Texas WIC NEWS

Special Supplemental Nutrition Program for Women, Infants, and Children
Fall 2004 Volume 13, Number 4

WIC pilots Electronic Benefits Transfer — EBT arrives in El Paso, and WIC celebrates 30 years in Texas!

By Mike Montgomery
Texas WIC Director

I am very proud to announce that the WIC program within the Department of State Health Services (formerly the Texas Department of Health) successfully launched its pilot of the Electronic Benefits Transfer system on June 1 in El Paso. During June, all participants at LA 28, Centro de Salud Familiar La Fe, became a part of this exciting venture into a new and improved method of delivering food benefits to our clients. In July, the pilot expanded to the 47,000 clients served by LA 33, the El Paso City-County Health District. The pilot will last for an entire year and is scheduled to roll into all WIC neighborhoods by the end of 2006.

Many people over the years have worked hard to make this Texas WIC program a success. Other state programs look to Texas WIC for ideas and guidance with issues as diverse as breastfeeding promotion and clinic design. I am proud of the good work that we do, and proud to be a part of such a successful effort.

What is EBT and why is it an improvement? In the EBT system, clients are issued "smart cards," plastic cards the size of a credit or debit card instead of vouchers. They look almost identical to the Texas Lone Star Card, but the WIC Lone Star Card has a microprocessor and gold memory chip embedded within the card. We like to think of it as the "gold card" because of all the improvements in service that little chip represents.

This chip allows the card to store information about the client and the entire family's food benefits. The card offers more privacy and security for the WIC client as he or she shops because no one can use it without knowing the PIN, a four-digit personal identification number chosen by the client. Clients no longer have to buy several foods at once. With EBT for example, clients can conveniently purchase just one can of formula, two cans of juice, or all their benefits at once. It also helps ensure that WIC clients purchase only authorized foods and are charged the same price as other customers, or less.

In addition, replacing food vouchers with the WIC Lone Star card eliminates the handling of millions of vouchers at the clinic, the store, and the state office, as well as the paper claims currently sent by grocers for payment for the foods they sold. Grocer claims can be submitted electronically, and grocers will receive their payments more quickly and more accurately. As you can imagine, our state staff who handle over 2 million vouchers and claims each month are overjoyed that by the end of 2006 those vouchers will be as obsolete as the old punch cards are now.

We are also very proud that most of the work of planning, designing, and implementing the system was done by in-house program and technical staff, and included meaningful collaboration every step of the way with the El Paso WIC directors, other WIC directors around the state, USDA staff, and our grocers.

I look forward to a successful pilot where we'll learn what's working and what's not working. We'll also be completing a project with the Food Stamps and Texas Assistance to Needy Families programs to combine all three programs conveniently on one card. By the time EBT rolls out statewide, the system will be even better than it is today at making government work even better for the citizens it serves.

As many of you know, 2004 is WIC's 30th anniversary year. I can't think of a better contribution we could make to celebrate 30 years of growing healthy Texas families.

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Columns

Cover design by Irma Choate and Brent McMillon

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Mike Montgomery
Texas WIC Director

Linda Brumble
Manager
Nutrition Education, Clinic Services Unit

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Sherry Clark
Publication Coordinator

Contributing Writers:
Linda Brumble, Isabel Clark, Amy Culp, Rachel Edwards, Tracy Erickson, Patti Fitch, Paula Kanter, Joyce Leatherwood, Mike Montgomery

Brent McMillon, Irma Choate, Lorise Grimball, Sharon Hipp
Graphic Design Support

Chris Coxwell
Photographer

Joyce Leatherwood
Writer/Editor

Health and Human Services Printing Services
Printing

Joyce Leatherwood
Subscriptions

WIC Warehouse, TDH Automation Mailroom
Mailing

TEXAS Department of State Health Services

Department of State Health Services
Nutrition Services Section
1100 West 49th St., Austin, TX 78756
<http://www.dshs.state.tx.us/wic/mainpage.htm>

Editorial comments may be sent to the editor at the above address or by e-mail to <sherry.clark@dshs.state.tx.us> or call (512) 458-7444, ext. 2142.

Local agency spotlight — LA 5, Driscoll Children's Hospital WIC program

By Joyce Leatherwood

The Driscoll Children's Hospital WIC program in Corpus Christi has a commitment to work with the community to improve breastfeeding awareness and acceptance. That's the sort of phrase that rolls right off the tongue and spills onto the page with ease. Putting it into practice is not so easy, but this local agency makes it look that way. Their motto is "creative communication in breastfeeding promotion."

Director Monica Stender outlined several ways that her local agency works to communicate with the community. Their promotion efforts are divided into two major areas — community-based and hospital-based initiatives.

Some of the community-based initiatives include forming a breastfeeding coalition that sponsors dinner events for doctors and educational conferences for nurses and for the community. The local agency prepares and distributes breastfeeding pamphlets to doctors' offices that help dispel breastfeeding myths. They participate in an annual La Leche League walk, and offer breastfeeding classes.

The hospital-based initiatives are just as ambitious, and provide WIC participants with a variety of opportunities to learn about breastfeeding. The local agency prepares a bulletin board in the clinics, sponsors breastfeeding promotions with prizes, gives presentations, and teaches classes. Agency staffers also support breastfeeding moms with a lactation center, a hospital-based breast pump program, and by providing peer counselors.

In physicians' offices and hospitals alike, LA 5 prepares *Mom's Memory Books*, scrapbook-style presentations of testimonials from breastfeeding moms. The local agency is also an original member of the Coastal Bend Breastfeeding Coalition, which provides continuing education for health-care professionals.

Ms. Stender adds: "In addition to these initiatives, we also provide a breastfeeding packet to all new prenatal clients, and the moms are referred directly to a peer counselor by the certifying authority. The purpose of this visit is to initiate the idea that breastfeeding is best."

As if all that isn't ambitious enough, Ms. Stender plans for her agency to "develop mother-friendly work sites by providing research-based, data-driven information" to explain the benefits of breastfeeding to employers. One of the common fears of many employers is that moms might take advantage of time allowed for breastfeeding, so LA 5 is conducting research to see how much time a mom needs to pump each day in order to educate moms and employers about the amount of time that is necessary and appropriate.

The clever and tireless folks at LA 5 even mounted a breastfeeding campaign to counteract a formula promotion. When the formula company gave hospitals materials that proclaimed, "Nurses and moms love Similac," the LA made its own materials to give to hospital staff saying, "Moms and babies love breastfeeding!" Now, *that's* creative communication!

