States that have used these options have higher rates of low-income households with bank accounts or other banking relationships, and higher savings rates among low-income households—both of which are needed for financial empowerment. ²⁹⁴ Conversely, states that still maintain asset limits, especially low asset limits, are associated with lower rates of households participating in banking and saving activities.
Connecting SNAP with child support	Making SNAP benefits contingent on child support and/or requiring cooperation from child support is inequitable for two reasons: (1) it can deter women who are fleeing domestic violence from applying for SNAP benefits due to fear associated with continuing relations with their abusers, and (2) it worsens food insecurity among non-custodial parents who are already dealing with high levels of food insecurity. Parents who are food insecure are more likely to be unable to provide for their children.
Banning Returning Citizens from Receiving SNAP	Black and brown communities are disproportionately profiled, arrested, incarcerated, and sentenced. ²⁹⁵ Therefore, they are disproportionately impacted by any partial or permanent ban on people with criminal records receiving SNAP. Some states have a lifetime ban on SNAP participation for anyone with certain felony drug convictions, while others place restrictions on returning citizens if they are reported to be noncompliant with parole conditions. Still others impose a period of ineligibility after release or require that all parole and probation requirements be completed before a person is eligible. ²⁹⁶ The majority of bans on receiving SNAP affect people convicted of drug offenses. Due to the so-called War on Drugs in the 1980s, which disproportionately targeted low-income communities of color, those impacted are disproportionately people of color. Despite the fact that studies show that returning citizens are more likely to experience hunger post-incarceration—according to the National Institutes of Health study, the rate is 91 percent ²⁹⁷ —returning citizens receive the least amount of support.
Mandating Stricter Work Requirements	Currently, SNAP has work requirements for all people ages 18 to 45, unless they are ill or disabled, caring for a child under 6, or caring for a disabled family member. ²⁹⁸ People who are subject to work requirements must participate in qualifying work activities for 80 hours a month. If they do not, then they may only receive SNAP for three months in any three-year time period. ²⁹⁹ In areas where there are not enough jobs available, states have the option to waive the work requirement, mandate participation in training, or temporarily suspend the three month time limit. ³⁰⁰ Some states, however, have pushed for additional and/or stricter work requirements, which has in effect created an additional barrier for recipients looking for stable work rather than helping them conduct effective job searches. ³⁰¹ It also ignores the reality of low-wage work, which has erratic hours and a lot of turnover. ³⁰² Work requirement policies tend to harm people most in need of assistance and people facing job discrimination—both groups disproportionately people of color. ³⁰³

Appendix 9: Higher Food Prices in Indigenous Communities

A study conducted by the First Nations Development Institute tracked food prices in 40 Indigenous communities from December 2016 through November 2017. The food items included dairy (milk), eggs, meat (ground beef and whole chicken), fruit (apples), and vegetables (tomatoes). Here we can see at a glance that for Indigenous communities, particularly Alaskan Natives, these common grocery items cost much more than the national average—sometimes twice as much or even more.

Food Group	Food Item	U.S. National Average	Native Communities (including Alaskan Natives)		Average Cost to Alaskan Natives	
			Average Cost	Additional Amount Paid By Indigenous Communities	Average Cost	Additional Amount Paid By Alaskan Natives
Dairy	Milk (per gallon)	\$3.25	\$4.82	\$0.56 (148 percent)	\$8.70	\$5.45 (268 percent)
	Eggs (one dozen)	\$1.42	\$2.01	\$0.59 (142 percent)	\$3.77	\$2.35 (265 percent)
Bread	Loaf	\$1.34	\$2.43	\$1.09 (181 percent)	\$4.43	\$3.09 (331 percent)
Meat	Ground Beef (per pound)	\$3.36	\$4.35	\$0.66 (129 percent)	\$6.27	\$2.58 (187 percent)
	Whole Chicken (per pound)	\$1.47	\$2.49	\$1.02 (169 percent)	\$4.55	\$3.08 (310 percent)
Fruit	Apples (per pound)	\$1.30	\$1.71	\$0.41 (132 percent)	\$2.54	\$1.24 (195 percent)
Vegetables	Tomatoes (per pound)	\$1.92	\$2.02	\$0.10 (105 percent)	\$3.56	\$1.64 (187 percent)

For more on this study, please see: Indian Country Food Price Index: Exploring Variation in Food Pricing across Native Communities. A Working Paper II. First Nations Development Institute. 2018. <https://www.firstnations.org/publications/indian-country-food-price-index-exploring-variation-in-food-pricing-across-native-communities/>

Appendix 10: Equity-Centered Approaches to Food Production

Equity-centered food production approaches not only focus on access to food but are intentional about ensuring that the production process presents an opportunity to practice racial equity. Two key ways for food production processes to promote racial equity are ensuring that the producer is a farmer/distributor of color and that the food is culturally appropriate. An example of how this approach has been implemented can be seen on the Wind River Indian Reservation in Wyoming. In an attempt to ensure that food insecurity was addressed a racially equitable way, the reservation wanted to ensure that Indigenous farmers had the capacity to serve the community in culturally traditional ways. Unfortunately, due to the racial wealth divide affecting Indigenous communities, lack of capital to build the capacity to grow and distribute food is a barrier to entering the food production process for many Indigenous people.

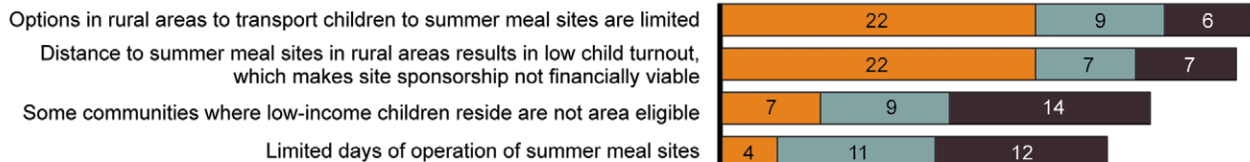
Fortunately, USDA designed and made available a grant to work with 20 producers on the reservation to set up businesses to produce Indigenous foods, including wild honey, artichoke, alfalfa, free range chicken, cattle, fruits, vegetables, and various plants. The goal of this project is to cultivate wealth for Indigenous producers, while simultaneously addressing the need for culturally appropriate, healthy foods in areas that otherwise would have been food deserts. Working with 20 producers to provide capital and technical assistance will enable the reservation to eventually cultivate a food hub, a farmer's market that will benefit SNAP recipients.

Appendix 11: No Kid Hungry Using Food Trucks to Transport Food

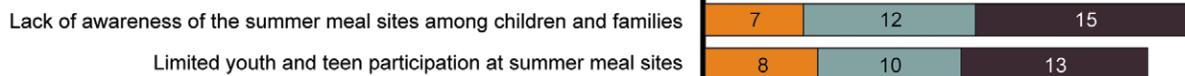
According to a recent GAO report, the top barriers that people in rural areas face when trying to access the Summer Food Service Program are long distances to the nearest meal site and lack of transportation options. See below.

Issues Reported as a Moderate to Extreme Challenge with the Summer Food Service Program (SFSP) by Half or More of States in GAO's Survey

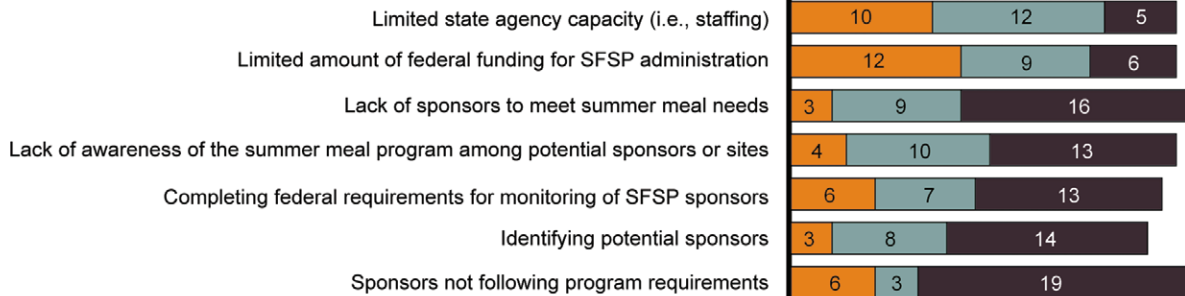
Challenges with availability of meal sites



Challenges with children's participation



Challenges with program administration



0 10 20 30 40

Number of states



NOTE: Respondents from some states also reported these factors as slightly challenging or not at all. In addition, fewer than half of states reported other factors as moderately to extremely challenging.

