

Commodity Supplemental Food Program

The Commodity Supplemental Food Program (CSFP) began in 1968. With the goal of improving the health of low-income women and their infants and children, CSFP provided supplemental foods, information about good nutrition, and a link to health care. Over time, the program's focus has expanded to include the low-income elderly, who currently make up the bulk of program participants. Little research has been done on the CSFP, and none has been done at the national level.

Program Overview

The impetus for creation of the CSFP stemmed largely from response to concerns in the late 1960s about hunger and malnutrition among vulnerable low-income populations. The "Hunger in America" report, released by the National Board of Inquiry, as well as the "Poor People's Campaign," led by several advocacy groups, were especially influential in generating the groundswell of concern that led to the program's creation (Mahony Monrad et al., 1982).

The Supplemental Food Program, as it was initially known, was developed jointly by the U.S. Departments of Agriculture (USDA) and Health, Education, and Welfare (the forerunner of the current U.S. Department of Health and Human Services). The program provided food packages, including evaporated milk, corn syrup, and "reinforced" cereals, to low-income women, infants, and preschool children. Food packages were distributed to participants—upon "determination [of need] by a competent medical authority"—through health clinics, visiting nurses, and health centers that served low-income populations (Mahoney Monrad et al., 1982).

Over time, other types of social service organizations have come to serve as local CSFP agencies. In the current configuration, not all local agencies that provide commodity foods also provide direct health services, but all are encouraged to provide health information and links. In addition, with the inception and growth of the Special Supplemental Program for Women, Infants, and Children (WIC) and the growth of interest in issues related to aging, the CSFP has shifted emphasis toward the low-income

elderly.¹⁵¹ Elderly participation in the CSFP began with a pilot project in FY 1982.

Today, individuals eligible to receive free commodity foods through the CSFP include low-income individuals who are elderly (at least 60 years old); women who are pregnant, breastfeeding, or up to a year postpartum; infants; and children who have not yet reached their sixth birthday. Women, infants and children are not eligible to participate in the CSFP if they participate in the WIC program. Eligible individuals must reside in the State or Indian reservation that administers the CSFP. States may determine other local requirements, such as nutritional risk or residence in a particular area. For women, infants, and children, income eligibility requirements are established by individual States (typically 185 percent of poverty). For elderly persons, income eligibility is federally set at 130 percent of poverty (USDA/Food and Nutrition Service (FNS), 2003a).

Individual States may or may not participate in the program. To initiate the CSFP or to continue it each year, States apply to USDA by submitting a plan for program operations. Each State plan includes information about all local agencies expected to administer the program in the coming year, income criteria and nutritional risk criteria to be used in determining eligibility, plans for outreach and nutrition education, procedures for monitoring local agencies, procedures for involving local agencies in planning for the following year, plans for financial management and detection of duplicate participation, and audit procedures (7 CFR, Part 247).

Local agencies use a variety of outreach and education strategies to reach potential participants. Typically, a

¹⁵¹Startup problems with the CSFP may have catalyzed the development of the WIC program. In 1970, after about a year of CSFP operations, USDA began expressing concerns that many CSFP programs were surpassing budgets and providing food to individuals who may not have been eligible. As a result, USDA temporarily stopped expansion of existing CSFP projects, prohibited initiation of new projects, and limited eligibility to pregnant women, postpartum women up to 12 months after delivery, and infants up to 12 months of age. At the same time, USDA began experimenting with an alternative pilot program that would provide pregnant and postpartum women with certificates redeemable in retail stores for infant formula, infant cereal, and milk. Concern within Congress about having curtailed the CSFP program hastened the expansion of this pilot program into what eventually became the WIC program (Mahony Monrad et al., 1982).

client comes to a local agency, has his/her eligibility confirmed, and then receives a monthly food package, along with nutrition education. Food packages are tailored to meet individual needs. Packages contain foods such as infant formula and cereal, nonfat dry and evaporated milk, juice, farina, oats, ready-to-eat cereal, rice, pasta, egg mix, peanut butter, dry beans or peas, canned meat, poultry or tuna, cheese, and canned fruits and vegetables (USDA/FNS, 2003a). Local agencies use a variety of methods to provide nutrition education.

The CSFP is one of the smaller of USDA's food and nutrition assistance programs. As noted, the program does not operate in all 50 States. In FY 2003, 32 States, the District of Columbia, and two Indian reservations were authorized to operate the program (USDA/FNS, 2003a). In FY 2002, 427 million individuals, the majority of whom were elderly, participated in the CSFP each month. The total Federal expenditure for the program was \$110 million, or less than 1 percent (0.3 percent) of total USDA expenditures for food and nutrition assistance (USDA/FNS, 2003b).

