Nutrition Services Are a Health Equity Intervention

Melissa: On today's webinar, we have Steve Schuman presenting. Steve will introduce himself in a moment. We also have with us today, Shonika Kwarteng, Nutrition, Training, and Technical Assistance Associate, who will moderate the Q&A discussion later. Next slide.

Steve Shuman: Thanks, Melissa. I am Steve Schuman. I'm the Director of Outreach and Distance Learning at the National Center for Health, Behavioral Health, and Safety, and I am the Co-lead for our Equity Workgroup. I'm so pleased to be here today to talk about this particular aspect of health equity and be joined by our nutrition subject-matter expert, Shonika. If there's a question that's specific to nutrition, that's not my area of expertise. That's Shonika. We'll have time to respond to those questions. We hope that you put them into the Q&A pod. Thanks. Next slide.

Today, we hope to explain the difference between equality and equity. We hope you'll be able to identify how the social determinants of health can affect a child's nutritional intake. We hope you'll be able to think about how to use Head Start and other early childhood high-quality practices to address nutrition-related disparities and, together, help children and families on their own health equity journeys. Next slide.

This is a model that our Center came up with to talk about how Head Start programs, specifically, are a health equity intervention and within that, our Head Start nutrition services. This aligns with the Department of Health and Human Services Healthy People 2030 Guideposts. When we address social determinants of health, we have the opportunity to reduce health disparities and help folks work towards health equity.

Head Start and other high-quality early childhood programs have an important role in the journey to health equity for the children and families we all serve and the staff who work in our programs. Head Start programs, including nutrition services, are designed to help reduce health disparities, eliminate barriers, and provide a healthy foundation to ensure children enter school ready to succeed.

Every journey to health equity is unique. We highlight some common steps in the path to increase awareness and understanding to be really intentional in our actions for achieving health equity from wherever we start and wherever we stand. We will share some program examples along the way to help inspire your thinking and application and demonstrate some of the ways in which nutrition services are a health equity intervention. Next slide, please.

A few important items here nutrition has always been an important part of Head Start requirements since its very, very beginning. Nutrition is included in definitions of high-quality early childhood programs. Today, I may be using early childhood programs and Head Start interchangeably. When I do, I am talking about high-quality programs that include nutrition services.

When most people think about Head Start programs, they think about early childhood learning and education. And while that's true — it's an educational community service that millions have counted on since the program was first launched — the nutritional services of Head Start are just as important. It's that cooperative effort between education, comprehensive health services, family engagement, and quality nutrition that makes the Head Start program so successful. Head Start staff and families identify the nutritional requirements of every child.

This helps the program and the family learn what each child needs based on their height and weight, their cultural preferences, any allergies, health problems and disabilities that they may know about or identify. They don't just identify what each child needs. They support families in how to feed and care for their very own child based upon their personal data. Next slide, please. What is equity? When we think about equity, most people start by thinking about equality. Equality is something where everyone is getting the same thing.

We're serving apples at lunch, and everybody's getting an apple. But what if one of the people at the table doesn't have teeth yet? Or what if they're allergic to apples? Perhaps an alternate fruit or vegetable would be appropriate for that child or person. That would be equity. Everybody getting what they need. Here are a couple of graphics that also demonstrate the difference between equality and equity. In the top, these are from the Robert Wood Johnson Foundation. When it comes to expanding opportunities for health, thinking the same approach works for everybody is like expecting everyone to be able to ride the same bike.

You can see in the top part, where it's equality, everyone's getting the same bike. It doesn't exactly work for everybody, depending on their height and their ability. In the equity graphic on the bottom, everybody has access to something they can ride appropriately. Next slide, please. Here's another opportunity to see the difference between equality everyone crossing the street from the same kind of curb to equity, where everybody is able to cross the street safely using a curb and data or signals that are appropriate for their various visual and mobility impairments. Nobody is impeded. Next slide.