SOURCE: <https://www.gao.gov/assets/700/692193.pdf>

No Kid Hungry, an initiative of Share Our Strength, a partner organization of Bread for the World, is using mobile food trucks to take summer meals nearer where children live. To read more about the approach and what worked best, please see [Optimizing Summer and Afterschool Meal Service](#).³⁰⁴

Appendix 12: The Healthy Food Financing Initiative

The Healthy Food Financing Initiative (HFFI) was launched in 2010 to bring grocery stores and other retailers of healthy food to high-poverty communities identified as food deserts (see definition of concentrated poverty on page 54) or communities with limited access to full-fledged grocery stores. HFFI works to reduce the impact of food deserts on both food security and nutrition.³⁰⁵

HFFI boosts economic opportunity for entrepreneurs and business owners of color by providing them with access to the credit and financing needed to build their businesses. Lack of sufficient capital is a longstanding barrier that has prevented many people of color from starting or sustaining food businesses.³⁰⁶

In 2011, California passed legislation that created a state version of the Healthy Food Financing Initiative. The state then launched the California FreshWorks Fund (CAFWF) with private donors to help fund this effort. CAFWF has provided loan and grant financing to grocery stores and other eligible initiatives seeking to increase access to healthy food. To date, CAFWF has supported nearly 70 projects serving urban and rural communities across the state. Together, they have improved access to healthy food for more than 800,000 Californians as well as creating or retaining 1,600 jobs.³⁰⁷

In 2014, Ohio stakeholders came together on a taskforce and recommended a statewide HFFI initiative. This was created in 2016 as the Healthy Food for Ohio program. It supports the development of new and existing grocery stores and other healthy food retail outlets in lower-income areas by providing loans and grants to help businesses acquire land, build their stores, and purchase equipment. It also covers some credit needs not typically filled by traditional financial institutions.³⁰⁸ As of August 2017, more than 45,000 people in Ohio had improved access to healthy food and 166 jobs had been created.

To read about more state efforts to reduce food insecurity and boost nutrition in high-poverty areas, [see this report on HFFI impacts](#).³⁰⁹

Appendix 13: Transit Subsidies for Low-Income People

A number of cities and other localities are working to make it easier for low-income residents to get around. While transportation does not come under the jurisdiction of SNAP or the other nutrition programs in this report, transportation is clearly essential to getting to the grocery store, work, a doctor's office, and other destinations.

Researchers found that in New York City, low-income people spend more than 10 percent of their incomes on transit.³¹⁰ Their costs will only increase as rising rent pushes lower-income people to increasingly distant suburbs. This is also true of many other U.S. cities.³¹¹ Of course, spending more money on transit leaves less money for food. New York's mayor and city council have proposed fare subsidies for low-income people, many of whom are SNAP participants³¹² and are disproportionately people of color.

Other cities have adopted similar policies. San Francisco has created a Muni Lifeline Program, which pays for nearly half of the monthly transportation costs for Muni riders who live at or below 200 percent of the federal poverty line. Transit is free for children 17 and younger.³¹³ The Twin Cities area, Minneapolis/St. Paul, is implementing a Transit Assistance Program that allows low-income residents to ride for \$1.³¹⁴

Appendix 14: Increasing SNAP Benefits through Matching Programs

Localities across the country have begun to help SNAP recipients put healthy food on the table by offering matching programs that add an additional amount for fruits and vegetables to monthly SNAP benefits. Many matching programs take place in farmers markets and can add as much as \$25 per shopping trip if the recipient spends \$25 of SNAP benefits. Some programs match the amount spent on fruits and vegetables by a certain amount and cap it anywhere from \$20 to \$50 spent that day.

Indianapolis, for example, has a program called "Fresh Bucks Indy." Someone with SNAP benefits can go to a participating farmers market and be given tokens, known as Fresh Bucks, worth double the amount of the SNAP benefit she uses, up to \$20, on fruit and vegetable items.³¹⁵ Washington, DC, has a similar program. Participating farmers markets allow recipients to swipe their EBT cards at the market and receive SNAP dollars plus Matching Dollars to spend on fresh fruits and vegetables. The program offers a match of up to \$10 per day on fresh fruits and vegetables.³¹⁶

Local efforts such as these are important to enable people to purchase additional healthy food, and local and state governments should continue to do their part. But they cannot take the place of increasing the monthly SNAP benefit amount. To participate, people must know about the program in the first place, be able to get to a participating market during its operating hours, and preferably, because matching funds are limited and the foods are perishable, be able to go more than once a month.

Appendix 15: What the Larger Public Health Community Can Do

The larger public health community should make a concerted effort to apply a racial equity lens to current policies and practices and to provide targeted support to communities of color. As part of this effort, leaders from different sectors should meet with the National Association of Professional and Peer Lactation Supporters of Color and the CSI National First Food Racial Equity Cohort.

Decision makers outside the structure of the federal nutrition programs can improve racial equity by taking the following actions:

- 1. Adjust the requirements to become a certified licensed lactation consultant to make this more accessible for people of color.** As explained in Appendix 5, there are many barriers to becoming a certified lactation consultant, including both initial costs and costs to remain certified.
- 2. Provide targeted financial support for International Board of Lactation Consultant Examiners (IBLCE) education standards, exams, and recertification costs for people of color.** Providing these supports in a targeted way can increase the number of certified lactation consultants of color who had wanted to earn a IBLCE but could not afford the classes and testing. This in turn improves the cultural sensitivity of breastfeeding support for women of color.
- 3. Set a goal and devise a plan to racially diversify the field of lactation consultant (both certified and not formally certified) to reflect U.S. demographics by 2025.** There is currently no comprehensive plan in place to do this.
- 4. Increase support for the Community-Based Doula Program to work in concert with WIC objectives and supports.** The Community-Based Doula Program’s culturally sensitive and intimate on-the-ground model is one of several home visiting models. Growing evidence of the impact of community-based doula programs strengthens the case for increasing funding to reach additional mothers of color.
- 5. Increase support for communities of color that need specialized, culturally sensitive support from other providers of color.** When this support is carried out as a complement to WIC, it could help both programs achieve their goals of increasing breastfeeding support for women of color and strengthening health outcomes for women and children of color. [Learn more about this in the resource Prenatal Revolution by HealthConnect One.](#)

Appendix 16: Breastfeeding Rates in WIC Offices With and Without Peer Counseling

The chart on pages 68-69 shows differences in the breastfeeding initiation rates of women participating in local WIC offices with peer counseling support, compared to those participating in local WIC offices without peer counseling. As seen in the chart, the impact of peer counseling on African Americans was not as strong as it was for other communities of color: Latino/a, Asian/Pacific Islander, and Indigenous. This is to not to say that peer counseling support is not helpful, but perhaps indicates a need to reassess how the support is designed and implemented and ensure that it sufficiently reflects principles of cultural humility, sensitivity, and competence.

Appendix 17: Infant Mortality Rates among WIC and Non-WIC Recipients³¹⁷

The chart at right summarizes the strong evidence from Hamilton County, OH, that WIC services can help narrow the racial divide in infant mortality rates between African Americans and whites. Based on the chart at right, it is likely that infant mortality disparities between other communities of color and their white counterparts could also be reduced through WIC support and services, assuming that services are culturally sensitive and responsive.