Central-office spotlight — the training team, before and after

By Linda Brumble, B.S., M.A.
Manager, Nutrition Education/Clinic Services

Left to right, top row: Danny Cordova, Marguerite King, Jewell Stremler, Elaine Greiner, Janice Carpenter, Linda Brumble, and Missy Hammer. Bottom row, left to right: Pat Ogle, Benny Jasso, Deanna Lockett, Rachel Edwards, Yolanda BazDresch, Anita Ramos, Hellen Sullivan, Elvia Andarza, and Todd Shaw. Not pictured are Shirley Ellis, Nancy McCown, Liz Bruns, Anna Garcia.

Furnishing training on all WIC issues has long been a goal of the WIC program — one that has been accomplished for many years by the hard work of the staff pictured on this page. Until recently, the entire staff was in a division called Training and Technical Assistance that was housed at the WIC program office in Austin. Recent changes have dissolved this group and reshaped it with a new organizational structure. Nutrition, breastfeeding, certification, civil rights, PFA, formula, and customer service training — all trainings essential for the WIC local agency service providers — have been included in the newly formed Nutrition Education and Clinical Services unit, while training of WIC vendors has been placed in the Food Instrument Redemption Services, or FIRS, unit. Mary Van Eck and Hellen Sullivan supervise the professionals whose shared expertise provides training and professional development for local agency staff, while the vendor trainers are supervised currently by the unit manager over the FIRS area.

The nutrition trainers cover the whole spectrum of nutrition education for WIC staff. While the emphasis is on basic nutrition, there are also classes on prenatal and postpartum nutrition, as well as on formula (including special formula), and nutrition during pregnancy. They also teach WIC staff about infant and child nutrition and about individual counseling techniques that inspire clients to choose a healthy diet. The group also offers classes on how to teach nutrition education to clients with helpful hints for class management.

Certification trainers help WIC personnel who are the first to interact with potential WIC clients. These trainers teach staff how to certify WIC clients, what criteria to use when determining eligibility, how to appropriately measure hemoglobin or hematocrit levels, and other fundamental responsibilities.

Until now, the trainers would routinely travel to the local agencies to conduct the staff training. That still happens with some of the intensive two-day breastfeeding trainings, but the last six months have seen a major shift in training protocol with the introduction of Interactive Distance Learning. These live training events take place at a studio at Department of State Health Services headquarters in Austin, and are broadcast via satellite to the local agencies. Staff at the local agencies can see and interact with the trainer in Austin in real time. This new way of providing staff development is a win-win for all concerned, providing training when needed for the staff of local agencies, decreasing travel and time away from home for the trainers as well as local staff, and reducing training costs.

While the structure has changed, the focus for the trainers has not. Furnishing training on all WIC issues to staff, community groups, and vendors is still what the training team is all about. And now the blended groups will focus on an even wider range of subjects, including many advanced classes offered via IDL for continuing education credits. As Sullivan says, "We are recognized nationally as trendsetters, partly because we've had such strong leadership that has allowed us to be creative, and encouraged us to be creative, that it has fueled that energy that allows us to be where we are today."

Family grocery shopping, food availability and food choices: How to get kids to eat fruits and vegetables

By Paula Kanter, R.D., clinical nutrition specialist

In a session at the 2004 Texas WIC Breastfeeding Conference, Janice Baranowski, a pediatric behavioral nutrition researcher at Baylor College of Medicine's ARS/USDA Children's Nutrition Research Center, reviewed the results of several studies that looked at consumption of fruits and vegetables by children of school age. Whether or not fruits and vegetables are available to children in the home appears to be an important variable in understanding children's fruit and vegetable intake.

Those of lower socioeconomic status report using more canned and frozen foods, and the presence of fresh fruits and vegetables in the home may also depend in part on the time of the month when money is available. Studies concluded that as children of school age were educated about fruits and vegetables and introduced to them, the children tended to influence their parent's purchasing in favor of the fresh foods.

Baranowski summarized the implications for the WIC population. Parents can play a key role in getting children to eat more fruits and vegetables. WIC should teach parents it is important to:

- create a positive eating environment;
- be a role model by eating fruits and vegetables;
- serve fruits and vegetables with meals or as snacks; and
- interact with children during meals.

Also to use authoritative parenting skills:

- To give reasons for eating fruits and vegetables and let children know that they can *always* have fruits and vegetables when they are hungry. (The thinking is that it is better to spoil a meal because of fruit or vegetable consumption than for the children not to consume fruits or vegetables at all.);
- Not to use food as a reward;
- To ignore or redirect undesirable behavior;
- To eliminate or establish barriers (e.g., not making fatty and sugary foods available or accessible at home)

Availability *and* accessibility are key to increasing fruit and vegetable consumption. Here are ways WIC can help parents:

- Offer a taste test of simple fruit and vegetable recipes to both children and parents.
- Help them find grocery stores and markets such as farmer's markets that sell a variety of higher-quality fruits and vegetables because most low socioeconomic neighborhoods have smaller stores with little variety in produce and produce of low quality.
- Encourage parents to buy a variety of canned, frozen, and fresh fruits and vegetables, and how to buy fresh produce when in season.
- Suggest establishing purchasing co-ops with family and friends to get the best price (e.g., joining in to go to stores that sell fruits and vegetables by the case).
- Teach parents to have fruits and vegetables accessible by making them easy to grab and eat (e.g., have them in small bags in the refrigerator instead of whole fruit or vegetables hidden in a refrigerator drawer).
- Offer fruit in small bite sizes (e.g., canned pineapple chunks, fruit cocktail).
- Cut vegetables into small pieces and serve with low-fat ranch dressing or peanut butter.
- Set out a bowl of fruit.

Gastroesophageal reflux disease in children with special health-care needs

By Roxanne Konze Robison, R.D., L.D., Children with Special Health Care Needs nutrition consultant

It is normal for babies and young children occasionally to spit up small amounts of breast milk or formula following a feeding, especially when being burped or when having a diaper changed. In otherwise healthy infants, spitting up usually stops when the baby begins to stand or walk. But, for babies and children with gastroesophageal reflux disease, spitting up is more than just a nuisance — reflux can lead to serious health consequences.

GERD, commonly referred to as heartburn in adults, results from food in the stomach moving backward into the esophagus. Since part of what returns is stomach acid, a burning sensation can occur. Health problems associated with GERD in infants and children may include:

- Weight loss, if pain or discomfort causes refusal to eat or when too much of what is eaten is lost from reflux.
- Inflammation or erosion of tissue in the esophagus from chronic exposure to stomach acid. If erosion is severe, blood loss resulting in anemia is a possibility. Inflammation can also lead to scarring and narrowing of the esophagus.
- Aspiration of stomach contents into the airways of the lungs. Repeated aspiration can lead to chronic lung disease or pneumonia, which can result in permanent damage to the lungs.
- A cessation of breathing and a slowed heart rate. This condition, known as apnea and bradycardia, can be life threatening.