Our Center worked hard to come up with a definition of health equity. It's based on a number of leading researchers on what is health equity. What we came up with is that health equity is a principle underlying a commitment to reduce and eliminate disparities that affect children, families, and staff. It means striving for the highest possible standard of health and behavioral health for everybody. It includes making sure that everybody has access to a continuum of resources, services, and this is very important positive experiences within systems.

It also includes giving special attention to the needs of those at greatest risk of poor health and behavioral health outcomes based on systemic and structural racism and other forms of oppression. Next slide, please. A few more definitions to help us along today these are definitions about food security and food insecurity and hunger. You can see them right here. When we talk about food security that means that everybody has enough food all of the time to lead an active, healthy life. When you have high food security, there aren't any problems reported.

However, that changes when we talk about marginal food security, when there may be one or two signs that cause anxiety over, do I have enough food? Is it the appropriate food? Is it the right food for my family, for the individual needs of my family? Lower food security refers to reduced quality, less variety, perhaps less desirability of the food. You're eating things that you'd rather not eat. However, you are getting food. Very low food security is when there are disrupted eating patterns and a significant reduced food intake.

When we talk about food insecurity, that's at a household level, when economic and social conditions limit access to adequate food in some way. Hunger is at that individual level. That's the physiological condition that results from food insecurity. Next slide, please. Some not-so-good news some of you may be very familiar with this already that food insecurity in early childhood makes it harder for our children to gain skills, participate in activities, and really be able to succeed in both our early childhood programs and later on in school.

Food insecurity is associated with a number of adverse social and health outcomes and is increasingly considered a critical public health issue. Children who don't get enough to eat, especially during their first three years, begin life at a serious disadvantage. Children facing hunger are more likely to be hospitalized, and they face higher risks of health conditions like anemia and even asthma. As they grow up, kids who miss meals are more likely to have problems in school and other social situations.

You can see on this slide some specific health conditions. We have some data directly from the Office of Head Start Program Information Report that, if you're in Head Start, I know you're familiar with. This is from last year's report. You can see that while nearly 60% of our children come in at a healthy weight. We still have 40% who are either underweight, overweight, or obese. This is a great concern for the children that we're seeing, and it matches what we're seeing across the country that the proportion of children and adolescents with poor diets may have declined, but there are still a large number of children with poor diets that are struggling at various age groups. Next slide.

This is from a study that the Centers for Disease Control released a couple of years ago but, unfortunately, still true that fruit and vegetable intake among young children is at a low point among children. The ages that we serve from infants through five years of age half did not eat a vegetable every day, and a 1/3 did not eat fruit every day. We know there's a link between fruit being able to eat fruits and vegetables and healthy growth and development. Important to include that so that in the meals that we serve while the children are with us, they are getting access to a daily fruit and a daily vegetable more, if possible. Next slide.

That's a little bit about nutrition. Now, a little bit about our concepts around health equity, particularly social determinants of health. The social determinants of health are defined as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks, benefits, and outcomes. Your social determinants of health may be really good, and you may have resulting good health outcomes and very few risks. Or there may be some deficits in your social determinants of health, and you may have increased number of risks, poorer health outcomes, and perhaps, a poorer quality of life.

When we think about health, we often think about genetics and behavior. But 80% of our overall health outcomes are actually driven by these social determinants of health things such as our physical environment, our social and economic factors, and other aspects of our lives. This data comes from Medicaid and from our county health rankings, which is quite significant.

We're going to talk about each of these five categories of social determinants of health: economic stability, education access and quality, health care access and quality, neighborhood and built environment, social and community context, as well as the circle that our Center has added in our graphic which many definitions of social determinants of health include, but we've added to our graphic around structural and systemic racism and other forms of oppression. These are all very, very interconnected with health outcomes. You'll see how we make them connected to nutrition services. Next slide, please.

Back to our graphic, and you can see some of this data. We're going to start with social determinants of health. We're going to dig a little deeper there. We're going to talk a little bit about health disparities, and then we're going to really get into the practices that can make a difference and help children, families, and staff on their health equity journey. Next slide. Social Determinants of Health or, as we abbreviate it, SDOH, are unevenly experienced. When we talk about these conditions, we acknowledge the fact that low-income communities and communities of color are disproportionately impacted by social determinants.