Preterm Birth and Infant Mortality Outcomes in Prenatal WIC Participants and the Non-WIC Comparison Group, Stratified by Race: Hamilton County, OH, 2005–2007

	Prenatal WIC, No. (Rate %)	Non-WIC Comparison Group, No. (Rate %)	P
Preterm (< 37 wk)			
White	357 (10.3)	878 (8.7)	.004 ^a
African American	787 (13.7)	668 (20.0)	<.001 ^b
Moderately preterm (34-36 wk)			
White	278 (8.0)	615 (6.1)	<.001 ^a
African American	559 (9.8)	397 (11.9)	<.001 ^b
Extremely preterm (<34 wk)			
White	79 (2.3)	263 (2.6)	.376 ^a
African American	228 (4.0)	271 (8.1)	<.001 ^b
Infant mortality rate per 1000			
White	23 (6.7)	79 (7.8)	.486 ^c
African American	55 (9.6)	70 (21.0)	<.001 ^c

NOTES: WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

^aThe reference population was White term births (≥ 37 wk) in the WIC population (n = 3099) and non-WIC comparison group (n = 9196).

^bThe reference population was African American term births (≥ 37 wk) in the WIC population (n = 4944) and non-WIC comparison group (n = 2667).

^cThe reference population was the number of infants surviving 1 year for the selected populations.

SOURCE: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837444/>

Appendix 18: Improving Birth Outcomes Among Infants in Baltimore

The *Strategy to Improve Birth Outcomes in Baltimore City*³¹⁸ was developed by community partners to reduce the racial infant mortality divide between African American and white residents and improve overall infant survival in Baltimore. The strategy was to conduct a comprehensive baseline study, followed by provision of comprehensive services. Some of the services that are offered include primary health care, obstetric care, home visits, drug and alcohol treatment, intervention for domestic violence, mental health care, smoking cessation, family planning, nutrition support, breastfeeding promotion, and safe sleep education.³¹⁹

B'more for Healthy Babies launched in 2009. The city's infant mortality rate has since fallen by 38 percent—from 13.5 deaths per 1,000 live births in 2009 to 8.4 in 2015. Sleep-related infant deaths (SIDS) in Baltimore have also decreased by more than 50 percent since 2009 (from 27 deaths in 2009 to 13 deaths in 2015).³²⁰

Appendix 19: Brief History of Obesity in Indigenous Communities

High rates of obesity and overweight among Indigenous communities are due in large part to the history of forced migration and to the many food desert areas on reservations and in urban areas where Indigenous people live. Corner markets are often the only nearby source of groceries, and they may offer only prepared foods with low nutrient value and high levels of salt and sugar. Many Indigenous people participate in FDIPR, a USDA food commodity program that provides an alternative to SNAP but often offers few fresh foods and many canned and high-calorie foods. These factors contribute to overweight and obesity.³²¹

As a result of the forced migration of Indigenous communities in earlier generations, many were forced to live on land that may have not been ancestral.³²² This initiated a process of disengaging and disconnecting Indigenous communities from their original homelands and original food sources—a separation that only deepened over time.³²³

Before forced migration, many Indigenous communities lived and worked off the land, and had adequate supplies of food that included fish and other wildlife. In more recent years, however, pollution, habitat destruction, and other environmental problems have put many wild food sources on or near reservations at risk of contamination.

These factors reduce the availability of healthy foods and increase the overweight and obesity epidemic in Indigenous communities. Both overweight and obesity put people at higher risk of diabetes. While diabetes did not appear to be a problem before colonization³²⁴—for example, many Native languages did not have a word for the disease³²⁵—poor food quality and lack of food sovereignty have made it a significant problem today.

Appendix 20: Participation Incentive Models

Mary's Center is a community health center based in Washington, DC, that provides health care, nutrition support, family literacy teaching, and social services to individuals and families.³²⁶ Most clients live in low-income households, and they are disproportionately people of color. In addition to hosting an onsite WIC agency and providing breastfeeding support to mothers, Mary's Center provides access to additional healthcare services regardless of patients' ability to pay.

Mary's Center encourages participation in its programs by offering as incentives items that people have indicated they need. For example, women who attended breastfeeding classes were each given a box of diapers. Even more important, however, was the center's offering free child care so that women could attend class and focus on their babies. Lack of child care is a barrier to participation that many women encounter.³²⁷ Another strategy—used to enable participants to eat more fresh fruits and vegetables—was bringing the farmer's market directly to the center, where women were already assembled. They could then use their SNAP match dollars in a convenient way that eliminated the need to secure transportation to a market and spend time traveling.

Breast-feeding initiation rates in PC and non-PC agencies by selected agency and participant characteristics

	BREAST-FEEDING INITIATION RATE											
	Non-PC agency (n 13 602)					PC agency (n 15 788)					Total (n 29 881)	
	Prenatal cases		Postnatal cases			Prenatal cases		Postnatal cases				
	%	95%, CI	%	95%, CI	%	95%, CI	%	95%, CI	%	95%, CI		
AGENCY-LEVEL CHARACTERISTICS												
Region												
North-west/Cameron	46.5	43.1, 49.8	40.0	33.0, 47.0	50.9	45.4, 56.5	58.3	46.7, 70.0	48.0	45.4, 50.6		
North-east	45.3	42.2, 48.4	51.1	43.9, 58.3	49.5	42.6, 56.4	64.3	49.2, 79.4	47.5	45.0, 50.1		
Central	42.0	39.6, 44.3	43.3	37.8, 48.7	49.9	47.4, 52.4	46.0	40.7, 51.2	46.2	44.6, 47.7		
South-east	39.8	37.6, 42.0	35.5	30.1, 40.9	40.1	37.5, 42.6	38.2	32.1, 44.3	39.9	38.4, 41.5		
South-west	58.5	56.3, 60.7	54.3	49.8, 58.9	57.7	55.7, 59.6	54.6	49.9, 59.3	58.0	56.6, 59.3		
North-west/Metro	59.1	56.5, 61.7	54.5	49.1, 60.0	54.1	52.5, 55.8	46.5	43.3, 49.8	55.2	54.0, 56.4		
East	49.2	47.0, 51.4	41.6	38.6, 44.6	48.2	46.4, 49.9	36.6	33.9, 39.4	46.6	45.5, 47.8		
INDIVIDUAL-LEVEL CHARACTERISTICS												
Maternal race/ethnicity												
White, non-Hispanic	47.5	46.5, 48.6	47.6	45.4, 49.9	50.6	49.5, 51.7	48.6	46.4, 50.9	49.6	48.9, 50.3		
Black, non-Hispanic	41.1	38.6, 43.6	33.8	30.3, 37.3	45.8	44.1, 47.5	29.7	26.9, 32.5	41.8	40.6, 42.9		
Hispanic	73.0	70.1, 76.0	58.1	51.0, 65.2	68.4	65.6, 71.1	63.3	56.8, 69.7	69.4	67.5, 71.2		
American Indian/ Alaskan Native	53.9	44.8, 63.0	59.1	38.5, 79.6	55.3	47.6, 63.0	62.2	46.5, 77.8	56.6	51.3, 61.9		
Asian/Pacific Islander	51.6	41.5, 61.6	57.1	40.7, 73.5	61.3	53.3, 69.3	56.8	42.2, 71.5	58.0	52.6, 63.3		
All other	30.0	1.6, 58.4	75.0	45.0, 100.0	53.1	35.8, 70.4	61.1	38.6, 83.6	54.4	42.6, 66.2		
Maternal age												
<20years	44.3	42.5, 46.2	36.8	32.0, 41.6	49.2	47.4, 51.0	38.1	33.5, 42.7	46.3	45.1, 47.4		
20-29 years	49.5	48.3, 50.7	46.5	44.2, 48.7	50.9	49.8, 52.1	44.0	41.9, 46.1	50.0	49.3, 50.7		
30-39 years	54.1	51.5, 56.8	46.6	42.3, 50.9	55.7	53.3, 58.1	47.3	43.1, 51.4	53.7	52.1, 55.2		
≥40 years	48.7	37.4, 59.9	52.4	31.0, 73.7	45.4	36.4, 54.3	42.1	26.4, 57.8	47.3	41.2, 53.4		
Maternal education												
<12years	41.5	39.9, 43.0	32.7	29.3, 35.9	43.9	42.5, 45.4	31.3	28.4, 34.2	41.6	40.6, 42.5		
12 years	47.8	46.4, 49.2	41.7	39.0, 44.4	50.4	49.1, 51.8	40.3	37.7, 42.9	48.4	47.5, 49.2		
>12years	64.2	62.1, 66.3	63.3	59.9, 66.6	66.0	64.2, 67.9	62.9	59.7, 66.1	65.4	64.2, 66.5		
Maternal employment status												
Yes	51.2	49.5, 52.9	46.1	42.2, 49.9	52.9	51.3, 54.5	46.2	42.8, 49.6	51.8	50.7, 52.8		
No	47.7	46.6, 48.8	44.7	42.6, 46.8	50.2	49.2, 51.3	42.9	40.9, 44.8	48.7	48.0, 49.4		
Monthly household income												
\$US 0-500	42.3	40.5, 44.1	34.9	31.8, 37.9	47.1	45.5, 48.6	34.9	32.3, 37.6	43.4	42.4, 44.5		
\$US 501-1000	46.7	44.5, 48.9	41.4	36.7, 46.0	49.1	47.1, 51.1	40.2	35.7, 44.7	47.5	46.1, 48.8		
\$US 1001-1500	50.0	47.8, 52.1	47.8	43.1, 52.5	51.9	49.8, 53.9	47.7	43.0, 52.3	51.0	49.6, 52.3		
\$US 1501-2000	53.7	51.3, 56.1	52.4	47.3, 57.5	52.9	50.6, 55.1	52.3	47.6, 57.0	53.8	52.3, 55.3		
>\$US2000	54.6	52.5, 56.6	56.8	53.0, 60.6	58.1	56.0, 60.1	54.9	51.1, 58.7	57.1	55.8, 58.4		