Infants or children with neurological or developmental disabilities are especially prone to GERD and with them it tends to be more severe and persistent. Low muscle tone, common with conditions such as Down syndrome, causes slouching, putting more pressure on the stomach, which forces food back up into the esophagus. Children with low muscle tone also tend to get constipated more frequently, and constipation can make reflux worse by backing up the system.

Many children with neuromuscular disease — cerebral palsy being one of the most common — are prone to reflux. Uncoordinated movement of the esophagus and stomach can cause an upward (instead of downward) movement of stomach contents. Constipation is also more common in children with neuromuscular disease.

A high proportion of children with cystic fibrosis, asthma, bronchopulmonary dysplasia, and other respiratory diseases develop GERD.

Signs of GERD may include one or more of the following:

- vomiting or spitting up
- rumination
- irritability and crying
- refusal or aversion to feeding
- weight loss
- wheezing, coughing, asthma
- swallowing frequently
- drooling
- nighttime awakening with unexplained irritability
- pneumonia
- arching backwards (especially during and after a feeding)
- apnea (episodes of not being able to breathe)

Fortunately, several treatment options for GERD are available. Treatment may include giving medication to control or buffer stomach acid, or medication to help move the stomach contents through the system faster and to tighten the opening from the esophagus to the stomach, and changing positioning and feeding practices, with surgery as a last resort.

When recognized and treated early, serious problems associated with GERD can be avoided. A heightened level of suspicion of GERD should be adopted for children with special health-care needs who exhibit symptoms.

Continuing to breastfeed after returning to work: A recipe for success

By Amanda Hovis, nutrition education consultant

With all of the great breastfeeding support WIC provides and the availability of free breast pumps, more and more WIC moms are choosing to continue breastfeeding when they return to work or school. However, the demands of school and work do pose challenges to the breastfeeding relationship, and without proper planning and support many WIC moms find themselves unable to successfully combine the two. You can increase your clients' chance of success by making sure they are well prepared for their return.

Talking to Employers

Many moms are nervous about speaking with their employer regarding breastfeeding. While most employers are happy to accommodate their breastfeeding employees, the law does not require that they do so. Encourage clients to schedule a meeting with their employer to discuss their return. If possible, this meeting can even take place before the baby arrives. At the meeting, clients should be prepared to talk about why they feel it is important that they continue to breastfeed and explain the benefits the employer receives for supporting breastfeeding. Here are a few ways breastfeeding benefits both the employee and the employer:

1. Studies of work-site lactation programs show that breastfed infants have fewer illnesses than formula-fed infants. That means lower health-care costs for employers. Studies have shown average savings of $400 per breastfed baby.
2. Since breastfed babies are healthier, their parents use fewer sick days. The insurance company Aetna reported an average of three fewer sick days per breastfeeding employee. This was reported in the 1998 book, *Breastfeeding: The Best Investment*, by D. Bailey.
3. Over the long term, breastfeeding decreases the mother's risk of osteoporosis and breast and ovarian cancer. It also decreases the child's risk of developing obesity, asthma, meningitis, food and airborne allergies, and diabetes. Thus breastfeeding may have the long-term impact of decreasing medical costs for employers.
4. Mothers who are able to continue working and breastfeeding are also more satisfied with their jobs and report increased loyalty to their employers. This leads to decreased turnover and increased morale and productivity among employees.

At the appointment your client should be prepared to discuss:

1. How she is planning to combine breastfeeding and working — for example, whether she is planning to pump at work or nurse the baby onsite.
2. Address any concerns the employer has regarding her desire to pump at work or nurse her baby on site.
3. Since the law does not require businesses to give women extra breaks for pumping, the employee should be prepared to offer to come in early or stay late to make up lost time used to pump or nurse.
4. The employee should ask where she should store her breastmilk. It is perfectly safe to store human milk in a common-area or break-room refrigerator. If a refrigerator is unavailable, be sure to tell her that an insulated bag with ice packs will work.
5. She should also ask if there is a private space she can use to pump or nurse. If a separate private room is not available here are some other options:
   - If she has her own private office see if she can pump there. If the door doesn't lock, she can hang a sign outside her door when pumping or see if the employer will have a lock installed so no one will accidentally walk in on her.

- If she sits in a cubicle, she can use a shower curtain rod to hang a large curtain outside the cube when she needs to pump. Then she can pump discreetly in her cubicle.
- If she doesn't have an office or cubicle but her manager does, she can ask if her manager will allow her to pump there.
- A bathroom should be used only as a last resort, for reasons of hygiene and safety.

Breastfeeding Support

To ensure success, moms need to know that they have support. It is best if that support comes both from her employer and from her family and friends. Encourage moms to tell their family that they plan to continue breastfeeding after returning to work and ask them for their support. Show *your* support by giving her a phone number for someone at the WIC office she can contact with any further questions or concerns. Provide moms with the handout *Tips for Caring for the Breastfed Baby in Day Care,* stock number 13-28, and encourage them to discuss their plans to continue breastfeeding with their child-care provider.

Ensuring a large milk supply

After returning to work, some women find their milk supply has diminished. In general, moms may notice that their supply decreases the most near the end of the workday and near the end of the workweek. This happens because their bodies know the difference between their baby and the breast pump. Encouraging moms to breastfeed as often as possible when at home will help keep up their supply. If needed, provide moms with the new WIC pamphlet *Addressing Your Concerns About Breastfeeding: What if I don't have enough milk?,* stock numbers 13-06-12038, English, and 13-06-12038A, Spanish.

Combining work or school with breastfeeding can be a challenge, but it offers health benefits that will last a lifetime and is well worth the effort. Clients who are prepared for their return and have support from their employer, family, and child-care provider have the recipe for success.

Additional WIC resources for staff and moms who are returning to work or school

- Lesson BF-000-29, *Breastfeeding and Returning to Work*. This lesson contains an excellent checklist that can help clients plan their return to work. It also contains a *Letter From Your Employee's Physician* that can be given to participants and signed by their doctor. The letter states that the participant's doctor would like her to continue to breastfeed and asks the employer to support her decision. This letter is also available on the Web site at: <http://www.dshs.state.tx.us/wichd/bf/phyletter_a.pdf>.
- Pamphlet number 13-06-11496, English, and 13-06-11496A, Spanish, *Breastfeeding and Working Works for Me!* This brochure includes tips on pumping and storing and managing working and breastfeeding.
- Pamphlet number 13-58, English, and 13-58A, Spanish, *Becoming a Mother-Friendly Worksite.* This revised brochure targets employers, informs them about the benefits they receive from moms who continue to breastfeed, and suggests ways they can support their breastfeeding employee.

Postpartum depression — more than just the baby blues

By Joyce Leatherwood

The term *postpartum depression* is commonly used to refer to a variety of mood disorders that affect many women after childbirth. Sometimes mistakenly referred to as the "baby blues," postpartum depression is actually more complicated — and potentially more dangerous — than the brief moodiness that the "blues" describes.