It's clear that they have a negative impact on the health of people, from historically marginalized communities, such as Black, Indigenous, Latino, and other communities of color, people with disabilities, LGBTQIA2S+ people, and people who live in under-resourced neighborhoods. Research has shown that for decades, systematic marginalization and discrimination all kinds of documented patterns of discrimination of people have occurred consistently over time and across multiple systems. Next slide, please.

That's why we have raised racism up to identify it as a social determinant of health and on a number of levels. On the systemic level, you might think about immigration policies, incarceration policies, or predatory banking policies that have long marginalized or discriminated against certain people. At the community level, various resources may be allocated to some wealthier communities and fewer resources are relegated to poorer communities. Another example are when schools are segregated by race or class. At the institutional level, there may be hiring or promotion practices that are discriminatory or an under or over-value of contributions, leading to various differences in wages.

At the interpersonal level, internalized racism, threats of being stereotyped, and various inequities embodying our behaviors contribute to what's happening inside of us. Externally, at the interpersonal level that's the overt discrimination that we often hear about, unfortunately more and more these days. Next slide, please. We know that racism has this direct impact on health. The researcher David Williams from Harvard, Dr. David Williams, speaks about how racism makes us sick. The stress contributes to various chronic diseases and a higher vulnerability of various infections.

We definitely saw that play out during the height of the COVID pandemic. Racism is prevalent on many levels and in many areas in the environment, in housing, and jobs, in education, and the delivery of health care. Next slide. We're going to start with one of the dimensions of social determinants of health care access and quality. This is the domain that talks about access to primary care, as well as getting care from a specialist. It's also the quality of the care. It's not being able to just access the care, but the quality of care.

You have insurance. You have a health care provider that's been assigned to you. You have a health care provider that listens to you, understands you, may even reflect your culture and language. It also includes a level of health literacy. Is the health care delivery system providing you information that you can understand and take appropriate actions? It includes medical research. Is the advice, is the medication, is the treatment that's being recommended for you has that been tested on your gender, on your age, on your environment, on your race? Or has it been limited to only one area? Next slide, please.

We'll talk a little example here of health literacy and why it's important for our nutrition services. When we think about health literacy, it really is about helping people get the information they need. They have to be able to find it, understand it, and use it in order to make decisions for them and their families to stay healthy. When we think about this in terms of nutrition, we want to be able to help families apply for benefits like SNAP and WIC. We want them to take precautions, like staying away or practicing food safety to stay away from foodborne illnesses or stay safe from foodborne illnesses.

We want them to understand the nutritional values on labels and what they're getting and how much they're getting. Is it the appropriate amount? Is it the right ingredients? Ultra-processed foods, which we'll talk about perhaps later, are something that contributes to unhealthy diets. People don't know it's ultra-processed until they are able to understand read and understand the label. Access to services like food banks, farmers markets, and community nutrition programs you need some level of health literacy to know where they are, when to access them, where to access them, and the various eligibility requirements.

Finally, health literacy is critical in managing health conditions such as diabetes, blood pressure, and for everyone to maintain a healthy weight. Next slide, please. The next domain is neighborhood and built environments. This is the quality of housing, the safety of a neighborhood, access to transportation, the availability of healthy foods, how much crime and violence in the neighborhood, how many playgrounds, or parks, or green space; how close that is to where people are living, environmental conditions like clean air and water.

Even broadband access is included in this domain. You can imagine, going back to our health literacy, if you don't have access to the internet, you may have more limited access to health information, which will impact your level of health literacy. Next slide, please. For this example, for nutrition, we're going to talk about food deserts and food swamps. Food deserts talk about the availability and accessibility of healthy, affordable food. Availability most often refers to the physical location or how close a food store is to where people are living for example, if a neighborhood has or is close to a grocery store.