table continued

	BREAST-FEEDING INITIATION RATE											
	Non-PC agency (n 13 602)					PC agency (n 15 788)					Total (n 29 881)	
	Prenatal cases		Postnatal cases			Prenatal cases		Postnatal cases				
	%	95%, CI	%	95%, CI	%	95%, CI	%	95%, CI	%	95%, CI		
OTHER MATERNAL HEALTH INDICATORS												
Maternal smoking status during pregnancy												
Yes	42.8	41.4, 44.3	34.5	31.5, 37.4	44.2	42.8, 45.6	37.7	34.8, 40.5	42.8	41.9, 43.7		
No	53.2	52.0, 54.5	51.0	48.7, 53.3	55.4	54.3, 56.5	47.0	44.8, 49.1	54.0	53.3, 54.8		
Maternal drinking status during pregnancy												
Yes	54.2	51.5, 56.9	56.0	50.1, 61.8	52.1	49.4, 54.7	58.9	52.2, 65.6	54.2	52.4, 55.9		
No	48.0	47.0, 49.0	44.0	42.1, 46.0	51.0	50.0, 51.9	42.7	41.0, 44.5	49.1	48.5, 49.7		
Maternal pre-pregnancy weight status (n 27 316)												
Underweight	44.6	40.5, 48.7	36.7	28.4, 45.1	44.6	40.8, 48.4	36.1	27.9, 44.3	44.0	41.5, 46.5		
Normal weight	46.4	44.9, 47.9	44.2	41.4, 47.0	50.4	49.0, 51.8	43.6	40.9, 46.2	48.3	47.4, 49.2		
Overweight	48.3	46.3, 50.4	45.5	41.6, 49.4	50.3	48.4, 52.2	42.2	38.5, 45.9	49.1	47.8, 50.3		
Obese	46.3	44.4, 48.1	44.4	40.6, 48.3	48.3	46.5, 50.0	41.7	38.2, 45.1	47.1	46.0, 48.2		
NEWBORN INDICATORS												
Birth weight												
Low birth weight (<2500 g)	47.6	44.0, 51.1	38.0	32.2, 43.7	49.2	46.0, 52.3	44.2	38.8, 49.7	47.7	45.6, 49.7		
Normal birth weight (2500-3999 g)	49.5	48.5, 50.5	45.5	43.5, 47.6	52.0	51.1, 53.0	44.1	42.2, 46.0	50.4	49.8, 51.0		
High birth weight (≥4000 g)	43.4	40.4, 46.4	50.4	44.1, 56.8	43.7	40.7, 46.6	39.8	33.9, 45.7	44.3	42.4, 46.2		
Preterm delivery (n 29 850)												
Yes	39.5	36.8, 42.1	38.4	33.6, 43.2	43.2	40.7, 45.6	34.3	30.0, 38.7	41.0	39.4, 42.6		
No	50.0	49.0, 51.0	46.1	44.1, 48.1	52.2	51.2, 53.1	45.2	43.3, 47.0	50.9	50.2, 51.5		
Parity (n 29 867)												
1st birth	51.4	50.0, 52.9	54.3	51.0, 57.7	55.0	53.6, 56.3	54.8	51.7, 57.9	54.2	53.3, 55.0		
2nd-4th birth	46.6	45.3, 47.9	42.0	39.6, 44.3	48.1	46.8, 49.3	39.6	37.4, 41.7	46.7	45.9, 47.5		
5th or more birth	48.5	45.4, 53.4	34.9	28.5, 41.3	48.7	44.7, 52.7	32.8	27.1, 38.6	45.0	42.4, 47.5		
Method of delivery - Caesarean section (n 27 705)												
Yes	48.1	46.3, 49.9	47.2	43.8, 50.7	51.3	49.7, 53.0	47.7	44.4, 51.0	50.0	48.9, 51.1		
No	50.1	49.0, 51.3	43.9	41.6, 46.3	52.0	50.9, 53.0	42.1	39.9, 44.3	50.4	49.7, 51.1		
Late or no prenatal care												
Yes	46.5	44.5, 48.6	23.9	18.2, 29.7	51.2	49.3, 53.0	28.0	22.8, 33.2	47.2	45.9, 48.5		
No	49.3	48.3, 50.4	47.0	45.0, 48.9	51.1	50.0, 52.0	45.3	43.5, 47.1	50.2	49.6, 50.8		

SOURCE: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/23A3C26A3A709AB1BB15C0295EA33D3C/S1368980009990668a.pdf/evaluation_of_the_missouri_wic_special_supplemental_nutrition_program_for_women_infants_and_children_breastfeeding_peer_counselling_programme.pdf

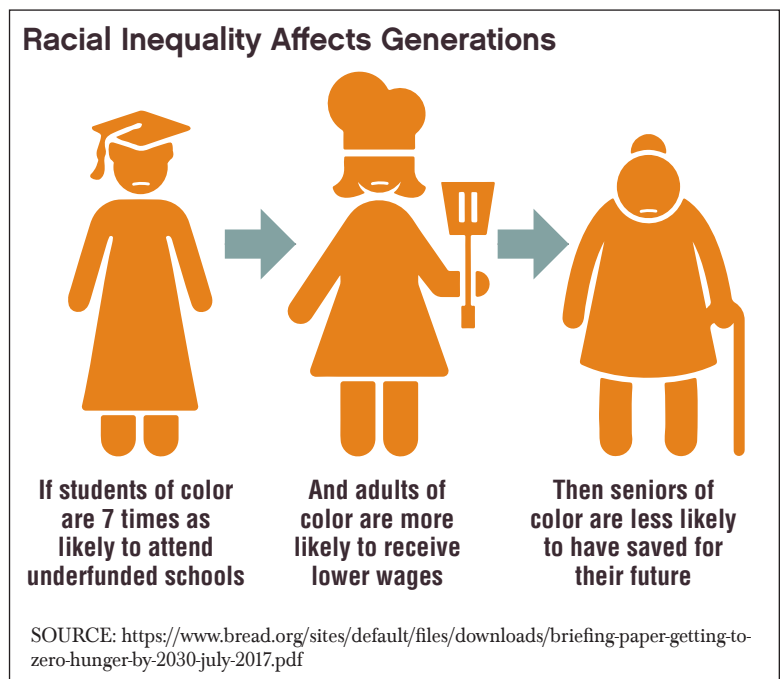
Appendix 21: Impact of the Racial Wealth Divide on SNAP Recipients of Color

To learn about the racial wealth divide and its connections with hunger in greater detail, please review the [Racial Wealth Gap Learning Simulation](#).³²⁸

The racial wealth divide and racial discrimination in the workforce impact an individual's ability to save enough for the future. See graphic at right.