Chan McDermott is the coordinator of the Department of State Health Services' Perinatal Health Program. She explains, "Postpartum depression is complex. About 80 percent of women experience some sadness, some weepiness after giving birth — they get some TLC and they move on. But at least 10 percent of women experience something more serious that requires treatment."

The mildest form of postpartum depression appears after the baby's birth and can last for up to a year following delivery. Symptoms can include marked weight loss or gain, changes in sleeping patterns, despair, crying spells, withdrawal, and avoidance of the baby. The recommended treatment — which usually follows a medical assessment — can involve hormone therapy, a support group, and mild medication for depression or sleep disorders.

One in ten women have more severe symptoms

Unfortunately, some women experience prolonged depression, anxiety, and even psychosis that requires more than a hug and a good night's sleep to overcome. According to the Postpartum Resource Center of Texas, about **one woman in 10** experiences some form of these more severe disorders.

Postpartum anxiety disorders are more serious and potentially more dangerous for both mom and baby than the milder, more common, and short-lived depression. These disorders can manifest themselves in uncontrollable worry or anxiety, obsessive-compulsive behaviors, and panic. Treatment often involves medication in the form of antidepressants and sleep medication, as well as talk therapy and support groups.

The most serious and dangerous of the broad spectrum of PPDs is *postpartum psychosis*. This usually shows up within two to three weeks after childbirth, and can include symptoms such as delusions, often of a religious nature; severe insomnia; loss of appetite; suicidal or homicidal thoughts; and extreme anxiety. Also, women affected by postpartum psychosis often pay little attention to their personal hygiene and

lose interest in eating — both are clues for health care professionals.

Fortunately, postpartum psychosis is rare, occurring in only 1 of 1,000 women during the postpartum period. But, for those women who experience this disorder, diagnosis and treatment must be immediate. Untreated, this disorder can be life threatening for both the mother and her children.

Ms. McDermott adds, "The more serious disorders require intensive management, and families are often in denial. Because of this, we need to educate whole families about PPD, and let them know that these conditions are real and treatable, but they often require outside assistance."

Partnerships promote awareness

At DSHS, two efforts are designed to assist mothers who suffer from PPD. In response to recent legislation, DSHS developed a Pregnancy, Parenting, and Depression Resource List that includes professional organizations, nonprofits, and hospital-based providers that can provide information on the topic of PPD and support for sufferers. The list is provided to physicians, midwives, hospitals, and birthing centers that provide prenatal care, who are required to give the list to their clients. The list is also available on the DSHS Web site (see sidebar) and is provided in both English and Spanish.

DSHS, in partnership with the American College of Obstetrics and Gynecology, has also established a group of stakeholders that includes obstetricians, social workers, representatives from other state agencies, community-based organizations, consumers, and others. The group's primary goal is to build awareness among both the public and health-care providers, of perinatal mood disorders. The group hopes to begin its education efforts later this year.

The Texas WIC program can play a huge role in the lives of women with postpartum depression. Clinic staff may see women more regularly than the doctors who attend to them, and staffers have an opportunity to observe the women interacting with their children, taking classes, and participating in a variety of other activities where behavioral clues to postpartum depression become evident. The WIC clinics are also ideal locations for distributing materials that educate the whole family about the realities and dangers of postpartum depression, as well as the resources available to women and their families.

Resources

Postpartum Resource Center of Texas
(877) 472-1002 toll free
<http://www.texaspostpartum.org>

Texas Department of State Health Services
Family Health Services, Information and Referral line
(800) 422-2956

<http://www.dshs.state.tx.us/mch/depression.htm>

Enabling women to consider breastfeeding

By Tracy Erickson, R.D., L.D., I.B.C.L.C., WIC breastfeeding coordinator

Numerous studies have shown that most women enrolled in the WIC program are familiar with the benefits of breastfeeding. Yet many WIC moms choose not to breastfeed because of certain perceived barriers such as fear of pain, embarrassment, lack of support from family or friends, lack of confidence, return to work, or cultural myths and misconceptions. If a woman's concerns about breastfeeding are not addressed, the advantages may seem petty and insignificant when compared to the perceived disadvantages. In that case, she may choose not to breastfeed.

The benefits of breastfeeding should not be the focal point of counseling sessions. Rather, sessions should focus on identifying a woman's concerns about breastfeeding, acknowledging them as genuine, then providing education on related topics, such as:

- Pain and breastfeeding: what's normal — what's not
- How to convince family members that breastfeeding is best
- How to breastfeed discreetly in public
- How to talk to an employer about pumping at work
- How to make enough milk

Many concerns about breastfeeding are deep-seated, meaning it may take several counseling sessions before a woman recognizes and reveals all of her concerns. Breastfeeding-support groups, facilitated discussions, and counseling sessions led by peer counselors are perfect venues for encouraging women to talk about their concerns with others in order to bring up and defuse any perceived barriers.

The Transtheoretical or Stages of Change Model (Table 1) is widely accepted as an effective tool for lifestyle-change intervention and has been used successfully to influence other health-related behaviors, such as improving exercise and dietary habits and quitting smoking. You can apply the Stages of Change Model to breastfeeding counseling to estimate where a woman is in her readiness to consider breastfeeding and to counsel appropriately.

Remember, focusing on the benefits of breastfeeding is not the most effective way to convince a woman to breastfeed and you're probably not telling her anything she doesn't already know. Addressing the woman's concerns should be the counselor's primary focus. Only then can you enable her to consider breastfeeding. Counseling about the benefits of breastfeeding can be expanded on in future educational opportunities.

Table 1. Stages of Change Model

Stage of Change	Counseling Technique
Precontemplation. A woman who is in the precontemplation stage is not ready for change. She is not considering change and she gets tired of being told to change. She may be unaware of the risks of not breastfeeding to her health and her child's. She probably has unresolved concerns about breastfeeding and will not be able to move to the next stage of change until her concerns are addressed.	Initiate a conversation about infant feeding with "What have you heard about breastfeeding?" and encourage the woman to express any concerns she may have. Acknowledging the woman's concerns as real and valid with compassion, understanding, and acceptance is a critical first step toward enabling the woman to consider breastfeeding. An example of acknowledging a woman's concern is "Your mom told you breastfeeding hurts? A lot of women have heard that. I can see why you haven't considered breastfeeding." Once you have acknowledged her concerns, she will be more open to receiving education regarding her concerns and the health benefits of breastfeeding. This is what many call "learning readiness" or a "teachable moment."
Contemplation. A woman in the contemplation stage is aware of the benefits of breastfeeding or the health risks associated with not breastfeeding. She may be considering breastfeeding, not necessarily with the child she is currently carrying, but perhaps a future child. Without some form of "teachable moment" or emotional arousal, she may stay at this stage for a long time.	An example of a teachable moment that might be effective in moving her to the next stage: her mother was recently diagnosed with diabetes or suffered from a serious diabetes-related health condition. She is informed that breastfeeding may reduce her child's risk of developing diabetes.
Preparation. She is planning to breastfeed her baby and will tell others about her intent to breastfeed.	Congratulate her on her decision to breastfeed. Expand on the many benefits of breastfeeding to reinforce her decision.
Action. She is currently breastfeeding. She may initiate breastfeeding but wean early due to difficulties. Or, she may be overwhelmed, fatigued, and encountering breastfeeding difficulties but will do everything in her power to overcome all obstacles.	Provide her with phone numbers and resources for breastfeeding help to enable her to have a successful experience. Congratulate her on her efforts to breastfeed if she only breastfed for a short time.
Maintenance. She successfully breastfeeds for many months. She breastfeeds subsequent children with no consideration of artificial feeding. Breastfeeding has become the infant-feeding norm for her.	Congratulate her on her success with breastfeeding. Consider recruiting her as a peer counselor.