Sometimes, the term is used to describe the presence of healthier foods within those stores for example, whether or not a small store, like a convenience store, sells fruits and vegetables, whole grains, and other healthier items, or is it just processed food? Accessibility is a broader concept that includes the availability, as well as the selection, how much it costs, and quality of foods. Healthier food options may be available, but if the prices of those foods are beyond the customers' budgets, or if the selection or quality of foods is inadequate for example, limited varieties, spoiled produce, or expired dairy products then the healthier foods are not accessible.

Those are food deserts. And many of our families, rural and urban, live in food deserts. The other example on this slide are food swamps. The Centers for Disease Control defines food swamps as those places with too many unhealthy foods because of the large numbers of corner stores with ultra-processed foods and fast-food outlets that are in areas with four or more of those places within a quarter mile of where somebody lives. In the United States, low-income and racial and ethnic minority populations are more likely than high-income, white populations to live in food swamps. And living in a food swamp has been associated with unhealthy dietary behaviors.

If you're seeing a lot of fast-food restaurants, if you're seeing a lot of the kind of convenience stores associated with a gas station or something like that, and there's a large number in an area, you may be in a food swamp. Now we can go to the next slide. The next domain in our discussion of social determinants of health is economic stability. Probably, this one, we are all familiar with because it includes poverty. It includes employment. It includes food security, and it includes housing security, all of which impact a person's health, whether they be a child or an adult. Next slide, please.

Increasing and stabilizing family income is related to increased food security and improved child behaviors and better mental health. This slide and the next slide have a little bit of data about food security status in the United States. Here, we see in 2021 that household food insecurity affected 12.5% of those homes with children. In 2.3 million households with children, both children and adults were food insecure. In a quarter of a million of those households, one or more of those children experienced reduced food intake and disrupted eating patterns at some time during 2021.

Next slide. This is the same data set described differently. I just want to point out in the note on this slide that, in most instances when children are food-insecure, it means the adults in the household are food-insecure. The adults are the last ones to eat. But if the children are food-insecure, it usually means the adults are also functioning with food insecurity, not getting enough food. You can imagine what that might do in a family the anxiety, the stress, or just what it's like how you might feel when you're hungry.

Are you more short-tempered? Are you less understanding? Are you are less aware of developmental milestones and appropriate expectations for children, as well as various learning abilities for those children in question? Next slide, please. This is one of my favorite domains to talk about social and community context because this is where we talk about connecting with

other people, social cohesion, civic participation, being involved in community activities. It also includes perceptions of equity and discrimination and privilege, as well as incarceration and institutionalization. People's relationships and interactions with their family, with their friends, with their coworkers, and other community members really do have an impact on health and well-being.

When you have an opportunity to talk to other people about your negative experiences or can refer people to more positive experiences, it improves health outcomes. The lack of meaningful connection and communication with other people is definitely linked to poorer physical and mental health. Next slide. One example referring to social and community context is the idea of food sovereignty. This may be a new term for some of you, but it has long been held high in a number of cultural and nutrition circles, particularly in American Indian and Alaska Native communities.

it's described as the ability of communities to determine the quantity and quality of food that they consume by controlling how their food is produced and distributed. The prevalence of food cooperatives, of growing your own food, of community gardens, of being able to access and consume traditional foods all fit into this idea of food sovereignty. Initiatives like farm-to-table and farm-to-preschool programs are part of the food sovereignty movement and lead to long-term health, economic stability, and cultural preservation.

Just yesterday, the US Department of Agriculture announced significant — new grant funding to a number of tribal communities and Alaska villages, Alaska Native villages to promote and enhance food sovereignty efforts, such as being able to raise and harvest traditional foods and meats on land, including bison, and reindeer, and salmon, as well as growing traditional grains, and fruits, and vegetables. Next slide, please.

This one, we may be familiar with because most of us are involved at some level of high-quality education. This is the domain that includes early childhood education and development, enrollment in higher education, high school graduation rates, and language and literacy. Early childhood experiences shape lifelong physiology and development, including cognitive, social, emotional, and so forth. Early childhood stress and adversities are related to lifelong health and mental health concerns. Next slide, please.