Racial bias in the workplace means that older Americans of color are likely to have been paid less than whites doing the same work for their entire careers, preventing them from saving as much money for retirement. African Americans and Latinos who are nearing retirement have an average savings balance of \$30,000—only one-fourth the average \$120,000 in savings of whites in the same age group.³²⁹

As a result, older Americans of color must rely more on their families for support—in most cases, their adult children, who are also likely to work for lower wages. Caring for an older parent often pushes a family of color, which is already up to three times as likely to live below the poverty line, even deeper into hunger and poverty. Families don't have needed supports such as fairly paid jobs with benefits.³³⁰ This illustrates the generational effects of policies that limit the opportunities available to people from specific racial groups. Families of color have fewer resources to support themselves and their extended family.



Appendix 22: Health Tool to Screen Food Insecurity

[Excerpt from *Bread for the World Institute's 2016 Hunger Report*]

In the mid-2000s, Children's HealthWatch sites began piloting the use of a 2-item food security screening tool. The tool is based on a longer food security survey the U.S. Census Bureau administers annually to the population at large... The objective is to efficiently identify households at risk of food insecurity, so that the research approach of the 18-item USDA Food Security Scale can be translated into a clinically useful tool. The survey asks the parent or caregiver to rate two statements as "often true," "sometimes true," or "never true": "Within the past 12 months, we worried whether our food would run out before we got money to buy more," and "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more." This tool, the Hunger VitalSign™, has been validated with a sample of 30,000 caregivers. Responses can be recorded in electronic medical records along with other vital signs. Today, it has been widely adopted as a routine activity in pediatric and other healthcare settings, including newly established electronic health records.

For more information, read the 2016 Hunger Report, titled "The Nourishing Effect." The U.S. food security survey is discussed in the Introduction, pages 16-19. <http://hungerreport.org/2016/wp-content/uploads/2015/11/HR2016-Full-Report-Web.pdf>

Appendix 23: Food Insecurity in Puerto Rico Post-Hurricanes

Before the two massive hurricanes hit Puerto Rico, Bread for the World Institute estimated that 60 percent of all residents were food insecure.³³¹ Subsequently, people who already faced hunger had less access to food than before, and another large group of people who had previously been food secure also faced hunger. The hunger rate rose to at least 85 percent.

Because Puerto Rico has only a predetermined amount of money for food assistance (an arrangement known as a block grant), the government has had little flexibility to respond to the vastly increased needs. This is an important factor that drives soaring levels of hunger among Puerto Ricans—despite the fact that they are U.S. citizens.

After the hurricanes and at least as recently as March 2019, many communities lacked access both to basic necessities, such as regular, reliable access to healthy, nutritious foods, and to the resources needed to obtain them, such as functional roads, fully stocked grocery stores, and fairly paid jobs.

For more, please read "[Hunger and Poverty in Puerto Rico](#)."³³²

Appendix 24: Food Insecurity by Race and Household Type

	General Population	White Americans	African Americans	Indigenous Americans	Latino/a Americans	Native Hawaiian and Pacific Islander
All Households ³³³	11.7%	7.9%	25.1%	23.9%	19.6%	20.2%
Households with children	15.7%	11.9%	26.1%	N/A	21.9%	N/A
Female-Headed Households	30.3%	20.9%*	33.3%*	37.1% ³³⁴	34.3%	30.0% ³³⁵

NOTES: All Household level data used this source: Receipt of SNAP in the last 12 months by race. American Community Survey 1-Year Estimates. Table B220003. Table B220005, versions B, C, E, H, and I. Bread used this data instead of the USDA Food Insecurity Report to be consistent with calculations across all racial groups.

Rates for white and African American female-headed households were estimated by Bread for the World Institute. USDA does not disaggregate food insecurity data by race and female-headed household type. Based on U.S. Census Income, Health and Poverty Report data disaggregated by race and household type, Bread believes that food insecurity rates are similar to poverty rates for female-headed households by race.

Appendix 25: Barriers for Prime Age Adults and People Returning from Incarceration

Both groups face a myriad of barriers that contribute to hunger and poverty. An estimated 36 percent to 37 percent of all prime-aged adults³³⁶ (ages 18-49) without dependents live in poverty.³³⁷ Individuals in this category can also be referred to as disconnected workers (see glossary). They are twice as likely to earn less than 200 percent of the minimum wage.³³⁸ Structural barriers and discrimination mean that adults of color fare worse. Yet they do not qualify for long-term assistance,³³⁹ being limited to receiving SNAP for only three months in a three-year period. Considering racial disparities in unemployment rates and racial discrimination in the workforce, it is an inequitable practice to continue excluding this group from receiving nutrition support.

People who are returning to their communities from jail or prison also need support, whether they have recently been released after completing their sentence or are on parole, which is a conditional release that requires compliance with specific conditions.³⁴⁰ In a study conducted by the National Institutes of Health, 91 percent of returning citizens reported being food insecure and housing insecure.³⁴¹ Returning citizens are up to seven times as likely to be food insecure as the typical U.S. household.

Some states prohibit people with felony convictions from receiving SNAP for a period of years or even permanently. People who are not affected by these policies may still have difficulty qualifying for SNAP: they could be prime-age adults who face employment discrimination because of their criminal records. The unemployment rate among returning citizens is 27 percent—higher than the 25 percent unemployment during the worst economic years in U.S. history, the Great Depression.³⁴² When people are looking for work, it is inequitable to bar them from eligibility for nutrition assistance.

Appendix 26: How racial and ethnic diversity at all staff levels strengthens WIC

Businesses whose employees are members of the communities they serve gain credibility and trust.³⁴³ Beyond the benefits of building relationships with customers, the business also gains valuable cultural knowledge to help better understand the needs of the community.³⁴⁴ For instance, native Spanish-speaking employees from the local neighborhood are better positioned to serve other Spanish speakers and understand their priorities. This is even more true for a social services program such as WIC, whose effectiveness depends on providing needed services in ways that build trust among its clients, and on identifying ways of strengthening its program design and implementation.

Appendix 27. Historical trauma and Indigenous people's relationship with the federal government

From 1887 to 1934, the United States acquired more than 90 million acres of Indian Nation land—leaving Indigenous communities with only one-third of their original land.³⁴⁵ The continuing struggle over land, as well as historical racial inequity and trauma, has led to relationships between Indigenous communities and the federal government that are mistrustful at best.³⁴⁶ For more information on the history of racism against Indigenous communities and its impact on relations between the U.S. government and Indigenous people today, please see Appendices 1, 2, and 19, and read [Trust Land](#).

Appendix 28: Face-to-Face: Women of color serving other women of color using successful breastfeeding models

Strong evidence from practitioners of color supports the need for women of color to be supported in ways that address historical trauma and structural racism. Programs and initiatives that are designed without accounting for this, on the other hand, have proven to need redesign or improvement. Face-to-face models are critical among women of color since communities of color have had a historical of facing structural discrimination from white communities, and government entities, in the ways discussed in Appendices 1, 2, 3 and 27. This history has contributed to significant distrust between communities of color and white communities, as well as between communities of color and government entities. Face-to-face models allow for trust and community to be built where it was broken. More importantly, having women of color be the leaders of designing, establishing, and implementing face-to-face models helps to address the historical distrust that communities of color have of outside people coming into their community. Women of color from these communities have an understanding of what communities need, and therefore have additional capacity to respond to these needs in a culturally appropriate way.