Violence against women

By Paula Kanter, R.D., clinical nutrition specialist

In 2002, researchers conducted the first-ever state-representative surveys to determine the prevalence of sexual assault and domestic violence in Texas. The surveys found that 47 percent of all Texans experience domestic violence, and almost 2 million Texans have been sexually assaulted in their lifetimes.

Approximately one in 10 Texan girls were assaulted before they reached age 14. The findings of these surveys correspond with international statistics that show one-third of all women are physically or sexually abused in their lifetime.

Other studies have found that up to half of all homeless women are victims of domestic violence. Also, pregnant women suffer high rates of abuse with devastating health outcomes, including miscarriages and reproductive-health problems, chronic conditions, and physical, mental, and behavioral consequences. Victims often turn to alcohol or drugs to cope with the terror of domestic violence.

Migrant women in abusive situations face the additional concerns of the inability to support themselves economically; limited English skills; possible deportation; lack of continuity of services or bilingual, bicultural family violence services (services in their home base may be very different from services in Northern states); and a lack of health care services. Of these, the most complex involves women's legal status regarding residence in the United States.

Many times, women do not recognize that they are victims. A family history of violence can greatly obscure attitudes toward the violence. They do not realize a slap, push, kick, verbal abuse, extreme jealousy, or other controlling behaviors constitute abuse because they grew up with these behaviors in their household.

When a woman realizes she is a victim of abuse, in order to obtain the assistance needed to stay safe and become self-sufficient, she must know what services are available and whether those services will meet her needs. Knowledge of resources affects how the victim chooses to make the first contact for assistance.

A person living in a violent situation may face many complex issues. Fear for one's safety; pressure from family, religious leaders, or oneself to preserve the family; lack of resources; and the lack of another safe place to stay are all very real reasons not to leave. In fact, many decide to leave, are confronted with one or more of these problems, and have no choice but to return to their violent home.

Crucially, the time when someone chooses to leave a batterer is the most dangerous time for that person. Before making that decision or encouraging someone to leave, the victim or advocate should have a plan in place.

Approximately 60 percent of callers to the National Domestic Violence Hotline indicate that calling the Hotline is their first attempt to address the domestic violence they are experiencing; they have not called the police or other domestic-violence services. The Hotline's Web site is also a great resource for victims.

Hotline Web address: <http://www.ndvh.org>

Hotline telephone numbers: 1 (800) 799-7233, or 1 (800) 787-3224 (for the deaf)

The Texas Council on Family Violence operates the National Domestic Violence hotline. The council also provides lists of shelters and programs available in Texas. Their Web address is <http://www.tcfv.org>.

Possible warning signs

- Repeated injuries that are difficult to explain
- Frequent absence from work due to illness or taking short, sporadic vacations
- Little or no access to money or a car and apparent isolation from friends and family
- Frequent mention of their partner's anger, temper, or jealousy
- Receiving repeated and disruptive phone calls or visits from their partner at work
- Reluctance to speak in front of, or disagree with, their partner
- A partner who bullies or is abusive in front of others
- Apparent depression and mentioning stress or tension at home

From *Domestic Violence*, a SafePlace brochure —

Domestic violence can include:

Emotional abuse

- cheating
- threatening divorce
- preventing one from seeing family or friends or from holding a job
- controlling all finances
- threatening suicide
- intense jealousy
- criticizing partner

Verbal abuse

- threatening to do harm to victim, family or pets
- frequent name calling
- intense or frightening anger

Physical abuse

- using physical presence to threaten or control
- using objects (weapons, cars, etc.) to frighten or control
- actual physical contact including restraining, shoving, hitting, using weapons, forcing sex and abusing other family and pets

Who's the father? And why does it matter to WIC providers and clients?

By Rachel Edwards, training specialist

Last year in Texas approximately 125,000 children were born to unmarried parents. Over the last seven years 33 percent of births were to unmarried women. Children living with unmarried mothers are 5 times more likely to live in poverty. These are just a few of the facts Michael Hayes, manager of Family Initiatives for the Attorney General of Texas, shared in the breastfeeding conference session *Who's the Father? And Why Does It Matter to WIC Providers and Clients?*

Hayes wants WIC to partner with the Attorney General's office and become an information resource on this issue. WIC agencies can receive training from the Attorney General's office to assist parents in completing the Acknowledgment of Paternity.

Establishing paternity

The Texas Family Code states that the mom is the legal parent. So, how do unmarried fathers establish legal paternity? The ways to establish paternity are through an Acknowledgment of Paternity, a Paternity Agreed Order, or a Court Order (paternity suit).

The Acknowledgment of Paternity must be signed by both parents in order to have the father's name on the birth certificate. This form can be signed before the birth of the baby, at the time of the birth at the hospital, or after leaving the hospital. This form can be obtained at the hospital where the birth will take place, at a local Office of the Attorney General Child Support Office, or by calling (210) 304-7240. Why is this important? The biological father who signs this acknowledgment becomes the legal father of the child, which gives certain rights and responsibilities to the father. Knowing this ahead of time may give the couple an opportunity to discuss the process before the child is born. A **Paternity Agreed Order** is created at the child support office and it is a quick and easy visit that also includes creating the support, access, and visitation orders. The Paternity Agreed Order visit can include genetic testing**.** A **Court Order or paternity suit** requires a court hearing with DNA used as evidence. If the father doesn't show up for court, paternity may be ordered by default. If a man believes he is not the father and cannot attend the court hearing, he can write a letter to the court stating he is not the father; this releases him from being appointed the father by default.

