



Improving the Nutritional Well-Being of Women, Children and Families

ASTPHND BRIEF

The Association of State and Territorial Public Health Nutrition Directors (ASTPHND) provides state and national leadership on food and nutrition policy, programs, and services. The ASTPHND Maternal and Child Health (MCH) Nutrition Council offers this paper as a guide to improving the nutritional well-being of women and children throughout our nation. This brief presents recommendations and a call to action to state agencies working with the MCH population.

Introduction

The maternal and child health (MCH)¹ community is challenged to strengthen the nutritional status of women, children, youth and their families, including children with special health care needs. There are unmet needs in providing maternal and child health services; most states do not engage in state-level assessment and planning in this area. Additionally, unexplored opportunities exist to strengthen nutritional well-being for the MCH population. These opportunities include integrating public health nutrition concepts and interventions into health equity, life course health development, health promotion interventions, and social determinants of health-based projects.

Healthy eating and good nutrition habits are essential for health. The research is clear that nutrition is vital

to the healthy development and well-being of infants, children, youth, and adults. Throughout the country, we are sensing an unprecedented interest in improving health, especially in the areas of wellness, breastfeeding promotion, child health and obesity prevention. However, these improvements will not happen unless we address healthy eating and nutrition both at the individual and population levels. The nutritional well-being of the MCH population is currently inadequate as evidenced by current statistics on the increase in obesity, poor eating habits, low rates of breastfeeding initiation/duration and chronic diseases. Nutrition problems among the nation's women and children contribute to widespread health issues, intellectual and developmental problems, reduced productivity, and higher health care costs.

¹The term MCH is used within this paper to denote the discipline of public health that addresses the needs of women and children's health. It is not meant to limit the discussion to the Title V Maternal and Child Health Block Grant, which is a federal funding stream that supports state and territorial MCH programs.

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Is Anyone Monitoring the Nutritional Well-Being of Maternal and Child Health Populations?

Over time, there has been erosion in public health nutrition's ability to engage in population-based activities to improve the health of women, children and youth. It appears that no one entity is taking the lead in monitoring and improving the nutritional well-being of women and families within states. Historically, the federal Department of Health and Human Services (HHS), the Health Resources Services Administration (HRSA), and the Maternal and Child Health Bureau (MCHB) had a strong focus on ensuring the nutritional well-being of these populations. However, fewer MCH Block Grant-funded public health nutritionists exist today compared to 25 years ago.

Redirection of already insufficient resources and misunderstanding about the role of public health nutrition programs contributes to this problem. Reduction in funding for the Title V MCH Block Grant has forced states to prioritize the services they can offer and the positions they can fund. Additionally, the focus on addressing key performance measures and a movement away from a discipline-based focus has reduced the visibility of nutrition within MCH



Block Grant-funded programs. This change is often coupled with an inaccurate perception that programs, such as WIC, can cover all aspects of public health nutrition, which is not the case. The poor economy and state fiscal problems have also decreased the availability of public health nutrition staff; those remaining in state health agencies are experiencing a substantial increase in their workload. While we can understand the reasons leading to the reduction in nutrition services, it is still essential that state MCH and nutrition programs comprehensively address the nutritional well-being of vulnerable women, children, youth and families across funding streams.

Public Health Nutrition Workforce

A Public Health Nutritionist¹ is a nutrition professional with academic training in public health who assesses the community's nutrition needs and plans, directs and evaluates community nutrition interventions to meet these needs. The public health nutritionist works to promote health and prevent disease among the population at large. Since 1985, ASTPHND has conducted a series of surveys² on the public health nutrition workforce. ASTPHND completed the most recent survey in 2006-2007 with data collected from 7,550 public health nutritionists throughout the nation. The report gathered information by the three core public health functions: assessment, policy development and assurance. The report also identified management and administration responsibilities. The results indicated that nearly seven out of ten public health nutritionists work primarily in assurance-related tasks, predominately in the provision of direct care to clients. In contrast, 11 percent of public health nutritionists work in assessment activities such as implementing community assessments, program planning or evaluation. Another approximately 11 percent of public health nutritionists are primarily responsible for management and administration. Finally, six percent of public health

¹Dodds, J.M. (Ed.). (2009). Personnel in Public Health Nutrition For the 2000's. Retrieved at http://www.astphnd.org/resource_files/105/105_resource_file1.pdf. September 2010.

²Houghton, B., A. George. (2007) Survey of the Public Health Nutrition Workforce: 2006-07. Retrieved September 2010 http://www.astphnd.org/resource_files/117/117_resource_file1.pdf.

nutritionists work in the area of population-based interventions doing advocacy or policy development, communications or other areas.

