

Feeding Practices of Childcare Staff in CACFP-Funded Centers

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Background

As one of USDA's food assistance entitlement programs, the Child and Adult Care Food Program (CACFP) provides nutritious meals and snacks to 2.9 million low-income American children, by reimbursing eligible childcare providers. CACFP also has *suggested* written feeding guideline policies to foster a supportive feeding environment, including allowing children to serve themselves. Interestingly, these guidelines are congruent with recommendations to prevent childhood overweight. Moreover, they support the concept of Satter's *division of responsibility*. This concept assumes adults are responsible for selecting, preparing and offering healthful foods as well as determining when and where meals and snacks are served. On the other hand, children are responsible for how much they eat, or whether they eat at all—control of food intake.

Thus, in addition to being a partner in combating childhood hunger, CACFP can play a significant role in establishing healthy eating habits, promoting self-regulation of food intake, and supporting self-sufficiency. Moreover, since low-income households are at high risk for obesity, CACFP-funded centers can play a role in modulating childhood overweight.

While some information exists regarding food selection in CACFP-funded centers, little is known about the feeding environment in these centers. This unique study compares reported implementation of feeding policies in childcare centers that receive CACFP funding to non-funded centers who serve low-income children. Additionally, it explores issues facing CACFP funded centers who encounter very hungry children. This study answers the following questions:

1. Do centers serving low-income children receive CACFP funding?
2. What challenges do CACFP-funded centers face in response to feeding children coming into centers exhibiting signs of extreme hunger?
3. Do staff members in centers receiving CACFP funds and training report providing more opportunities that support the promotion of healthy eating and feeding behaviors espoused to prevent childhood obesity in young children than staff in centers not CACFP-funded?

Methods

Questions 1 and 3 were answered using quantitative data gathered from responses to a previously conducted survey – About Feeding Children (AFC). A stratified (by census density and state) random sampling method was used to identify 1,600 centers (400 from each state) within California, Colorado, Idaho and Nevada to receive mailed questionnaires. Responses were received from 574 centers (470 directors and 1210 staff). Interview data from 49 AFC staff as well as from 11 experts knowledgeable in CACFP was used to qualitatively explore question 2.

Findings/Discussion

Of centers responding to the AFC survey, 61% reported serving low-income families. Of these, 125 centers served meals and snacks, with significantly more receiving CACFP funding (66% vs. 34%, $p < .01$). Center location stratification revealed some centers in the poorest communities (i.e. the first quartile) do not participate in CACFP (24% with poverty rates ranging between 14.5% to 39.6% and 35% with median incomes ranging from \$20,129 to \$33,193). One could speculate that if eligible centers are aware of the program, they may not choose to enroll due to the arduous application process and/or the cumbersome record keeping required.

A pattern emerged regarding very hungry children entering CACFP-funded childcare. Both providers and experts stated that some children do not receive sufficient food or food of healthful nutritional quality over the weekend. Thus, early in the week (especially Mondays), some children enter centers in an apparent state of extreme hunger. Although this study could not determine if these children lived in food insecure households, they displayed behaviors reflective of that situation by acting out, being irritable, lacking concentration, and expressing an overwhelming desire to eat. Staff and experts state these children need

and want more than the one serving of food for which the center is reimbursed, resulting in unmet hunger. In some centers, these children remain hungry until the next eating occasion, as second helpings were not prepared. Other centers meet the increased hunger by maintaining a stock of food provided by food banks or purchased without CACFP reimbursement.

In general, CACFP-funded centers were more likely than unfunded centers to report practices consistent with feeding guidance and with an overall environment purported to support self-regulation of food intake in children. CACFP funded staff allowed children more involvement in determining what to eat, the order in which to eat and how much to eat. Interestingly, staff in both funded and non-funded centers did not believe it was extremely important to teach children how to serve themselves food (52%) as much as they did to teach social skills (75%), conversational skills (72%), table manners (76%) and motor skills (using spoons and cups) (72%). This is reflected in the frequency of teaching so that 42% always taught children how to serve foods as compared to always teaching social skills (75%), conversations skills (79%), motor skills (83%) and table manners (84%). However, requiring self-service may not work for all CACFP-funded centers, even Head Start Centers, since some centers receive foods preplated.

In summary, this study suggested several strategies that CACFP could implement in response to both child hunger and overweight. For those centers who serve extremely hungry children, CACFP needs to reconsider the reimbursement policy. For example, additional quantities of food could be prepared for Mondays and Tuesdays when children enter centers most hungry and on Fridays to accommodate weekends, where food is scarce. CACFP reimbursement policies also may not coincide with obesity research. Reimbursement allows for a specified amount of food per child. However, research suggests that children self-regulated their food intake. Implicit in this suggestion is that some children will eat less than the reimbursed serving size whereas others will need to eat more. In theory, for most centers, sufficient quantities of food would be available for all. In reality, this may not happen, especially in centers with very hungry children. Finally, CACFP could specify funds to be set aside to train all CACFP-funded staff, directors and sponsors on the role CACFP can play in child overweight prevention and in setting up a supportive feeding environment. However, none of these strategies will help low-income children if eligible centers do not enroll in the CACFP program. Increased outreach efforts and reduced paperwork may entice centers, especially those in the poorest neighborhoods, to seek program benefits.