Appendix 29: Sustainable Development Goals

Many factors contribute to hunger and food insecurity—see Figure 2 on page 11. The Sustainable Development Goals (SDGs),³⁴⁷ adopted by the United States and 193 other countries in 2015, are 17 interconnected human development goals that include ending extreme poverty,³⁴⁸ hunger, and malnutrition³⁴⁹ in all its forms by 2030. As an integrated whole, the SDGs do a good job of identifying other factors that create, sustain, and increase hunger. A few of these are adequate, affordable, and equitable education, health care, and work opportunities.³⁵⁰

The SDGs emphasize that to improve conditions and enable people to avoid hunger, it is necessary to consider the larger ecosystem that impacts a person’s or family’s ability to survive and thrive. Structural racial inequities inform our larger ecosystem by creating and sustaining significant problems such as lack of adequate and affordable health care, housing, city planning, and education, as well as high levels of unemployment and job segregation, inequities in the criminal justice system, and disparities in access to full-service grocery stores. Addressing these inequities will disrupt stubborn disparities of high food insecurity among communities of color.

Appendix 30: Food Insecurity among Southeast Asians by Ethnicity

The chart below includes food insecurity data from nine Southeast Asian ethnic communities for which data is available in the American Community Survey. The four communities with the highest levels of food insecurity are Burmese (42.9 percent), Hmong (32.2 percent), Cambodian (23.2 percent), and Vietnamese (20.8 percent).

Food Insecurity among Key Southeast Asian Communities in 2015 (most recent disaggregated data available for race and ethnicity)

	Burmese	Hmong	Cambodian	Laotian	Vietnamese	Thai	Filipino	Indonesian	Malaysian
Food Insecurity by Household	42.9%	32.2%	23.2%	20.8%	13.3%	7.6%	6.4%	5.4%	3.2%

SOURCE: DP03. Selected Economic Characteristics. 2011-2015 American Community Survey Selected Population Tables.

NOTE: Since this data is disaggregated by ethnicity, there are higher percentages of food insecurity in some groups (i.e. Burmese), compared to food insecurity rates among other groups of color where data was not disaggregated by ethnicity/tribe/country of origin (i.e. African American, Indigenous, Latino/a). If data was disaggregated within these communities of color, we anticipate higher food insecurity disparities among certain groups by ethnicity, tribe, or country of origin.

Appendix, Tool 1 (Detailed Questions)

*To access the racial equity methodology tool individually, go to: bread.org/racialequitymethodology

Methodology: Applying a Racial Equity Lens to Anti-Hunger Policies

Our hope is to build on this method for future projects. This methodology is offered as a possible pathway for other organizations, policymakers, and implementing agencies to use in developing a racial equity lens for their work, whether inside or outside the nutrition field.

How the Racial Equity Lens was Applied

Achieving racial equity means that all people, regardless of race, have fair opportunities to enjoy equality. To ensure that the methodology contributed to this outcome, methods put the needs of communities of color at the center of the analysis. The process was divided into two steps: first, closing divides based on race so that programs achieve equal outcomes for participants of all races; and second, ensuring that communities of color reach optimal outcomes, in our case, around nutrition. Both steps are integral to realizing racial equality.

Below are the five stages used to apply a racial equity lens, followed by questions asked at each stage:

Stage 1: Do not assume that the program or policy did not already apply an equity lens. Many anti-hunger programs already include an equity lens or efforts to promote equity in their program design—for example, gender or class equity. Programs serve lower-income communities, so their overall goal is to help people with fewer resources achieve equal outcomes. But for many reasons, some within the program’s purview and some outside its control, equal outcomes are not always the result. Using additional equity lenses, including a racial equity lens, can move the program closer to its goal.

Stage 2: Analyze the outcomes for each racial and ethnic group. If outcomes are not equal across participants of all races, then there is room to use a strengthened racial equity lens to adjust the inputs to achieve equal outcomes. The way to do this is to put the needs of communities of color at the center of the analysis in order to identify whether or how barriers to equal outcomes are addressed and how these program or policy elements can be improved.

Stage 3. Analyze why and how the outcomes of each racial and ethnic group were different. Once racial and ethnic disparities are identified, it is important to respond to the history and other factors that created these divides. Understanding the “why” and “how” behind the data is critical, especially when determining which recommendations are the most culturally sensitive and appropriate in addressing the historical trauma associated with the disparity.

WHAT DOES IT MEAN TO “CENTER” THE NEEDS OF COMMUNITIES OF COLOR?

“Centering” means simply focusing attention. All decisions are informed by the barriers facing communities of color and solutions aimed at overcoming those barriers. Barriers and solutions are at the center of our thinking and discussions.

EQUITABLE ENGAGEMENT: MORE THAN JUST PARTICIPATION

Equitable engagement is different from participation. When experts of color are asked for feedback after a project has been designed, but before it is finalized (or, in some cases, even after it is finalized), they are participating. Experts of color do not hold real power in making decisions—for example, about framing how concepts are communicated. Often, there is no requirement or expectation that the project will include the feedback that participating experts of color have given in the final product.

Equitable engagement involves experts of color from the beginning and empowers them to drive the conversation at each stage: design/planning, implementation/execution, and evaluation. Experts of color also have real decision-making power in shaping the narrative, determining who should be at the table, etc. Equitable engagement also gives them appropriate credit for their ideas and work and compensates them for their time.

Stage 4: Use a racial equity approach to ensure that experts of color are equitably engaged in leading this project and shaping the narrative. To see what it means to equitably engage people of color, please see text box below. Any racially equitable approach enables and empowers people of color to make decisions about how their narrative is portrayed. It is critical to racial equity that people of color be empowered to exercise true leadership. This project, for example, empowered authors and researchers of color who are experts to lead the development of the methodology.

During our consultations, we met with program participants who are people and experts of color. Participants in programs are experts on the strengths and weaknesses of the programs. Feedback from people who receive or have received nutrition benefits should guide research areas and topics. Some of the topics were identified solely by listening to the perspectives of recipient experts of color.

Engaging with participants directly is an integral part of using a strengthened racial equity lens in order to empower the agency of participants, even when qualitative or quantitative research has not yet caught up.

Stage 5: Consult with people doing this work. Often, policy recommendations are inadvertently made in siloes. Initial consultations with experts on the issues should be made, but additional meetings with people who work with communities that receive nutritional support, including staff who help implement nutritional programs, are critical. When possible, learn about the racial equity work that nonprofit staff, intermediaries, and program implementers are already doing, and look for opportunities for the anti-hunger field to apply a racial equity lens.

Questions to Ask at Each Stage: Properly Applying a Racial Equity Lens

Below are detailed questions that should shape the process of gathering and evaluating information. This general methodology can be used to apply a racial equity lens to any policies and programs.

Stage 1. The first methodology principle is not to assume that the policy/program did not *already* apply an equity lens. Ask questions such as:

- a. What are the different aspects of this policy?
- b. Do we have the data, disaggregated by race and ethnicity, that we need to analyze possible disparities, the extent of equality in outcomes, etc.?
- c. In what ways does each aspect contribute to producing equal outcomes for people of color and whites? In other words, what is being done intentionally to close racial divides?
- d. In what ways is the program neutral? Neutral policies provide the same level of services and support to everyone, so they neither improve nor worsen racial inequities.
- e. In what ways do policies put people of color at a further disadvantage? How do aspects of the program harm the effort to achieve racial equity?

Stage 2. The second methodology principle is to analyze the outcomes of different racial and ethnic groups.

Ask questions such as:

- a. What is the racial and ethnic makeup of the population that this program serves?
- b. How does each racial and ethnic group fare with each outcome that is measured—for example, iron levels or food insecurity?