The United States Department of Agriculture (USDA) funds eight of ten public health nutrition positions, primarily through the WIC Program. The vast majority of the WIC workforce works directly with low-income women, infants, and children providing counseling, education and food vouchers.

A historical funding source for public health nutritionists is the MCH Block Grant. This funding stream has long funded broad based public health nutrition functions. Over time, there has been erosion in positions funded by this source. In 1994, the MCH Block Grant funded 226 or 3.5 percent of all public health nutrition full time positions. In 1999-2000 that amount decreased to 186 positions, or 1.9 percent of the workforce. The 2006-07 report showed that the MCH Block Grant funded only 147 positions, or 1.6 percent of the workforce.

The Centers for Disease Control and Prevention (CDC) also supports public health nutrition positions that address chronic disease prevention issues such as diabetes, cancer and cardiovascular disease. Recently, CDC has increased its funding and supports 48 positions focusing on obesity. Yet the total number of positions funded by the prevention block grant has decreased from 61 to 31 from the 1999-2000 to the 2006-07 reports.



Unmet State Needs Related to Population-based MCH Nutrition

It is critical that states invest in the broad assessment of the nutrition needs of women and children. It is a misconception that WIC can cover all aspects of public health nutrition. As funding is available, the WIC Program meets the needs of eligible women and children at the direct care and enabling levels of the MCH pyramid with education, referrals and other services. However, WIC was not designed to address infrastructure and population-building activities. Since many states rely on WIC as the MCH nutrition services for their states, these states may not be meeting public health functions related to assessment, assurance and policy development.

This concern becomes especially important when states address issues such as obesity where overall MCH assessment, monitoring and assurance functions are critical. Obesity is a key example of an issue that more state MCH programs are addressing. When focusing on obesity, states need to know population status relevant to weight, food and activity patterns, and they must have access to nutrition resources and what programs and interventions make a difference. While other professionals can and must monitor these issues, at a certain point it is necessary to have the skills of trained public health nutritionists who are dedicated to addressing MCH issues.

There are a number of nutrition programs that focus on the maternal and child health population; however none is responsible for meeting the population-based

needs of this group. The WIC program offers education, food and referrals to income-eligible pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. School Meals offers food to children within the school setting. The Child and Adult Care Food Program (CACFP) addresses nutrition needs within childcare homes and centers. Supplemental Nutrition Assistance Program (SNAP) provides food and advice to low income families receiving food stamps. Other programs such as Head Start emphasize meeting food and nutrition needs of the children they serve. Together these nutrition programs are essential in meeting the food and nutrition education needs of pregnant women and children with low incomes. However, these programs are income dependent, vary in the amount of nutrition education that they provide, and focus on the provision of healthy food. They touch the lives of children, their families, the health care providers and teachers, but they are not responsible for broad-based assessment and planning for states to meet the health needs of all MCH populations.

MCH Public Health Nutrition Tasks and Responsibilities

There are a number of ways to better integrate public health nutrition within MCH programs or conversely to consider the comprehensive needs of maternal and child health populations within state nutrition programs. Three organizing tools help identify where nutrition can be better integrated into services. One is the Life Course Health Development Model, an emerging approach embraced by the MCH community to organize services and outline interventions. Two other organizing tools are more familiar, the MCHB Pyramid and the Socio-Ecologic Model.



Life Course Health Development Model^{3,4,5}

The maternal and child health community is now embracing a life course approach to theory and practice that acknowledges that there are distinct periods in human development that present both risks and opportunities to intervene to make lasting improvements. Life Course Health Development looks at health not as disconnected stages (infancy, latency, adolescence, child-bearing years and old age) unrelated to each other, but as an integrated continuum. It also embraces the view that maternal health, built across the life course, affects future pregnancy outcomes. This perspective suggests that a complex interplay of biological, behavioral, psychological, social and environmental factors contribute to health outcomes across the course of a woman's life. The life course model builds on recent social science and public health literature that theorizes that each life stage influences the next and that social, economic, and physical environments interacting across the life course have a profound impact on individual and community health. This model is founded on the social determinants of health theory, as well as the concept of what an

³Fine A, Kotelchuck M, Adess N, Pies C. 2009. Policy Brief. A New Agenda for MCH Policy and Programs: integrating a Life Course Perspective.; Martinez, CA. Contra Costa Health Services. Retrieved January 2010 at http://www.cchealth.org/groups/lifecourse/pdf/2009_10_policy_brief.pdf.