Benefits for establishing paternity

One of the most important benefits of establishing paternity is that the child's birth certificate will bear the name of the father. This becomes very important to the child as he or she gets older and wants to know who the father is. Other benefits include:

- legal rights for the father
- Social Security and inheritance rights for the child
- legal "claiming" of the child
- access to school and medical records
- setting the stage for a formal financial relationship
- an extended family connection

For more information on this topic go to: <http://www.oag.state.tx.us/child/mainchil.shtml> **or e-mail** <michael.hayes@cs.oag.state.tx.us>**.**

Posters and brochures can be ordered at the following link: <http://www.oag.state.tx.us/newspubs/publications.shtml>

Celebrating 30 Years of WIC

Growing Healthy Families

By Patti Fitch, R.D., clinical nutrition coordinator

The year 2004 marks our grand 30-year anniversary and gives us a reason to celebrate the hard work and dedication with which WIC staff have continued to serve millions of Texas women, infants, and children.

Sometimes when we're caught up in the day-to-day work of WIC, we lose sight of how much we have to celebrate. In its 30-year history, WIC has been studied by various researchers and the results have been overwhelmingly positive and show that WIC works!

As we move into our fourth decade, we already have a clear vision of the new directions Texas WIC will be taking. With the start of the Electronic Benefits Transfer pilot project in El Paso, we are changing the way we provide benefits. We will provide benefits on a Lone Star WIC card that allows our participants to buy any part of their monthly foods at any time of the day or night — no more carrying home huge quantities of milk and juice. Participants can buy their WIC-approved foods as they need them! We anticipate, and are planning for, the EBT system to be available across the state within the next year or two.

While we celebrate WIC's innovations and its possibilities for the future, we also turn to acknowledge those legends of WIC that brought us to this point in time. We have been graced with illustrious state and local agency staff who had the vision and foresight to move this program aggressively forward. We salute every one of those staffers who that gave their time, effort, heart, and soul to better this program.

Texas WIC is celebrating its 30th year of providing services to women, infants, and children!

Newsworthy Nutrition

By Amy Culp, R.D., L.D., nutrition education consultant

Almost daily, nutrition and health news makes the headlines. Here are some of the top stories and bottom-line messages about breastfeeding to assist you as a nutrition and health educator.

Another reason to support breastfeeding

Researchers recently reported that breastfeeding appears to significantly reduce the chances that babies will die in their first year of life. The analysis included a nationally representative sample of 1,204 infants who died between 28 days and 1 year of age from causes other than congenital anomaly or malignant tumor and 7740 children who were still alive at 1 year. Overall, the children who were ever breastfed had a 20 percent lower risk of dying compared to the children who had never been breastfed. This is the first study to show an overall reduction in death. Research has shown that, in addition to boosting the baby's immune system — which protects against infections — there is also a reduction in the risk of sudden infant death syndrome. The researchers propose that, in addition, it is possible that women who breastfeed their babies tend to spend more time near their children, which could protect them from fatal accidents. Based on the findings in the study, the researchers estimated that about 720 infant deaths could be delayed or prevented annually if all American mothers breastfed their babies for the first year.

Source: Chen, A., and W. J. Rogan. 2004. Breastfeeding and the risk of postneonatal death in the United States. *Pediatrics* 113(5): e435–39.

Benefits of kangaroo care

Kangaroo care, or skin-to-skin contact, was first introduced for premature, low-birthweight infants in South America, and was used as an alternative to placing the newborns in an incubator. Since it was introduced, kangaroo care has been found to improve infant development, lead to less severe infections, and encourage breastfeeding. A new study looked at whether skin-to-skin contact shortly after birth might also benefit healthy, full-term newborns. The study included 47 healthy mother-baby pairs. Half of the newborns were brought to their mothers about 15 minutes after birth and allowed to spend an hour lying skin-to-skin on their mothers, with their heads nuzzled near their mothers'. The other infants went to the nursery during that time. Beginning four hours after birth, all the infants were observed for signs of adaptation. In the study, the infants that were given kangaroo care for one hour shortly after birth slept better and showed more flexed movements and postures (curling in toward their center), and fewer extended ones, with limbs outstretched. These movements and postures indicate greater adaptation to the surroundings and reflect stability in the central nervous system. Researchers say that the skin-to-skin contact provides the infants with warmth and the sense that they are

not alone, but as close to their mothers as possible. Therefore, the results of the study show that kangaroo care does seem to ease the transition from the womb to the outside world.

WIC bottom line: Encourage mothers to speak with their physician about skin-to-skin contact (kangaroo care) with their newborn immediately after birth. Even after parents leave the hospital, they can use this technique to soothe their babies. Both mothers and fathers can participate in skin-to-skin contact with their infants. Motivate your participants with the beautiful new poster that visually demonstrates skin-to-skin contact, "I'm a Proud Dad," available from the WIC Warehouse, stock number 13-57.

Source: Ferber, S. G., and I. R. Makhoul. 2004. The effect of skin-to-skin (kangaroo care) shortly after birth on the neurobehavioral responses of the term newborn: A randomized, controlled trial. *Pediatrics* 113(4): 858–65.

Overweight moms may need extra breastfeeding support

New research published in *Pediatrics* shows that new mothers who are overweight or obese have a lower prolactin response to suckling in the first week after giving birth. A newborn baby's suckling triggers the production of prolactin, a hormone responsible for stimulating milk production early in lactation. Previous studies observed that women who were overweight or obese before conception had a significantly increased risk of failing to initiate breastfeeding successfully. Those who did initiate successfully stopped significantly sooner than women of normal weight. The results of the current study may explain why overweight women often either do not start breastfeeding or soon give up on it a compromised ability to produce milk. The authors of the study emphasized that overweight women can successfully breastfeed — they just need extra support from a lactation consultant prior to discharge from the hospital, and close follow-up after discharge.

WIC bottom line: Lactation consultants and peer counselors can play an integral role in helping overweight moms successfully breastfeed by providing close support, especially within the first few weeks postpartum.

Source: Rasmussen, K. M., and C. L. Kjolhede. 2004. Prepregnant overweight and obesity diminish the prolactin response to suckling in the first week postpartum. *Pediatrics* 113(5): e465–71.

WIC bottom line: Promote breastfeeding!

The Texas Tech study: What did we learn about anemia in our WIC children?

By Isabel Clark, M.A., R.D., clinical nutrition specialist

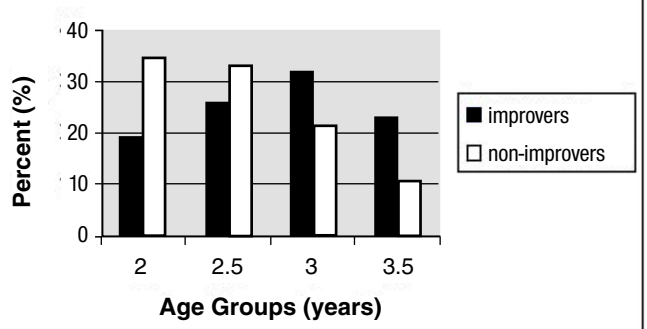
Texas WIC, in collaboration with Texas Tech University, studied the problem of anemia in its child population. The purpose of the study was to determine what differences, if any, existed among the children enrolled for low iron whose status improved compared to those whose status failed to improve. Children were randomly selected for the study, but all had been enrolled in the WIC program for either low hematocrit or low hemoglobin. Improvers were defined as: "participants who, over three consecutive hematocrit or hemoglobin tests, showed a consistent upward trend or a change from below the clinical cutoff value to within normal levels and maintained a normal level for two blood tests."