Stage 3. The third methodology principle is to analyze how and why people of different racial or ethnic groups have different outcomes. Investigate possible reasons for different outcomes:

- a. What are the factors that contribute to producing a specific outcome for a specific ethnic or racial group? Potential answers could have something to do with the design of the program or its implementation, or they could be unrelated factors.
- b. How are these driving factors different among each racial and ethnic group facing this same outcome?
- c. How are these driving factors similar among each racial and ethnic group facing this same outcome?
- d. What is the history behind this driving factor? When and where did it originate? What has been its impact on individual families and the larger community within each racial or ethnic group?
- e. Given this history, how might this driving factor impact the ability of community members to experience this program, or aspect of this program?

For more information on how your organization can apply a racial equity lens, both internally and through your decision making on policy, advocacy, and implementation, please use the [Racial Equity Assessment Tool](#), created by the Alliance to End Hunger.

- f. Given the history of this driving factor, what aspects of the program might need to change to reverse these trends among each racial or ethnic group? Will these proposed changes have unintended consequences that inadvertently hurt communities of color and the areas they live in?
- g. Given this history, how might communities of color respond to the proposed changes to the driving factors? Do they support these changes?

Stage 4. The fourth methodology principle is to empower experts of color to lead this project and shape the narrative.

- a. How are the processes within our organization empowering experts of color to lead the conversation without reducing their role and their work to mere tokenism?
- b. Do the time and money allocated to the project accurately reflect our organization's commitment to racial equity as an important priority?
- c. Who are the true decision makers regarding this project? Were project leads identified in a process that is racially equitable? Do experts of color hold real decision making power or are they merely consulted for feedback?
- d. Are we inviting conversations and comments from current and former participants of color in the programs? Are we unconsciously valuing formal research or other standard data sources over the perspectives and recommendations from people of color who have lived experience with these topic areas and programs?

Stage 5. The fifth methodology principle is to consult with people doing this work.

- a. Which organizations could help us understand how programs are implemented on the ground?
- b. What do participants and staff who work directly with programs in their community think is working and not working? Why?
- c. Are there additional specific factors or barriers that cause a particular racial or ethnic group to have poorer outcomes? Is there anything that was left out of the list for Stage 3 that should be included for additional research?
- d. What ideas do participants, former participants, and/or frontline staff have on things that need to change for results that are racially equitable?
- e. After the recommendations have been prepared, ask people on the ground what they think. Would the recommendations achieve equal outcomes for people of color? If not, ask them to draw on their experiences as implementers or participants to suggest changes.

In organizations where hiring practices and internal culture do not yet reflect the racially inclusive demographics needed for an intentional process such as the one outlined in this methodology, organizational boards, management, researchers, and staff are encouraged to consider the following:

- **Perhaps your staff is not racially diverse.** Think about how the overall culture could shift to become more racially inclusive and equitable. What should be different about hiring practices, and other practices?
- **Perhaps you have a racially diverse staff, but the decision making process is not racially equitable.** Think about how internal decision making processes could shift to become more racially inclusive and equitable, perhaps starting with individual projects. Organizations need to reach a point where people of each racial/ethnic group affected by the policy or program are equitably engaged in decision making. Refer to the racial equity assessment tool linked below for best practices on racially equitable decision making.¹
- **Review research on similar issues from experts of color.** Very often, this work has already been done. It may be on a smaller scale and/or released with less publicity, so finding it may require using some innovative approaches. In addition, people of color who live and work in marginalized communities have great ideas for overcoming the barriers set up by structural inequalities, ideas that very often prove to work quite well. We encourage bringing more attention to these ideas and giving credit to their originators.
- **Consult with experts of color as the project takes shape,** especially in its beginning stages to develop a better understanding of how to frame the narrative and learn about research and other resources you may otherwise have overlooked.
- **Create an advisory board of color whose members are people who are most impacted by the issues,** both those at the outset and those that emerge as the project proceeds. This should result in regular gatherings of experts of color, including experts by virtue of academic research background and experts by lived experience. The advisory board should play a key role throughout all stages of the project.
- **Review the reasons why certain groups experience unequal outcomes** (refer to the questions under the third stage) and brainstorm targeted ways that can reverse these trends. Get thoughts from your advisory group or consultant(s) of the impact of these innovative ways as well as the community's likely response to these changes.

¹ "Racial Equity Impact Assessment." Race Forward: The Center for Racial Justice Innovation https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