⁴Pies C, Parthasarathy P, Kotelchuck M, Lu M. 2009. Making a Paradigm Shift in Maternal and Child Health; A Report on the National MCH Life Course Meeting. Martinez, CA. Contra Costa Health Services. http://www.cchealth.org/groups/lifecourse/pdf/2009_10_meeting_report_final.pdf.

⁵USHHS,HRSA, MCHB. 2010. Retrieved September 2010 at Lifecourse Approach Resources <http://mchb.hrsa.gov/lifecourseresources.htm>

equitable and just society could look like. This approach identifies the need to intervene both medically and socially at different points along a person’s life span.

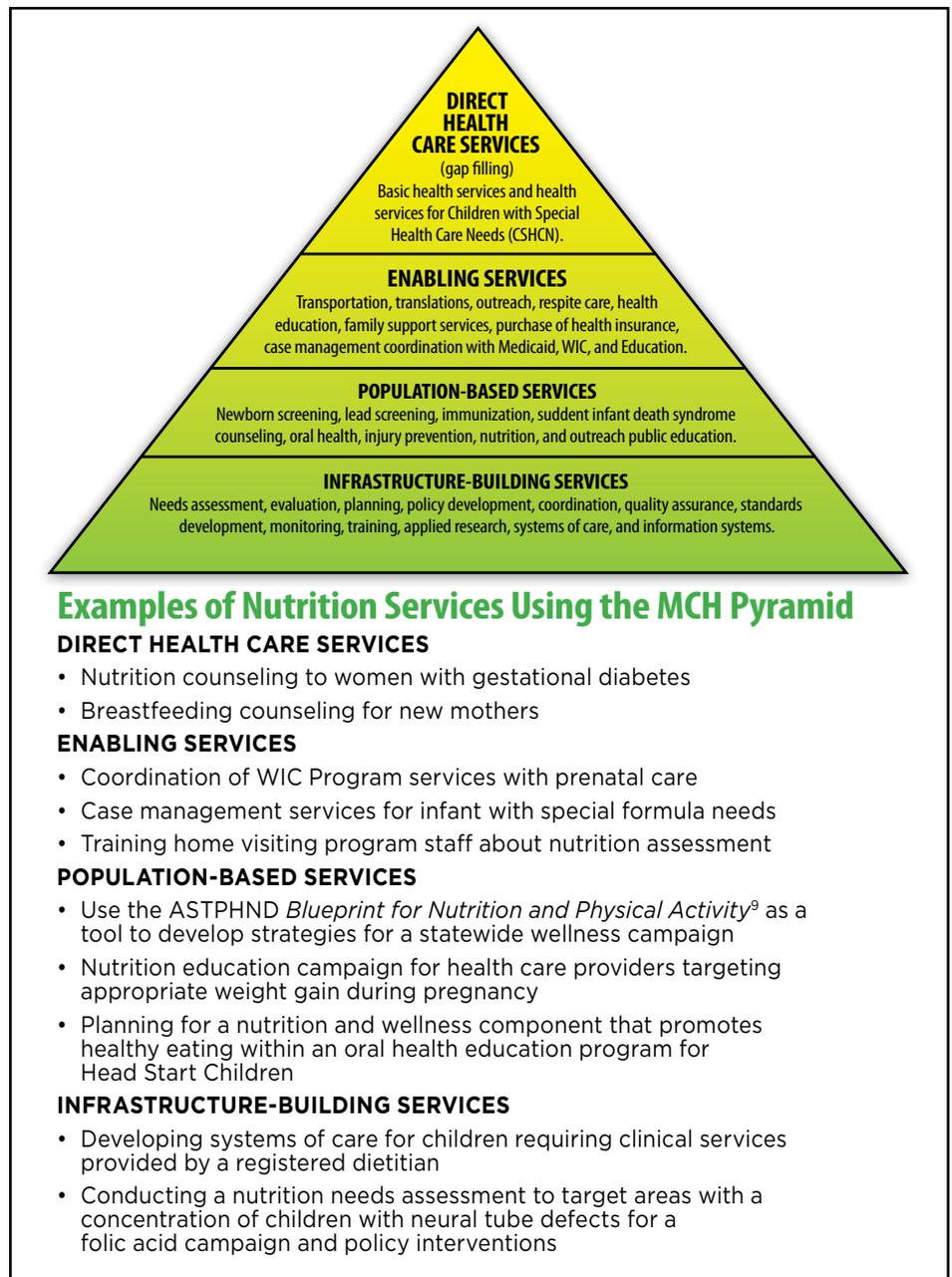
Nutrition has long been organized upon a lifecycle model that integrates well with the life course development model. It is well understood that the nutritional well-being of a pregnant women impacts the health of her infant. Breastfeeding and other feeding practices in infancy provide a positive start to life. Healthy eating and active living contribute to well-being in early childhood that supports the ability to grow, develop and learn. Finally, the healthy habits nurtured in childhood lead to well-nourished youth and adults who know how to prevent chronic disease and maintain a healthy weight as part of a healthy lifestyle. It is commonly acknowledged that there is no stronger way to support prevention and wellness than positive maternal and child health development.