We have an opportunity in our early childhood programs to think about various nutrition curricula that can enhance what and how children and families consume healthy foods. Home-based and center-based programs can integrate healthy nutrition messages through puzzles and games, dramatic play, stories, math, music, science, and physical activities, such as gardens. In fact, children's gardens are linked to children trying new and eating more fruits and vegetables. Consumption of fresh fruit and vegetables, like I mentioned before, can improve health because of the high concentration of fiber, vitamins, and minerals.

One study found that students who participated in gardening, nutrition, and cooking classes ate, on average, a half a serving more vegetables per day than they did before they started that particular program. Just going back to that slide where half of our kids aren't getting enough vegetables on a daily basis if we add gardening, and nutrition, and cooking classes, it already increases it by another half. Establishing school gardens is also recommended to promote healthy eating and improve nutrition and reduce obesity. Next slide, please.

Before we leave social determinants of health, I want to remind people that individuals do not cause health disparities. The social determinants of health do. These social determinants of health, reminding you, are 80% of the reason why folks may be experiencing significant health disparities. Next slide. What are health disparities? These are the differences in health outcomes and their causes among groups of people. Health disparities are a measure that we use when we're thinking about progress towards health equity. Health disparities are often inequitable and are directly related to the historical and current unequal distribution of social, political and economic, and environmental resources.

While, for many, disparities bring to mind racial or ethnic disparities, there are many dimensions of disparities that exist in health. For instance, rural families may be experiencing more disparities, or newcomer families may be experiencing more disparities. Based on your gender, your sexual identity, or your disability can also contribute to an individual's ability to achieve good health. Next slide. It's important to remember that health disparities can be prevented. Compared to non-Hispanic white children, Hispanic children had diets with better nutrition distribution and lower dietary energy density, while non-Hispanic Black children had diets with poorer nutrition intake.

Hispanic children had higher potassium and fiber intake we're talking about some cultural norms here and consumed more legumes, beans, and so forth, while non-Hispanic Black children had lower calcium and lower vitamin D intake and higher sodium intake and lower dairy intake compared to non-Hispanic white children. Just the data gives us some clues as to where some of these disparities may exist and how we might consider intervening. Next slide.

People living in food-insecure houses vary by ethnicity and race. And this data comes from the Department of Agriculture. You can see the racial and ethnic disparities clearly outlined here. Next slide. This slide gives us a clue as to some geographic disparities. You can see, in the darker orange color on this slide, where in food insecurity is the highest and, in the paler yellow slides, where food insecurity is the lowest. On top of that, recent studies have shown that food insecurity is higher in rural communities than in urban communities. Next slide.

We can acknowledge social determinants of health. We can think about opportunities to reduce health disparities. But luckily, Head Start programs and other high-quality early childhood programs have opportunities to address health disparities and eliminate barriers by promoting, preventing, and intervening. The 2019 report from the National Academy of Sciences, Engineering, and Medicine, Vibrant and Healthy Kids, has identified that Head Start and high-quality pre-K programs do make a difference in long-term health outcomes of young children. These children may have better access to dental care.

Fewer of these children maybe have unhealthy weight. They are better immunized. Hearing and screening issues are identified early, and intervention occurs to eliminate that. On top of that, children in these programs are less likely to have adverse childhood experiences and chronic stress. Next slide, please. Let's think about it in terms of nutrition. This is an opportunity for you to talk in the chat box. I know I've been doing a lot of talking here. How are Head Start nutrition services a health and equity intervention? Think about your program and how your nutrition services are acting as a health equity intervention.

You can put those right into the chat. I'd given you some clues to start thinking about what you may be doing or the areas you may be working in on the slide. Let's see what people have to say. Special diets for children that have allergies thanks, Leti. We know that allergies and food intolerances are a growing concern. Making sure that we have fruits and vegetables during meal times, working with children with an individual education plan. They may or may not have specific nutrition issues. Helping parents learn about cooking healthy recipes on a budget important. Making sure that our foods have high nutritional values. Access to dietitians and nutritionists. Using resources like myplate.gov. This is great, everyone.