Endnotes

- 1 The Institute recognizes that there are many other types of equity, including citizenship equity. Immigration policies have a significant impact on participation in nutrition programs. The Institute hopes to incorporate this and other lenses into future work.
- 2 Refer to pages 12-14 of this report, and also see this source: Blackwell, Angela Glover. “The Curb-Cut Effect.” *Stanford Social Innovation Review*. Winter 2017. https://ssir.org/articles/entry/the_curb_cut_effect
- 3 Residents living on or near reservations, as well as all residents of Oklahoma, have the option to participate in FDPIR. Households that receive FDPIR may also qualify for SNAP, but they cannot participate in the two programs simultaneously. For more information, please see Appendix 7.
- 4 Through the Nutrition Assistance Block Grant, each territory administers the Nutrition Assistance Program (NAP). NAP functions slightly differently in each territory. For more information, please see Appendix 7.
- 5 The Sustainable Development Goals (SDGs) are universal and apply to all countries, including the United States. Two essential tenets of the SDG framework that will enable the world to accomplish the goals are to leave no one behind and to reach the populations who are furthest behind, who face the greatest barriers and hardships, first. If the U.S. takes this approach to end hunger and food insecurity, the data shows that people of color (including African American, Indigenous, Latino/a (refer to glossary), Native Hawaiian, and Pacific Islander communities, and some groups from the Southeast Asian diaspora) consistently have higher rates of food insecurity than the general population and whites. See Appendix 24 for food insecurity rates by race among all racial groups and Appendix 30 for more on food insecurity rates among Southeast Asians by ethnicity.
- 6 Irregular Scheduling and Its Consequences. Briefing Paper #394. Economic Policy Institute. April 2015. <https://www.epi.org/files/pdf/82524.pdf>
- 7 “The Self-Assessment Workbook (SAW): Chapter 10 Racial Equity.” Alliance to End Hunger. 2018. <http://alliancetoendhunger.org/wp-content/uploads/2018/09/SAW-for-HFC-10-Racial-Equity.pdf>
- 8 “Nutrition and Early Brain Development.” The Urban Child Institute. March 2011. <http://www.urbanchildinstitute.org/articles/updates/nutrition-and-early-brain-development>
- 9 A nutrient-poor diet compromises a child’s ability to develop cognitively and physically and undermines her health as an adult—but the latter is critical to participating in the work force and providing for a family. Communities of color are more likely to suffer the health consequences of nutrient-poor diets, which include diabetes, high blood pressure, and other problems. <http://hungerreport.org/2016/wp-content/uploads/2015/11/HR2016-Full-Report-Web.pdf>
- 10 RTI International (July 2014), *Current and Prospective Scope of Hunger and Food Security in America: A Review of Current Research*.
- 11 USDA ERS. “Trends in U.S. Food Security: 2002-2016.” USDA Interactive Charts and Highlights. <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/interactive-charts-and-highlights/#trends> and <https://www.ers.usda.gov/webdocs/publications/90023/err-256.pdf?v=0>
- 12 Income, Poverty, and Health Insurance Coverage in the United States: 2016. U.S. Department of Commerce, U.S. Census Bureau, September 2018.
- 13 Ibid.
- 14 The Hamilton Project at the Brookings Institution published research that shows that U.S. rates of very low food insecurity fell during the Great Recession at the same time as the stimulus program increased SNAP monthly benefits. <https://www.brookings.edu/blog/up-front/2016/04/21/strengthening-snap-to-reduce-food-insecurity-and-promote-economic-growth/>
- 15 Nutrition programs continue to be important even after the recession. In 2012, for instance, the National School Lunch Program (NSLP) lifted 1.3 million people over the poverty line. http://www.hamiltonproject.org/papers/twelve_facts_about_food_insecurity_and_snap
- 16 In 2015, SNAP kept 8.4 million people out of poverty, including 3.8 million children. <https://www.cbpp.org/research/food-assistance/chart-book-snap-helps-struggling-families-put-food-on-the-table>
- 17 The Hamilton Project at the Brookings Institution found that an additional \$25 per month in stimulus funds given to each household decreased food insecurity in 2009 by 2 percentage points from 2008. http://www.hamiltonproject.org/assets/files/twelve_facts_about_food_insecurity_and_snap.pdf
- 18 In all U.S. states, communities of color are between two and six times as likely to experience hunger and poverty as whites. In South Dakota, communities of color are six times as likely to experience hunger and poverty as whites. <http://www.bread.org/library/us-hunger-and-poverty-state-fact-sheets>
- 19 Single race data was used in the calculations. For example, “African American or Black alone” was selected when calculating food insecurity data.
- 20 Household Food Security in the United States in 2017. United States Department of Agriculture. Economic Research Service. Report 256. September 2018. <https://www.ers.usda.gov/webdocs/publications/90023/err-256.pdf?v=0>
- 21 Read Appendix 24 to see how estimates were calculated and review sources.
- 22 Note: The majority of Southeast Asian communities are not at disproportionate risk of food insecurity. Three among the 11 identified ethnic groups within the Southeast Asian community do have high food insecurity rates: Laotian Americans (20.8 percent), Cambodian Americans (23.2 percent) and Burmese Americans (44.3 percent). See Appendix 30 for a more detailed chart.
- 23 “We Have a Story to Tell: Native Peoples of the Chesapeake Region.” National Museum of the American Indian. Education Office. 2006. <https://americanindian.si.edu/sites/1/files/pdf/education/chesapeake.pdf>
- 24 Racial Wealth Gap Learning Simulation. Policy Packet. Bread for the World Institute. May 2018. bread.org/simulation_policypacket
- 25 Gamblin, Marlysa D. “Ending U.S. Hunger and Poverty by Focusing on Communities Where It’s Most Likely.” Bread for the World Institute. Briefing Paper, Number 31. March 2017. <http://www.bread.org/sites/default/files/downloads/ending-us-hunger-marlysa-gamblin-march-2017.pdf>
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- 29 Resource segregation describes a lack of resources typically seen in areas where many of the residents are people of color. This is due to policies that facilitated racial segregation, not only of people, but also of loans for homeownership and capital for businesses. Segregation of these three pillars of neighborhood stability led to segregation in the resources that they generate, such as funding for schools, parks, transportation, grocery stores, and much more. To learn more about segregation, please see Rothstein, Richard. “The Color of Law: A Forgotten History of How Our Government Segregated America.” May 2017.
- 30 Gamblin, Marlysa D. “Mass Incarceration: A Major Cause of Hunger.” Bread for the World Institute. Briefing Paper, Number 35. February 2018. <http://www.bread.org/sites/default/files/downloads/briefing-paper-mass-incarceration-february-2018.pdf>
- 31 Gamblin, Marlysa D. “Ending U.S. Hunger and Poverty by Focusing on Communities Where It’s Most Likely.” Bread for the World Institute. Briefing Paper, Number 31. March 2017. <http://www.bread.org/sites/default/files/downloads/ending-us-hunger-marlysa-gamblin-march-2017.pdf>
- 32 Over-policing means that a community has a heavy police presence that is not in proportion to its rate of serious crime. Over-policing is seen mainly in low-income communities, particularly low-income communities of color. For more information on over-policing, see: Gamblin, Marlysa D. “Mass Incarceration: A Major Cause of Hunger.” Bread for the World Institute. Briefing Paper, Number 35. February 2018. <http://www.bread.org/sites/default/files/downloads/briefing-paper-mass-incarceration-february-2018.pdf>
- 33 Ibid.
- 34 <http://www.ride.ri.gov/cnp/NutritionPrograms/FreshFruitVegetableProgram.aspx>
- 35 Murray-Garcia, Jann, and Melanie Tervalone. “Cultural Humility Versus Cultural Competence: A Critical Distinction Defining Physician Training Outcomes in Multicultural Education.” *Journal of Healthcare for the Poor and Underserved*. Vol. 9, No. 2. 1998. https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf
- 36 Blood quantum is a term used to define bloodlines relating to ancestry. For example, a person with one Indian grandparent and three non-Indian grandparents has one-quarter Indian blood. Tribes that use blood quantum criteria require tribal members be at least one-half to one-sixteenth blood of their tribe. For more on blood quantum, see: “Will current blood quantum membership requirements make American Indians extinct?” National Museum of the American Indian. September 2011. <https://blog.nmai.si.edu/main/2011/09/will-current-blood-quantum-membership-requirements-make-american-indians-extinct.html>
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- 38 Most of SNAP’s budget (\$64 billion out of \$70 billion) is distributed through Electronic Benefit Transit (EBT) cards. Less than 1 percent of the SNAP budget is used for federal administrative costs and 6.5 percent is for state administrative costs. The remaining \$2.5 billion is allocated to other nutrition programs, including the Nutrition Assistance Block Grants (NABG) for food assistance in Puerto Rico, American Samoa, and the Northern Mariana Islands, and commodities for the Food Distribution Program on Indian Reservations (FDPIR). To read more about NABG and FDPIR—two programs that act in place of SNAP—please see

- Appendix 7. *Data calculated from Bread estimates for fiscal year 2017 based on data from: "Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)." Center on Budget and Policy Priorities. February 2018. <https://www.cbpp.org/research/policy-basics-the-supplemental-nutrition-assistance-program-snap>
- 39 Household Food Security in the United States in 2017. U.S. Department of Agriculture. Economic Research Report, Number 256. September 2018. <https://www.ers.usda.gov/webdocs/publications/90023/err-256.pdf?v=0>
- 40 Caroline Ratcliffe and Signe-Mary McKernan (March 2010), "How Much Does SNAP Reduce Food Insecurity?" The Urban Institute. <https://www.urban.org/sites/default/files/publication/28506/412065-How-Much-Does-SNAP-Reduce-Food-Insecurity-PDF>
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- 42 Ibid.
- 43 In a 2012 longitudinal study, USDA found that households that had received SNAP benefits for six months had nearly an 11 percent decline in food insecurity compared to new entrant households. <https://fns-prod.azureedge.net/sites/default/files/Measuring2013.pdf>
- 44 A more recent study of nearly 3,000 households with children published in *Pediatrics* found that child food insecurity rates were one-third lower in households that had been receiving SNAP for 6 months or more, compared to households that had been recently approved for SNAP but were not yet receiving benefits. This data points to the importance of SNAP in reducing food insecurity for millions of families across the country. James Mabil and Julie Worthington (April 2014), "Supplemental Nutrition Assistance Program and Child Food Security," *Pediatrics* Volume 133, Number 4.
- 45 "Policy Basics: The Supplemental Nutrition Assistance Program (SNAP)." Center on Budget and Policy Priorities. Feb 2018. <https://www.cbpp.org/research/policy-basics-the-supplemental-nutrition-assistance-program-snap>
- 46 "Wage Stagnation in Nine Charts." Economic Policy Institute. January 2015. <https://www.epi.org/files/2013/wage-stagnation-in-nine-charts.pdf>
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- 49 Earlier anti-poverty policies penalized married couples.
- 50 "Assessing the Impact of Electronic Benefits Transfer on America's Communities and the U.S. Payment System." Conference Summary. Federal Reserve of Philadelphia and Electronic Funds Transfer Association. September 20 - 21, 2004 <https://www.philadelphiafed.org/-/media/consumer-finance-institute/payment-cards-center/events/conferences/2004/ebt%20summary%20with%20cover.pdf?la=en>
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- 59 "Who Has Time to Cook? How Family Resources Influence Food Preparation." United States Department of Agriculture. Economic Research Service. Report Number 40. May 2007. https://www.ers.usda.gov/webdocs/publications/45797/11722_err40_1_.pdf?v=0
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