MCH Pyramid⁶

The Maternal and Child Health Bureau (MCHB) developed the MCH Pyramid to describe how MCH services are provided. These services range from direct care to population-based services. An example of direct care service is the provision of care for an individual patient while a population-based service impacts many individuals. MCHB encourages providing services at the population-building and infrastructure levels of the pyramid. Other providers, such as WIC or primary care practitioners, offer services at the direct care or enabling levels of the pyramid.

To illustrate this approach, within a MCH program seeking to provide more population-based services, a MCH nutritionist would not be responsible for the direct health care counseling to families and children with special health care needs, but would be tasked with developing a community-based system of care that ensures children have access to quality and appropriate nutrition counseling within their

community. Or, instead of providing nutrition direct care to women about appropriate weight gain, the MCH program develops an intervention to train health care providers in adequate weight gain counseling and offers web-based provider and patient education materials. Providing menu label information at the point of purchase is a policy level strategy that assists women with diabetes to make wiser food choices.

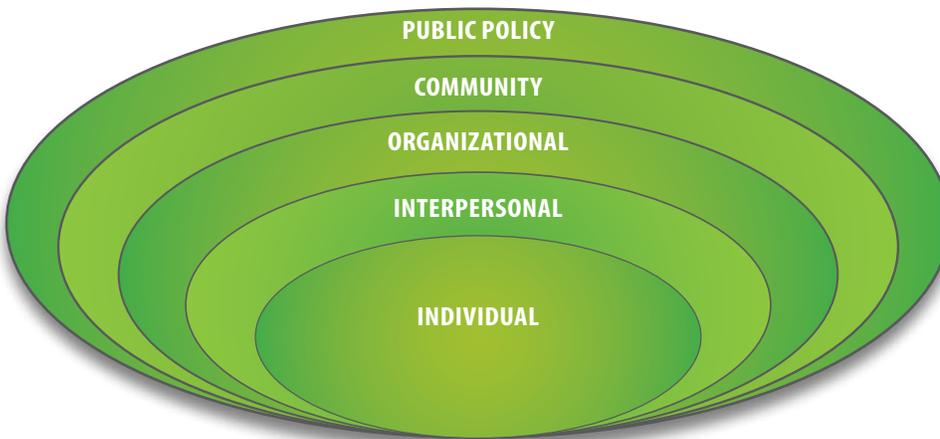


⁶ USHHS, HRSA, MCHB. Maternal and Child Health Bureau Strategic Plan: FY 2003-2007.

Socio-Ecologic Model

The socio-ecologic model shows how levels of interventions are interconnected and change is achieved by focusing on the various levels of influence concurrently. Obesity and chronic disease control programs often use this model. The socio-ecologic model identifies the need to provide services at several levels: direct care to individuals, interventions offered through places where people live, work, learn or congregate, as well as the need to impact institutions and society at large using policy and environmental change strategies. This approach emphasizes that health promotion

changes need to happen at all levels of society. For example, helping children maintain a healthy weight is about helping a family make good food and exercise choices. However, it is difficult for individuals or families to make and sustain positive behavior change if the state in which they live and work does not support healthy eating, physical activity and other policies that promote healthier communities. CDC-funded strategies often identify where nutrition services and intervention can be better focused to promote health and prevent disease for all populations. However, these strategies could be strengthened by embracing the life course approach with emphasis on improving maternal and child health.



Public Health Nutrition Personnel

Many states have not fully embraced public health nutritionists as an essential component of the interdisciplinary team that is addressing the multi-dimensional needs of the MCH population. A misconception about the provision of public health nutrition is that other skilled members of the interdisciplinary team can monitor and fully address the nutritional needs of the MCH population. While nutrition is a cross-cutting issue that should be addressed by a variety of professionals, a great need exists for specifically trained individuals versed in public health nutrition. Nutritionists bring knowledge of public health coupled with expertise in food and nutrition. The overall quality of programs is reduced when this tipping point is not recognized. The gold standard for nutrition services is to have access to a qualified public health nutritionist. This person will provide oversight to ensure that MCH populations are receiving appropriate nutrition guidance within programs and systems.