I hope you're all looking at the chat because there's some great ideas. It's now coming in fast and furious. I know this is making Shonika happy. We got farm-to-early care and education, referring folks to sources of local food, using USDA food programs like the Child and Adult Care Food Program, using local products, gardening. Super duper, everybody. Keep them coming. Everybody, make sure you're following in the chat because the folks on this call are experts. Next slide, please. We're going to talk about some of the practices, many of which you have already begun to identify in your chat contributions, that fall under our comprehensive services that Head Start in fact — Olivia, would you mind going back a couple of slides?

I want to go back to that bridge slide. What I didn't talk about when we referred to this slide are the elements of Head Start and other high-quality early childhood programs that include comprehensive services, opportunities to help parents become advocates and leaders, engaging with community partners, and, in Head Start's case, the Program Performance Standards, the regulations with which we work. In other programs, it may be licensing regulations. Of course, the funding, whether it be federal, state, or local funding that supports these high-quality programs. Thank you, Olivia. Could you go back to the slide with the three boxes? There you go.

This begins to give us an idea of how we can address nutrition-related health disparities the food insecurity issues, the access to fruits and vegetables, the health literacy, the opportunity to reduce the likelihood of people living in food deserts or food swamps. All these fall under these three categories, and we're going to look at a few of these a little deeper. Next slide. The first one I wanted to talk about is family engagement. We know that families need nutrition information services that they can easily understand, and find, and use. That's what we were talking about earlier around health literacy. A number of you mentioned that in the chat.

Someone said talking about shopping and cooking on a budget really important for many of our families. Cooking classes, community gardens, food safety all fall under this category or this activity, rather.

Helping families identify their nutritional priorities that may not what you think they need and what they think they can do may be two different things. Working together, it's a collaborative process, and they're making the final decisions based on what's best for them and their families. Helping families get access to any benefit programs that they're eligible for and using those programs, using other community food programs, and helping folks with supporting a healthy diet, particularly if they have specific health conditions. Next slide, please.

Something that we don't always pay a lot of attention to, unless we are caring for infants, is promoting breastfeeding and chest feeding. For those of you who don't know, I've been working in the field of early childhood for nearly 50 years, and I've never been in a program where there wasn't a pregnant parent somewhere in that program. We all have an opportunity, whether we care for infants or not, whether we are enrolling pregnant people in our program or not, to promote breastfeeding or chest feeding.

Chest feeding, for those of you who are new to this term, sometimes called body feeding, refers to feeding baby milk directly from the body. Sometimes this term is used for people that don't want to use the word breast to identify their anatomy. This is especially true for transgender persons. Chest feeding or body feeding is a little more neutral than breast feeding. But regardless of what language you're using, what terminology works best for you and the people that you're referring to, we want to be promoting the sharing of human milk whenever it's possible.

We can do that by using a balanced, family-centered approach. Breastfeeding or chest feeding may not work for everybody. We need to keep that in mind. But it's important for families to know that, in our program, that, in your program, this is something that is promoted, that you have information about how to access lactation support, how to get breast pumps, if that's what the family needs. Most programs have access to the use of breast pumps.

Understand that, in Head Start, we actually have requirements about promoting breastfeeding and creating a friendly environment that everyone can do, a place to safely, securely, and appropriately breastfeed or express milk or pump milk letting families ask about how we handle human milk and making sure that staff are comfortable with all of this and using our community partners. All of that goes into creating a breastfeeding or chest feeding-friendly environment in our early childhood programs.

Family-style meals is something that was originally initiated long ago in Head Start and is now widely there we go. Sorry widely accepted in the Child and Adult Care Food Program and widely encouraged as a best practice. It actually part of our Head Start Program Performance Standards. But we know for a fact that it contributes to healthier eating, both in the short term and in the long term. Next slide, please.

At our 2023 Health and Mental Health Leaders Institute, we were lucky to have Alison Tovar from Brown University share her relatively current research on the benefits of family-style meals. She has documented that family-style meals provide an opportunity for early care and education providers to really role model healthy eating, which is associated with healthier food consumption. It encourages children to make healthier food choices and improves how much food they're taking in.

