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WIC (The Special Supplemental Nutrition Program for Women, Infants, and Children): Policy versus practice regarding breastfeeding

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Abstract

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides foods, education, and referrals to participants who are considered to be at nutritional risk. The outreach of the program is impressive, and nearly 9.17 million people participated in the program in 2010. WIC participation is associated with many positive outcomes, including improved birthweights and childhood dietary practices. Despite these benefits, WIC mothers experience lower breastfeeding rates when compared with demographically similar women who do not participate in the WIC program. According to WIC, "A breastfeeding mother and her infant shall be placed in the highest priority level." Despite this statement and others that support breastfeeding, WIC allocates only 0.6% of its budget toward breastfeeding initiatives. Formula expenses accounted for 11.6% ($850 million) of WIC's 2009 expenses. The inconsistency between WIC's policies that encourage breastfeeding vs. practices that favor formula begs further examination. Research shows consistent success with peer counseling programs among WIC participants; however, little money is budgeted for these programs. Rebates included, WIC spends 25 times more on formula than on breastfeeding initiatives. The American Academy of Nursing Expert Panel on Breastfeeding is calling for a re-evaluation of how these taxpayer dollars are spent. Additionally, the American Academy of Nursing recommends a shift from formula bargaining to an investment in structured peer counseling programs. All WIC programs should offer peer counseling support services that encourage breastfeeding and meet the needs of the families they serve.

Keywords

WIC; Breastfeeding; Peer counseling; Formula

Approximately $3.6 billion would be saved if breast-feeding rates were increased to the U.S. Surgeon General's recommendations (Weimer, 2001). Breast milk provides infants with

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immunologic, developmental, psychological, and nutritional benefits that prevent illness and optimize the health of our nation's children. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves a large number of people who are at nutritional risk. The policies set forth by the program appear to promote breastfeeding; however, funding points to a practice that favors formula. This article outlines WIC policy vs. WIC practice surrounding infant feeding. Specific attention is made to the lack of peer counseling support offered to WIC participants, despite their consistent performance of improved breastfeeding initiation and duration (Gross, 2009; Kistin, Abramson, & Dublin, 1994; Yun et al., 2009). Lastly, recommendations, presented on behalf of the American Academy of Nursing (AAN) Expert Panel on Breastfeeding include budget re-evaluation that improves funding to peer counseling programs.

WIC: A Program Overview and Its Breastfeeding Policy

In 2010 WIC provided services to 9.17 million people. The population served includes low-income pregnant, postpartum, and breastfeeding women and infants and children up to 5 years who are at nutrition risk. This is a federal program, with funding administered by the United States Department of Agriculture's Food and Nutrition Service. Foods and services provided by WIC to participants at no cost include WIC foods, nutrition education, breastfeeding promotion and support, and administrative costs. Potential participants must be state residents, meet income guidelines (at or below 185% of the U.S. Poverty Income Guidelines), and be determined to be at "nutrition risk" by a health professional (United States Department of Agriculture [USDA], 2012a, 2012b, 2012c). This article focuses on WIC participants who are low-income pregnant, post-partum, and breastfeeding women and children up to age 5 who are at nutrition risk. For purposes of this article, this population is considered vulnerable to health outcomes that can otherwise be prevented with adequate breastfeeding support.

WIC participation among pregnant women is positively associated with gestational age and mean birth weight. Additionally, WIC participation is associated with improved and enriched childhood diets that are higher in iron, contain fewer sugars, and have an overall greater food variety. WIC participation is also associated with greater use of preventative and restorative dental care services. Although breast-feeding rates are now trending upward, WIC participants have not benefited from this improvement at the same rate as nonparticipants (Ryan & Zhou, 2006). WIC appears to be an ideal platform for lactation promotion for a vulnerable population with historically low breastfeeding rates. Statements from WIC appear to support the following agenda: "WIC recognizes and promotes breastfeeding as the optimal source of nutrition for infants" (USDA, 2012b).

Despite this ostensible support for breastfeeding mothers, the breastfeeding rate of WIC participants is at least 20% lower than non-WIC participants (Lawrence, 2006). Mothers not enrolled in WIC are more than twice as likely to breastfeed at 6 months (Ryan & Zhou, 2006). This inequality, although always present, is now becoming more divided. In 1984, a non-WIC mother was 1.41 times more likely to breastfeed than a WIC mother (Ryan, Rush, Krieger, & Lewandowski, 1991). Currently, non-WIC participants are 2.11 times more likely to breastfeed than WIC participants (Ryan & Zhou, 2006). Additionally, families who

were income eligible for WIC but not participants experienced higher breastfeeding rates than their WIC-participating counterparts (Li, Darling, Maurice, Barker, & Grummer-Strawn, 2005).