Program leaders will improve the quality of their programs if they determine how to include public health nutrition services for women, children and families. The MCH Block Grant is an ideal funding stream to support this position because of its flexibility. State funding can also support this type of position. Braiding several relevant funding streams can create support for a broad-based position that is not limited by a single program's

Examples of Nutrition Services Using the Socio-Ecologic Model

- **Individual** – Nutrition counseling for high risk women about weight gain during pregnancy
- **Interpersonal** – Nutrition counseling for a family with overweight children
- **Organizational** – Systematic changes within a child care, work or school setting regarding food choices
- **Community** – Statewide campaign to eat less/move more or improving community access to healthy food and elimination of food deserts
- **Public Policy** (social structures, policy, systems) – Reimbursement for nutrition services offered within a home visiting program; requirement of menu labeling

categorical requirements. Another option is to jointly fund positions for a public health nutrition professional in an area such as breastfeeding, early childhood wellness or healthy weight maintenance. It is also possible to contract externally with a public health nutritionist to provide needed services. Each state should choose the model most appropriate for its circumstances and seek to leverage resources to fulfill this need.

MCH Block Grant Opportunities

The Title V MCH Block Grant presents many opportunities to improve the nutritional status of women and children. Because of its flexibility and inherent mission to improve the well-being of women and children, the MCH Block Grant remains an ideal resource for ensuring that comprehensive public health nutrition services are available for this population. MCH has long supported efforts to improve nutrition and health, emphasized the development of partnerships across funding streams, and has taken a multidisciplinary approach to health. Today the block grant emphasizes the development of infrastructure and population-based interventions, which should include public health nutrition.

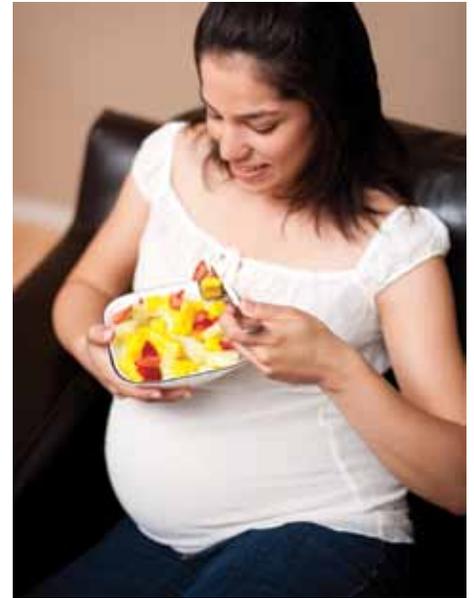
Multiple opportunities already exist within the MCH Block Grant in each state and territory to address public health nutrition. Each state

or territory must address children with special health care needs, breastfeeding promotion and the weight of children enrolled within WIC. However, opportunities for providing comprehensive public health nutrition are abundant. In 2010, a review of block grant applications show that 34 states/territories have state performance measures to address obesity and overweight and an additional 15 have also selected other nutrition and physical activity measures. Other opportunities for improving nutritional well-being within the MCH Block Grant include performance measures that focus on pregnancy, preconception health, oral health care coordination, surveillance and data.

Tasks and Roles for Public Health Nutrition⁷

Key roles and tasks for maternal and child health public health nutrition personnel include:

- Coordinate all public health nutrition programs within MCH
- Advocate for meeting the nutrition needs of the MCH populations
- Use a Life Course Health Development perspective to emphasize principles for optimal nutrition at the individual, population and policy levels
- Assure or plan interventions for individuals or groups that have illnesses or special health needs



- Develop and manage systems of clinical nutrition care for MCH populations, such as women with gestational diabetes
- Provide evidenced-base guidelines, training, oversight and services related to case management, care coordination, and nutrition counseling for high-risk clients
- Provide evidenced-based technical assistance, professional guidance, and training for nutrition or other staff
- Share successes and promising public health nutrition practices that meet the needs of MCH populations; collaborate to implement these practices
- Interpret and communicate evidenced-based nutrition information to the public using effective techniques and current methods; participate in interdisciplinary teams to ensure consistency in nutrition messaging

⁷ Adapted from Dodds, J.M. (Ed.). (2009). Personnel in Public Health Nutrition For the 2000's. Retrieved September 2010 from http://www.astphnd.org/resource_files/105/105_resource_file1.pdf.