It's associated with lower levels of food restriction and may prevent children from overeating compared to pre-plating when food is already put on your tray or already packaged up or proportioning food. It increases trying new foods and talking and this is so important. When we're thinking about family-style meals, it's not just the self-serving. It is also the atmosphere, the environment, the learning opportunities so talking with children and adults about food, whether it's served from a program kitchen or whether children are bringing in their own food.

Family-style meals allow children to practice self-regulation through their making their own choices. It provides opportunities to learn important, everyday skills, such as etiquette please and thank you setting a table, cleaning a table, washing hands all kinds of important elements to mealtime. It provides opportunities to practice social skills and other interactions with children. If you're in a classroom, and the adults have said, we're not going to be talking during meals, that is not part of the family-style meals. We don't want quiet. We want conversation. We want opportunities for learning and social interaction.

It's an opportunity to provide the development of motor skills, such as scooping, pouring, pinching. This can be done as children grow. You may want to practice pouring in the water table or the sand table with a pitcher and a cup before you start pouring at the table. You may want to have large cups with a line so children can see where they need to stop pouring. All of that is the development of motor skills. Otherwise, we may be crying over spilt milk. Next slide. One of the aspects that we can definitely promote in our programs are community events. This fits with that idea of social and community context.

This is where we can bring in culturally relevant programming, such as the names of foods in a specific language, serving traditional foods, using traditional music and storytelling during meal time, inviting elders and other community members into our programs to talk about food in relationship to culture and holidays, and having events where groups of people make food together. I live in Southern California. It's the holiday time. There's all kinds of tamale events. In a few months, in many Asian communities, there'll be events around preparing food for the Lunar New Year.

Preparing salmon jerky or other dried foods in many Native communities is a communal practice. And just bringing families together for a picnic or a potluck is an opportunity to express culture and community. Next slide, please. We're coming to the end here, and I just want to remind people that there are all kinds of benefits to high-quality nutrition services, whether you're in Head Start or in another early care and education program. We have the opportunity to reduce low food security and very low food security by intervening and referring.

We can help children be less likely to have nutrition excuse me nutrient inadequacies and more likely to consume more fruits, more vegetables, and more milk products at breakfast and lunch or if they're with us at dinner certainly, during snacks. We can serve meals and snacks that support and improve student physical and mental health, including addressing weight-related outcomes, improved attendance, behavior, academic performance, and academic achievement. All kinds of benefits to our nutrition services in our programs. Next slide, please.

Just reminding folks that health equity is a journey. We're not all going to get there at the same time. We won't even be in the same place. But what we talked about today is an approach to advancing health equity. If we are intentional, if we think about what we're doing with our nutrition services, we can be a nutrition intervention a health equity intervention. Sorry. Next slide. Just to remind you that we're all on this long journey, and here are the parts to the journey. Congratulations to each of you because I know that you care about children, families, and the staff that you work with.

As you are thinking about these social determinants of health that we all live, work, and play in, you are thinking about the possible health disparities that they may be causing and how we can promote healthy behavior, prevent health conditions, and intervene when a health condition is identified. Next slide. We have just a minute or two for questions. I wonder, Shonika, can you join me and let me know what kinds of questions we might want to answer now?

Shonika: Yes. Thank you, Steve. This has been very informative. I do have some questions that have been asked in the chat. The first question is, what would you recommend to be included in a nutrition assessment or questionnaire?

Steve: Great question. There's all kinds of models online. If you don't currently work with your WIC program, I would definitely reach out to them, not only because they have experience with these kinds of questionnaires, but they will also be familiar with local conditions. You want to be able to for sure ask about food security, and you need to ask those questions in a very sensitive way. People are not always comfortable talking about whether they have enough food in the home, whether they have enough money to buy food in a given month, whether they have access to food.

Be familiar with the community that the family comes from. Know right away if there's a grocery store. You can even ask, how far do you have to go for your groceries? Where do you get your groceries? If they're talking about going to a corner store or forgetting that there's a farmer's market, or they may be eligible for SNAP or WIC, and they aren't already part of that those are all important questions, as well as, what are your food preferences? What are your dietary preferences? Do they have religious, cultural, or special dietary needs?