The study made use of a questionnaire addressing issues that included demographics, behaviors, perceptions, attitudes, and knowledge. Out of 517 volunteers, a total of 459 surveys were usable for scanning and statistical analysis; 233 children were classified as improvers and 226 as non-improvers.

The age-related findings in this study are consistent with other research on anemia, which has suggested that younger children have a greater risk of the condition than older children. In this study, the children's ages ranged from 2 to 3½ years. As shown in *Figure 1*, younger children had a greater chance of being in the non-improver group. The number of non-improvers decreased with age, while the number of improvers increased up through the age of 3. By the time the children are 3½ years old, the number of children in the improvers was almost two times that of non-improvers.

In order to be eligible for participation in the WIC program, an applicant's gross income must not exceed 185 percent of the federal income guidelines; thus, all WIC participants can be classified as "low income." Information from the survey revealed that a very low household income — less than $1000 per month — is a risk factor for non-improvers. However, when asked to select reasons for non-improvement in their child's iron condition, only 1.1 percent of the respondents selected "the family can't afford iron supplements," and 0.9 percent

Figure 1. Age Distribution Between Improvers and Non-Improvers



selected "this family can't afford the right kinds of foods." Parents gave other reasons for non-improvement including: the child drank too many beverages such as juice or milk (12.2%), the child was a picky eater (6.1%), the child had poor eating habits (3.3%), low iron runs in the family (1.7%), and the child refused iron supplements (1.1%). Reasons the parents chose for improvement included: better food choices (43.4%), eating the right kinds of foods (41.8%), and taking iron supplements (16.6%).

Perceptions of the health and well-being of the improvers versus non-improvers did not differ significantly among the parents; almost all parents felt their child was healthy (97.1%) and did not get sick often (93.8%). Although all the children participating in the study were selected based on their low blood-iron values, according to most of the parents (86.8%) their child had not been referred to a doctor for his or her low-iron condition.

There was no significant difference in knowledge of food between the parents of improvers and non-improvers. As shown in *Table 1*, most of the parents did not have a very good understanding of food nutrients. When asked which food was the best source of iron, a little more than half (53.2%) chose the correct answer, while 46.8 percent chose the incorrect answer. Cow's milk was chosen as a

Table 1. Parents' knowledge of food		Frequency			
Question	Overall Percent	Improvers		Non-improvers	
The saying "Eat 5 a day" refers to:		N	%	N	%
Fruits and vegetables ++	57.6	129	57.6	126	57.5
Incorrect answer	42.4	95	42.4	93	42.5
Which of the following foods is the best source of iron?					
Meat ++	53.2	115	53.2	107	53.2
Incorrect answer	46.8	101	46.8	94	46.8
Which of the following fruits or vegetables is the best source of iron?					
Turnip greens++	63.2	132	60.6	134	66.0
Incorrect answer	36.8	86	39.4	69	34.0
Cow's milk is a good source of iron.					
Yes	68.4	169	73.8	141	62.9
No++	31.6	60	26.2	83	37.1
Which of the following vegetables is the best source of vitamin C?					
Green peppers++	14.3	31	14.2	30	14.5
Incorrect answer	85.7	188	85.8	177	85.5
Which of the following fruits is the best source of vitamin C?					
Oranges++	86.2	199	87.7	181	84.6
Incorrect answer	13.8	28	12.3	33	15.4
++ Indicates a correct answer from the list.					

good source of iron by 73.8 percent of parents of improvers and 62.9 percent of non-improvers, while only 26.2 percent and 37.1 percent respectively, chose the correct answer. When identifying the best source of vitamin C, only 14 percent chose green peppers, the correct answer, while 85.5 percent chose an incorrect answer.

Parents had a better grasp and more knowledge about anemia. When evaluating responses to questions about anemia, parents had an average score of 77 percent correct. Over 90 percent of the parents of both improvers and non-improvers knew that anemia was a condition of low iron in the blood and that iron makes up part of the blood cells. Over 80 percent responded correctly when asked if low iron can cause a child to do poorly in school and can cause illnesses.

Based on the results from this survey, the WIC program can achieve the strongest positive effect on children's iron status through education and referrals. Although the parents appeared to have a good understanding of anemia, they did poorly when asked questions regarding the nutrient contribution of foods. Educational materials available from the state office provide excellent information related to anemia and the foods recommended to help prevent it. But it is critical that WIC nutritionists ensure that parents understand the nutrition message. Only then can they feel empowered to make a difference in the health of their child. WIC can help parents identify correct foods and ways to prepare them to enhance iron absorption. Through knowledge and education, families can plan and make decisions to positively influence the health of their children.

News to Use

By Tracy Erickson, R.D., L.D., I.B.C.I.C., WIC breastfeeding coordinator; Elaine Goodson, M.S., R.D., L.D., nutrition education consultant; and Lynn Wild, M.A., R.D., nutrition education consultant, Nutrition Services Section

New Fax Number and Catalog for Ordering Texas WIC Materials

Please note that when you order materials using the Texas WIC Materials Order Form, you will now fax that form to the Publications Coordinator at (512) 458-*7445*. This is a new fax number. You can find the form with the new number at the Texas WIC Web site at <http://www.tdh.state.tx.us/wichd/gi/materials.pdf>.

The new WIC Materials catalog has been sent to all the local agencies in Texas, giving one to each permanent clinic.

New Breastfeeding Promotion Materials

A new poster titled *Women Who Breastfeed Have a Reduced Risk of Breast and Ovarian Cancer,* stock number 13-06-11924, is now available. This bilingual poster features an African-American mother breastfeeding her baby in bed and extols breastfeeding's benefit of reducing cancer risk. To order this poster, please use a Texas WIC Materials Order Form.

BF-000-31, *To Baby With Love: Overcoming Breastfeeding Barriers,* is a new lesson, video, and DVD that covers many common barriers to breastfeeding such as pain, embarrassment, and lack of support from family and friends. The lesson invites participants to talk about concerns they have about breastfeeding, which gives the instructor a chance to acknowledge those concerns and provide appropriate counseling. Participants leave the class with a "Breastfeeding Support" handout telling them where they can call for help and Breastfeeding Support Pledge Cards to take to their family and friends. This is a motivational lesson, appropriate for pregnant women.