- Assess the nutrition needs of the state; plan, direct and evaluate nutrition interventions or programs, either as freestanding programs or as a component of more comprehensive public health initiatives
- Engage in program and systems development associated with nutrition issues
- Develop health promotion strategies at the individual, community and policy levels
- Establish and oversee state advisory groups on topics such as food security, breastfeeding promotion or obesity prevention
- Initiate and carry out quality improvement of nutrition interventions
- Develop and use nutrition surveillance systems; assure the inclusion of nutrition and food data in epidemiologic studies; and participate in the interpretation of results and development of recommendations
- Integrate nutrition components, as appropriate, within emerging areas of MCH practice

We encourage MCH programs to review what tasks their program staff are currently addressing and to consider how they will incorporate the unaddressed tasks in the future.

Summary

The MCH community is challenged to strengthen the nutritional status of women, children, youth and their families, including children with special health care needs. There are unmet needs in the area of public health nutrition and many states do not engage in state-level assessment and planning in this area. Additionally, unexplored opportunities exist to strengthen nutritional well-being for the MCH population.

ASPTHND’s MCH Nutrition Council is calling on states and territories to take action to enhance the public health nutrition services they offer and ensure population-based services are available that support the health of women, infants, children, youth and families.





Call to Action to Improve the Nutritional Well-Being of Women, Children and Families

We are calling on maternal and child health (MCH) and child nutrition programs to take action to enhance the public health nutrition services offered within their purview and ensure that population-based services are available that support the health of women, infants, children, youth and families.

The Association of State and Territorial Public Health Nutrition Directors (ASTPHND) Maternal and Child Health (MCH) Nutrition Council calls upon programs serving women, children and families to enhance the public health nutrition components of their organizations and to include the services of a public health nutritionist when appropriate. **The ASTPHND MCH Nutrition Council recommends that:**

- ✓ **MCH Title V State Programs** provide a broad range of public health nutrition interventions to improve the health of women, children and families. Each state MCH program will benefit from having on staff at least one MCH public health nutritionist. This person will be responsible for assessing and assuring the status of comprehensive quality public health nutrition services at all levels of the MCH pyramid.
- ✓ **State and Federal Nutrition program personnel** work together to identify how to best promote the health of the maternal and child health population and to take action to carry out their joint plan. We further recommend that these program personnel collaborate to develop consistent and effective messages for the MCH population

around eating healthy and being active. Key nutrition and non-nutrition MCH partners can develop and use these messages to ensure greater consistency between programs and offer a united approach to promoting health.

- ✓ **Federal programs** clarify and address the role of public health nutrition when issuing rules regarding program content and staffing patterns. We also encourage programs to recognize the benefit of a life course approach that includes a strong maternal and child health component. Consider making regional public health nutrition consultation available to states.
- ✓ **Federally funded nutrition programs** identify opportunities for coordination to meet the overall maternal and child health nutrition goals at the state and federal levels. State personnel from WIC, Maternal and Child Health, Child and Adult Care Food Program, Supplemental Nutrition Assistance Program (SNAP) and Centers for Disease Control and Prevention-funded and other similar programs are encouraged to work together to improve the health of women and children. Together they can identify shared goals; delineate gaps; outline and achieve objectives. Such an effort would

maximize resources, build on each organization's strengths and maintain individual program integrity.

- ✓ **Nonprofit organizations** working with nutrition and/or maternal and child health populations address the nutrition well-being of their constituents. These organizations could involve public health nutritionists from ASTPHND, the American Dietetic Association, the National WIC Association and other public health nutrition organizations.
- ✓ **University personnel** develop curriculum and training programs that expose students to public health and maternal and child health principles and experiences.
- ✓ **Credentialing organizations** recognize the skill sets needed for public health nutrition and include these experiences as part of training expectations for registered dietitians.



Public Health Nutrition Tasks

The MCH community is challenged to strengthen the nutritional status of women, children, youth and their families, including children with special health care needs. ASTPHND's MCH Nutrition Council encourages state personnel to review the public health nutrition task checklist below, identify what tasks they are currently addressing and consider how they can strengthen their program by incorporating the unaddressed tasks.