According to WIC, “A breastfeeding mother and her infant shall be placed in the highest priority level” (USDA, 2012c). It remains unclear then why only $34 million or 0.6% of the total WIC budget is designated for breast-feeding initiatives (Lawrence, 2006). Meanwhile, formula accounted for $850 million (11.6%) of WIC’s fiscal year 2009 expenses (Neuberger, 2010). Approximately 1 of 9 WIC participants are pregnant or breastfeeding mothers according to the National WIC Association’s breastfeeding strategic plan; yet, 44% of all food items purchased through WIC is infant formula (USDA, 2012a). WIC reports cost savings in the form of rebates from formula manufacturers in exchange for their business and that they are legally required to bid for contracts with formula makers. This exchange allows WIC to serve more women (USDA, 2012b). Unfortunately, formula companies are the primary beneficiary of this practice because WIC purchases account for more than half of all the infant formula sold in the United States (Neuberger, 2010). Formula companies have capitalized on this business exchange and submit bids for the pricier formulas (Marcus, 2010). Formulas submitted for consideration contain additives that, according to manufacturers, optimize formula to more closely resemble human milk. As a result, an additional cost of $91 million dollars is spent yearly on additive-fueled formula that is provided at no cost to some of our nation’s most vulnerable infants (Marcus, 2010).

Peer Counseling

An inexpensive and widely accepted approach to alleviate poor breastfeeding rates is peer counseling. Peer counseling is a community-driven public health practice that has consistently improved breastfeeding rates for WIC participants, including black (Caulfield et al., 1998) and adolescent populations (Volpe & Bear, 2000; Wambach et al., 2010). Peer counseling provides one- on-one support by mothers who have breastfed for at least 6 months, though group counseling programs are also common. In 2004, Best Start Social Marketing, Tampa, FL released results of a peer counseling program model that was contracted with the Department of Agriculture’s Food and Nutrition Service to develop a breastfeeding peer counseling program model. This extensive project included a literature review, an assessment of current practices, and semistructured telephone interviews of WIC staff and WIC peer counselors. This project was specifically designed to meet the needs of WIC participants and staff to implement and expand breastfeeding peer counseling programs. Many barriers were identified as a result of the Best Start Program, including but not limited to: insufficient resources for program initiation, funding stream discontinuity, inadequate or lack of compensation for counselors, and lack of program structure consistency. Overall, the lack of funding was a common thread underlying many of the obstacles identified that prevented the implementation and sustainability of a peer counselor program (Best Start Social Marketing, 2004). Walker and Avis (1999) support these conclusions in their review of peer education and state that peer counseling programs often fail because of numerous factors including an absence of defined program goals, insufficient training, and inadequate funding. When used well, peer counselors are seen as “... filling a unique and vital role in the WIC program” (Best Start Social Marketing, 2004).

WIC participants who receive peer counseling support experience higher breastfeeding rates. Gross (2009) conducted a cross-sectional study that examined Maryland WIC participant breastfeeding initiation rates in three groups: peer counselor, lactation consultant, and standard care. Breastfeeding initiation was significantly higher among those who received peer counseling, but not in the lactation consultant or standard care group. Peer counselors were trained using an International Board Certified Lactation Consultant (IBCLC)-designed curriculum, and Maryland protocol requires that peer counselors contact all pregnant clients upon referral, at 1 month and 2 weeks before their due date, and near their delivery date. Postpartum contact is structured, and breastfeeding clients are called regularly.

In a large (N = 328) randomized controlled trial, Pugh et al. (2010) showed that breastfeeding rates could be improved in the WIC population using a nurse-peer counselor model. WIC mothers were randomized to an intervention or usual care group and followed for 24 weeks. The intervention was performed by a community health nurse and peer counselor (breast-feeding support team) who provided hospital and home visits, telephone support, and 24-hour pager access. Results showed statistically significant higher breastfeeding rates at 6 weeks postpartum (intervention group = 66.7% breastfeeding vs. usual care = 56.9%; odds ratio = 1.71 [95% confidence interval]). In addition, breastfeeding at 12 weeks was higher in the intervention group (49.4%) vs. the usual care group (40.6%), although this was not statistically significant.