Shonika: Yes. To add on to some of the things that Steve mentioned, I think it's really important that you know the families he mentioned this know the families that are coming into your program. Your community assessment is a source of great information, and what is it that you need to know about your families that are coming in to support them in the goals that they have for their children, for their own lives? Thank you so much, Steve.

I have another question that I thought was a really good question, and I think we could also get some of these comments from our chat members, as well. The question was about you mentioned farm-to-early childhood as being one of those opportunities. Farm to early childhood is one of my favorite things. I mean, I just think that the earlier and the sooner we get children started on understanding the food systems, where food comes from you start that interest very early in our children.

With that, Sarah asks, how have programs found funding to support some of those farm-to-school interventions? Most of the funding that she sees is usually associated with the National School Lunch Program. But do you have any ideas or resources? Then, also, too, for our attendees, if you could also drop some suggestions in the chat, that would be awesome.

Steve: While people are putting it in the chat, I will say, please write to health@ecetta.info. Melissa is going to put that address right into the chat. I think it's been there before. But there are specific awards every single year for early childhood programs to apply for funding for farm-to-early care and education or early childhood education programs. There are a number of other nutrition- and food-related funding sources.

If you don't already, subscribe to our monthly resource list. Every single month, there are funding opportunities in that that you can apply for. While there is a farm-to-school program that funds food for the National School Lunch Program, there's a separate program that's farm-to-early care and education.

Shonika: Thank you so much, Steve. Now, it's the top of the hour, so don't know if you want to answer one more question, or if we can go ahead and get ready to close out our webinar.

Steve: I think we need to get ready to close because Melissa has some ending things. I see a bunch of questions in the Q&A box. Please write to health@ecetta.info, and we will answer your question specifically because I see some good questions in there. There are resources on your handout that also answer some of those questions, like curriculum ideas. And Melissa also put the subscription address in the chat. Melissa, you want to take us away?

Melissa: Thank you, Shonika, and thank you, Steve. Thank you, everyone, for your great contributions and questions today. If you have more questions, as Steve mentioned before, you can write to health@ecetta.info or go to MyPeers. The evaluation URL was also placed in the chat. We'll put it in there again. It will also appear after you leave the Zoom platform. If we could go back to the evaluation slide for a moment, there's a URL and a QR code. That also brings up the evaluation.

The evaluation survey is anonymous. Your feedback is important to help us improve future training and technical assistance offerings. A reminder that, after submitting your evaluation, you will see a new URL. This link allows you to access, download, save, and print your certificate. Next slide, please. We want to make you aware of the proposed changes to the Head Start Program Performance Standards. The Office of Head Start is soliciting feedback on the significant changes proposed to the Head Start Program Performance Standards in a notice

of proposed rulemaking in the Federal Register. The proposed changes, if enacted, will stabilize the Head Start workforce and improve the quality of the comprehensive services that Head Start families count on.

Learn more about the proposed policies and how to share your feedback on the Federal Register using this QR code and on the ECLKC website. The public comment period closes 60 days after publication. Questions please email ohs_nprm@acf.hhs.gov. We thank you, and we invite you to subscribe to our mailing list, if you don't already, at this address. Remember to follow us on social media and use MyPeers to continue the conversations on today's topic with your colleagues from across the country.

Steve: Melissa, I'm just going to interrupt you for one second. I saw a number of people ask about the recording and the notes. Within the next 24 to 36 hours, you will get a copy of the recording, the slides without the notes, we don't share our notes. You will have a recording, you will have the slides, and you will have the resource handout and an additional link to the evaluation and certificate. That will be coming out in the next 24 to 36 hours to all of you, whether you attended or not. If your colleagues registered but didn't attend, they will get that. I want to make sure that people know that. Thanks.

Melissa: Thank you, Steve. Lastly, you can find our resources in the Health section of the ECLKC website, or write to us at health@ecetta.info. Thank you for joining us today.