TASK	NOT MET	PARTIALLY MET	MET
Provide leadership and advocate for meeting the nutrition needs of the MCH populations			
Use a Life Course Health Development perspective to emphasize principles for optimal nutrition and wellness at the individual, population and policy levels			
Assure or plan interventions for individuals or groups that have special health needs or conditions			
Develop and manage systems of clinical nutrition care for MCH populations such as women with gestational diabetes			
Provide evidence-based guidelines, training, oversight and services related to case management, care coordination, and nutrition counseling for high-risk clients			
Provide evidence-based training and technical assistance, professional guidance, and training for nutrition or other staff and students when appropriate			
Share effective and promising public health nutrition practices with partners and collaborate to implement these practices			
Communicate and interpret evidence-based nutrition information to the public using effective techniques and current methods; ensure consistency and accuracy in nutrition messages across interdisciplinary teams			
Assess the nutrition needs of the state; plan, direct and evaluate nutrition interventions or programs, either as freestanding programs or as a component of more comprehensive public health initiatives			
Engage in program and systems development associated with nutrition issues and others such as emergency preparedness			
Develop health promotion and wellness strategies at the individual, community and policy levels			
Establish, support, participate, and/or oversee state advisory groups on topics such as food security, child health or obesity prevention			
Initiate quality improvement of nutrition interventions			
Develop and use nutrition surveillance systems; assure the inclusion of nutrition and food data in epidemiologic studies; and participate in the interpretation of results and development of recommendations			
Integrate nutrition components, as appropriate, within emerging areas of MCH practice			

History of Nutrition in MCH⁸

Nutrition has long been an important component of public health. The following information from the MCH Timeline provides a brief review of key milestones for public health nutrition.

1922

The Sheppard-Towner Act of 1922 provided funds that states could use to improve children's health and reduce the rate of infant mortality. The first MCH training program provided specialized training. In 1943 public health nutrition programs were established.

1935



Title V of the Social Security Act is the longest-standing public health legislation in American history and continues to work to improve the health of women and children. Title V provided programs for maternity, infant, and child care, as well as a full range of medical services for children. The Act allocated funds to states to pay for Maternal and Child Health and Crippled Children services provided by nutritionists.

1940

The White House Conference on Children in a Democracy addressed malnutrition and the elimination of discrimination on the basis of race or creed. One result was a proposal for a national program on maternity care.

1944

Marjorie Heseltine, first nutritionist with the Children's Bureau, called the initial conference of state nutrition directors. Subsequent meetings were held in conjunction with the American Dietetic Association and the American Public Health Association.

1946

Congress passed the National School Lunch Act to secure the well-being and health of children as well as to encourage consumption of local food. The Act established multi-year authority for the financing of school food programs. It now permanently authorizes the National School Lunch Program and the Child and Adult Care Food Program.



1947

The first federally funded long-term MCH training programs at universities were established. These departments' primary goal was to train administrators with a public health and child/family focus for the new programs being developed in

the states under Title V. Today the program invests in graduate level leadership training programs across the U.S. in areas including nutrition.

1953

The first official meeting of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND). ASTPHND provides state and national leadership on food and nutrition policy, programs, and services.

1963



Maternity & Infant Care (MIC) Projects addressed the prevention of mental retardation and the reduction of infant mortality in low income families. These MIC projects took a multidisciplinary approach that included nutritionists to increase access to prenatal care to prevent infant mortality.

1964

The Food Stamp Program (FSP) was established nationwide to improve the nutrition of low-income individuals and families. Qualified recipients received federal assistance (food stamps) on a term-by-term basis to purchase foods at FSP participating stores.



1965

Children & Youth Projects resulted from amendments to Title V of the Social Security Act. The intent of these projects was to provide comprehensive health care including nutrition to children and youth.

1966

The Child Nutrition Act intent was to ensure that children were provided with adequate food in order to promote better development and learning.

1969

The White House Conference on Food, Nutrition, and Health brought to the forefront the importance of nutrition in maintaining a healthy nation to the forefront. Many landmark policies were developed from this conference, including further development of the food stamp program, the school lunch

program, food labeling and the establishment of the Food and Nutrition Service in order to administer the federal food assistance programs.

1972

The Special Supplemental Food Program for WIC was created as an amendment to the Children's Nutrition Act of 1966. Through its efforts, WIC has been consistently associated with health improvements and reduced rates of low birth weight, infant mortality, and anemia.



2002

The Farm Security and Rural Investment Act of 2002 authorized the Fresh Fruit and Vegetable Pilot in four states and one Indian Tribal Organization. The program is now available nationally to determine the best practices for increasing fruit and fresh vegetable consumption in schools.

⁸ USHHS, HRSA, MCHB. MCH History Timeline. Retrieved September 2010 at <http://mchb.hrsa.gov/timeline>.

Photos courtesy of the USDA and School Milk Photo Collections, Child Nutrition Archives, National Food Service Management Institute, The University of Mississippi



2009

The American Recovery and Reinvestment Act of 2009 designated about \$142 billion for children, including funding for school modernization, Head Start, foster care and adoption assistance, the Child Tax Credit, and the Supplemental Nutrition Assistance Program.