Research Review

Research on the CSFP is scant. Only one study addressing impacts of the CSFP on participants was identified in the literature (Mahony Monrad et al., 1982). This 1982 evaluation, completed for USDA, collected retrospective administrative and medical records data from two CSFP project sites in Memphis, TN, and one CSFP project site in Detroit, MI. All three of the sites were large. Together, they accounted for 43 percent of all CSFP participants.

Participants from the selected CSFP sites were compared with a sample of nonparticipating pregnant women and children drawn from the same local health care facilities. Pregnant women in the treatment and comparison groups were matched with respect to race, marital status, age, number of previous pregnancies, smoking behavior, and prepregnancy weight. Children in treatment and comparison groups were matched with respect to sex, race, and birthweight. The final sample included 842 pregnant women and 472 children.

The authors provide no information on the processes by which some women and children became CSFP participants and other, apparently equivalent, individuals at the same facilities did not. One possibility is that case-loads were limited, in which case, we might expect little or no selection bias. Alternatively, participation may have been based on the individual's request, or health

care providers may have made judgments about need in recommending some people for participation and not others. If the latter scenario is true, selection bias could be an important factor even though the two groups were matched on recorded characteristics.

Program exposure data, collected for participants, included number of food package pickups, number of health care visits, and participation in social welfare programs. Outcome measures collected for women included hemoglobin and hematocrit, pregnancy weight gain, and birth outcomes. Outcome measures for children included hemoglobin and hematocrit, immunization status, height-for-age, weight-for-age, and weight-for-height. Analysis methods included t-tests and multivariate analysis of covariance.

For pregnant women, impacts of CSFP were positive and statistically significant. Participants delivered infants with greater gestational age, birthweight, and birthweight adjusted for gestational age. They also had lower incidence of low birthweight and shorter length of stay in the hospital after birth. The association between participation and improved birth outcomes was significantly greater among high-risk pregnancy groups, including women with a delivery age of younger than 16 years or women who were anemic at the beginning of their participation, who received inadequate prenatal care, who had five or more previous pregnancies, or whose weight gain during pregnancy was less than 11 pounds. The amount of food received and the amount of prenatal care received both had statistically significant associations with improved birth outcomes.

For children, the amount of CSFP services received was associated with some positive outcomes, but differences in these associations across study sites, as well as severe problems with sample attrition, led the authors to avoid conclusive statements about the overall effects of the program on children. In two of the three sites, CSFP participation was associated with a significantly lower incidence of low weight-for-height.

Only one study focusing on elderly CSFP participants was identified but it was entirely descriptive. Koughan and Atkinson (1993) studied 104 elderly CSFP participants in New Orleans, LA. The researchers measured participants' height and weight and completed a screening checklist (the DETERMINE checklist developed by the Nutritional Screening Initiative (NSI)) specifically designed to determine nutritional risk among the elderly (Posner et al., 1993).

The authors reported that 80 percent of the CSFP participants studied were at moderate or high nutritional risk as measured by the DETERMINE checklist. Participants were an average of 69 years old, and about three-fourths were African-American females. The median body mass index (BMI) was 30, indicating obesity, and, of those with a BMI over 30, 50 percent were considered to be at high nutritional risk. All of those who had a BMI under 21, indicating that they were underweight for their height, were considered to be at nutritional risk.^{152,153}

¹⁵²The number of participants with BMI under 21 was not reported.

¹⁵³This is a more conservative cutoff for defining overweight than the cutoff recommended by the Centers for Disease Control and Prevention (Schoenborn et al., 2002).

Summary

Existing literature provides very little information on which to base an understanding of the impact of the CSFP on participants' nutrition and health status. Only one study has attempted to estimate the impact of the CSFP. It found positive, statistically significant impacts for pregnant women and suggestive evidence of positive impacts for children. That study is quite dated, however, and may have been subject to selection bias. Moreover, the study population did not include the elderly, who now account for about three-quarters of program participants.

Clearly, the CSFP is a program that needs evaluation. Not only is research needed on the impacts of the program on participant nutrition and health status, but also on why States and Indian reservations choose to operate the CSFP and how it interacts with the WIC program and the Nutrition Services Incentive Program, formerly known as the Nutrition Program for the Elderly.

References

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