New Diabetes Lesson

NR-000-10, *Diabetes Matters to Your Family,* is a new lesson with three exhibits. The lesson covers the different types of diabetes and diabetes prevention. It also includes posters and other colorful materials to help educate clients about diabetes and its complications.

New on the Texas WIC Web site

Notes from the 2004 Texas WIC Nutrition Breastfeeding Conference: Select speakers' notes from the 2004 Texas WIC Nutrition Breastfeeding Conference, Creating Change Through Communication, are located at the Web site at <http://www.wicconference.com>.

Training

If you would like more information on upcoming classes, contact the appropriate staff for the following classes.

Certification Classes
Anita Ramos, (512) 341-4400, ext. 2218
<anita.ramos@dshs.state.tx.us>

Teaching Group Classes
Janice Carpenter, (512) 341-4400, ext. 2248
<janice.carpenter@dshs.state.tx.us>

Class Management
Janice Carpenter, (512) 341-4400, ext. 2248
<janice.carpenter@dshs.state.tx.us>

Patient Flow Analysis
Anna Garcia, (512) 341-4400, ext. 2246;
<anna.garcia@dshs.state.tx.us>, or

Nutrition Training
Shirley Ellis, (512) 341-4400, ext. 2304;
or Rachel Edwards, ext. 2296
<shirley.ellis@dshs.state.tx.us>, or
<rachel.edwards@dshs.state.tx.us>

Vendor Training
Todd Shaw, (512) 341-4400, ext. 2266;
<todd.shaw@dshs.state.tx.us>

Breastfeeding Training
Web site:
<http://www.dshs.state.tx.us/lactate/courses.htm>
Hellen Sullivan, (512) 341-4400, ext. 2302
For registration fliers, call 341-4400, ext. 2302,
or e-mail <hellen.sullivan@dshs.state.tx.us>

Peer-Counselor Training
Jewell Stremler, (512) 341-4400, ext. 2303
<jewell.stremler@dshs.state.tx.us>

Formula and G.I. Training
Liz Bruns, (512) 341-4400, ext. 2268
<elizabeth.bruns@dshs.state.tx.us>

Certification Training

New WIC Staff — Austin @ Howard Lane
November 16–18

Teaching Series

Class Management
November 3 Austin

Facilitated Discussion
October 13 Austin

Patient Flow Analysis (PFA)

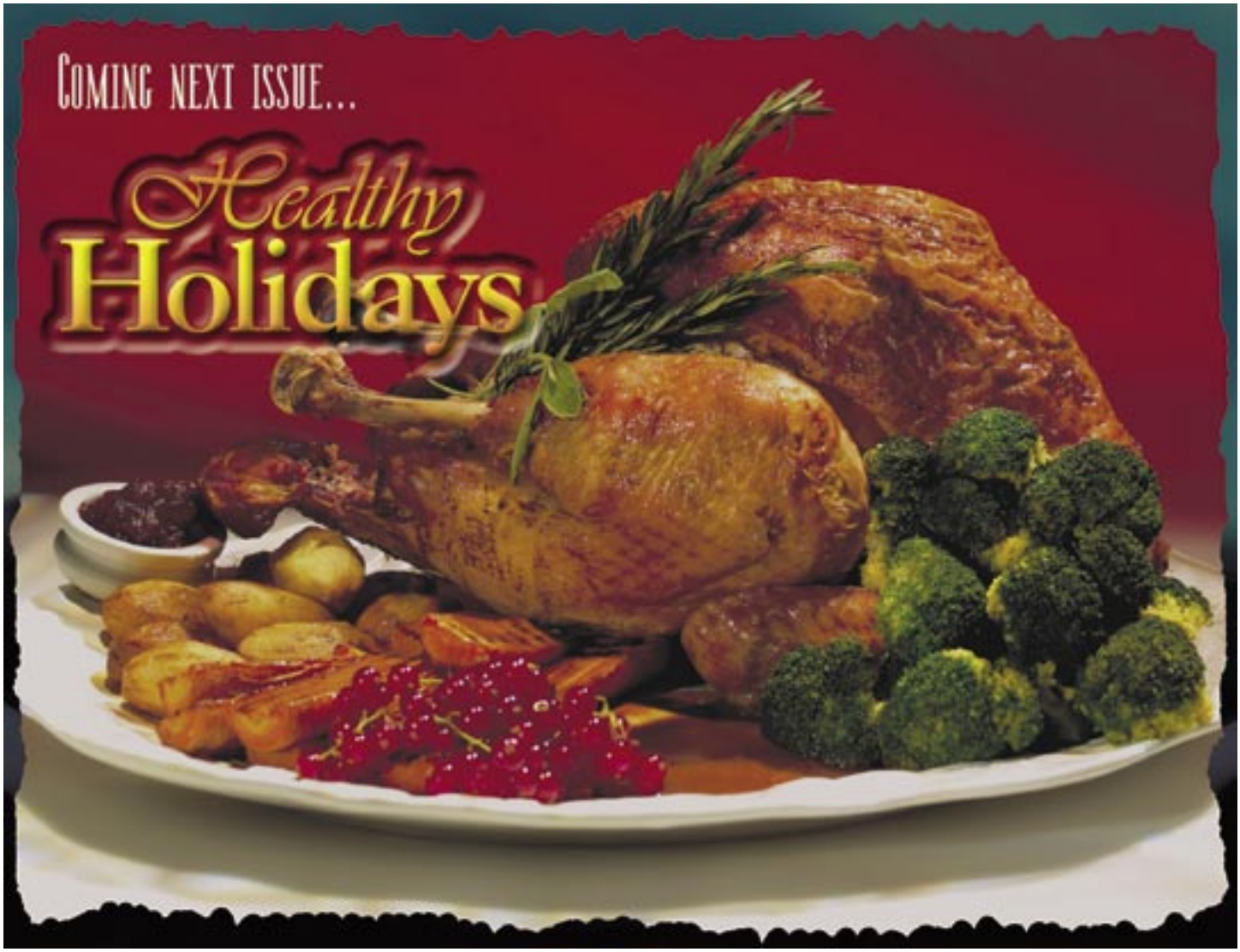
Regional Training: Introduction to WINPFA

WINPFA — Phase I
October 26 El Paso

Breastfeeding

Mini I

October 14	Parkland Hospital, Dallas
November 4	Tomball Regional Hospital, Tomball
November 9	King's Daughters Hospital, Temple



Texas WIC News is now available on the Texas WIC Web site!
<http://www.dshs.state.tx.us/wichd.gi.wicnews.htm>

For information about subscriptions to *Texas WIC News*, e-mail <joyce.leatherwood@dshs.state.tx.us> or call (512) 341-4400, ext. 2288#.

WIC, Nutrition Services Section
Department of State Health Services
1100 W. 49th St.
Austin, TX 78756

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