2009

The Association of State and Territorial Public Health Nutrition Directors launched the Maternal and Child Health Nutrition Council. The MCH Nutrition Council provides leadership to achieve optimal well-being through healthy eating and active living among the maternal and child health population, including those served by Title V/MCH Block Grant.





Nutrition in Maternal and Child Health Primer

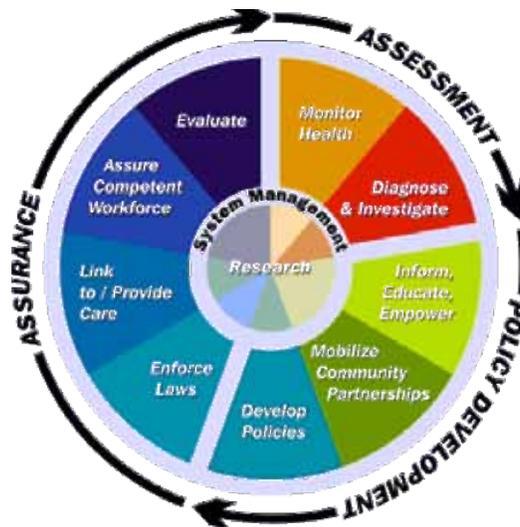
This primer provides a brief introduction to the roles and the practices of public health nutritionists skilled in the disciplines of nutrition and public health who work predominately within the area of maternal and child health.

Public Health. The Institute of Medicine¹⁰ has defined public health as “what we do collectively as a society to create conditions in which we can be healthy.”

Maternal and Child Health (MCH)¹¹ is a fundamental component and a specialty area within public health that focuses on the determinants, mechanisms and systems that promote and maintain the health, safety, well-being and appropriate development of children and their families in communities and societies. MCH is distinguished by a focus on promoting the health and well-being of all women, children, adolescents, fathers and families, especially in disadvantaged and vulnerable populations. As a public health discipline, it addresses health promotion/prevention and facilitates the development of systems of care within communities.

Public Health Nutrition’s goal within maternal and child health is to promote optimal nutritional status, maintain health and prevent or control disease for women, infants, children, youth, families, including people with special health care needs.¹²

A Public Health Nutritionist¹³ is a nutrition professional with academic training in public health who assesses the community’s nutrition needs and plans, directs and evaluates community nutrition interventions to meet these needs and works to promote health and prevent disease among the population at large.



Assessment: regular, systematic collection, assembly, analysis and distribution of information on the health of the community, including statistics on health status, community health needs, and epidemiological and other studies of health problems. Public health nutrition examples of assessment include:

- Assess the nutritional status of a population or geographic area
- Identify target populations that may be at nutritional risk
- Initiate and participate in nutrition data collection

Policy Development: using the scientific knowledge base in making decisions about public health and taking a strategic approach to leadership for public health policy with a positive appreciation for the political process. Public health nutrition examples of policy development include:

- Develop health and nutrition policies
- Raise awareness among decision makers about food and nutrition issues
- Advocate for the MCH population regarding nutrition and physical activity

Assurance: engaging policy-makers and the public in determining those services that will be guaranteed to every member of the community, and making services necessary to achieve agreed-upon goals available by encouraging action by public and private entities, implementing regulatory requirements, or directly providing services. Public health nutrition examples include:

- Assure the availability of quality nutrition policies and services to target populations
- Participate in nutrition research and evaluation
- Develop and provide specific nutrition training and programs to reduce gaps in health status nutrition content.



The Ten Essential Functions of Public Health¹⁴ Are:

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** competent public and personal health care workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

¹⁰ Institute of Medicine (U.S.). Committee for the Study of the Future of Public Health. (1988). The Future of Public Health. Washington, D.C.: National Academy Press.

¹¹ Stahl, M.J. (Ed.).(2004). Encyclopedia of Health Care Management. Thousand Oaks, CA.: Sage Publications Inc Pg 356.

¹² The American Dietetic Association. (1995). Public Health Nutrition: Definition and Function. In The ADA Public Health Nutrition Practice Group News Personnel in Public Health Nutrition for the 1990's, A Comprehensive Guide.

¹³ Dodds, J.M. (Ed.). (2009). Personnel in Public Health Nutrition For the 2000's. Retrieved at http://www.astphnd.org/resource_files/105/105_resource_file1.pdf. September 2010.

¹⁴ Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee. (1994). Retrieved September 2010 National Public Health Performance Standards Program <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPublicHealthServices.htm>.

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