Yun et al.'s (2009) retrospective study also uncovered a positive response to peer counselors among WIC participants in Missouri. Breastfeeding initiation rates among WIC agencies that provided peer counseling were higher than agencies without peer counseling programs. In peer counseling agencies, participation length was positively associated with the likelihood of initiation. Gross et al. (2009) and Yun et al. (2009) both revealed a positive impact of peer counseling programs on breastfeeding initiation among WIC participants. Despite this benefit, a survey conducted by Evans, Labbok, and Abrahams (2011) distributed to WIC directors in North Carolina uncovered a racial/ethnic disparity in breastfeeding rates and support services available. WIC offices located in areas with a higher black population were significantly less likely to provide breastfeed support services, including peer counseling. Although the study is older, Kistin, Abramson, and Dublin (1994) showed that black, urban, low-income women experienced a breast-feeding duration longer than 6 weeks among women with a peer counselor compared with 28% among those without peer counselor support.

Review of 4 WIC peer counselor programs revealed that 24% of counselors received no monetary compensation (Bronner, Barber, Vogelhut, & Resnik, 2001). Additionally, fundamental components of peer counselor programs were absent; there were inconsistent policies, a failure to match counselor demographics with new mothers, and an inability to provide adequate counselor training programs. Both Best Start and Bronner et al. (2001) revealed that most of the barriers identified by Walker and Avis (1999) still exist, preventing the successful implementation of breast-feeding peer counselor programs. Although WIC acknowledges the value of peer counselors and frequently cites their potential use in a position paper (National WIC Association Position Paper, 2012), there is no mention of counselors in their recently published and detailed Breastfeeding Strategic Plan (National

WIC Association National Breastfeeding Strategic Plan, 2012). Perhaps most concerning is that, despite the advantages of peer counselor programs on breast-feeding among disadvantaged women, only 16.7% of WIC service delivery sites offer this support (Walker & Avis, 1999).

Discussion

WIC provides a vital public health nutrition service and should be a safe, supportive, and proactive venue for breastfeeding. Unfortunately, breastfeeding initiatives for the most vulnerable dyads are grossly outspent by profitable formula corporations. Despite research that has revealed consistent success with peer counseling programs, WIC allocates little money to sustain these successful programs. Rebates included, WIC spends 25 times more on formula than on breastfeeding initiatives for mothers who experience some of the lowest breastfeeding rates and subsequent infant health consequences.

Structural barriers to breastfeeding exist that do not implicate WIC. The potential for breastfeeding success is optimized when new mothers have the support of their partner and workplace. These support systems are often absent for low-income women, and poor breastfeeding rates persist. The Temporary Aid to Needy Family Program requires that those who receive welfare benefits be employed, often at hourly or entry-level jobs. Employers are often not amenable to providing facilities for breastfeeding mothers. As a result, many new mothers decide against breastfeeding because they view breastfeeding while employed as stressful. Factors regarded as ideal for-breastfeeding success include a private space with a locking door, time to pump, and adequate storage facilities (Stewart-Glenn, 2008). Entry-level or hourly jobs often do not provide adequate breastfeeding support, and new mothers are frequently without pumping facilities or a place to store milk. The recent passage of Section 4207 of the Patient Protection and Affordable Care Act is a good start to support new mothers because it requires employers to provide “... reasonable unpaid break time and a private, non-bathroom place for non-exempt employees who are nursing mothers to express milk during the work day” (United States Breastfeeding Committee, 2008).

Summary and Recommendations

WIC provides valuable services to a large portion of our country’s population who are at nutritional risk. Despite other positive health outcomes, breastfeeding rates have not increased among WIC participants. Breastfeeding is a public health issue that should be a targeted lifestyle practice because it improves health outcomes and minimizes health cost spending. Despite numerous WIC policy statements that support breastfeeding, funding is overwhelmingly spent on formula with only a small fractional portion allocated toward peer counseling programs. The evidence is clear that peer counseling programs are an economically feasible option for providing breastfeeding support, and the implementation of such programs is associated with improved breastfeeding.

The AAN urges our government partners to re-evaluate how taxpayer dollars are spent. Ferguson (2001) addresses the unique perspective nurses contribute to healthcare policy development. Nursing experts are instrumental in policy change (Ferguson, 2001), and the

AAN Expert Panel on Breastfeeding is comprised of lactation experts who firmly believe that WIC is medically and ethically obliged to improve breastfeeding efforts. We strongly recommend that the funding source for WIC state agencies, the Food and Nutrition Service, re-evaluate money allocation and consider mandates to ensure that all WIC programs have a robust and structured peer counseling program. The AAN Expert Panel on Breastfeeding challenges the traditional formula contractual obligations in favor of investment in peer counseling programs that would result in increased breastfeeding rates. A change in funding allocation and subsequent WIC practice is needed to meet the breastfeeding needs of the vulnerable families they serve.

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