THE STATE OF WIC

HEALTHIER PREGNANCIES, BABIES, AND YOUNG CHILDREN DURING COVID-19

National WIC Association

FEBRUARY 2021

ACKNOWLEDGMENTS

The **National WIC Association (NWA)** is the non-profit voice of the 12,000 public heath nutrition service provider agencies and the over 6.3 million mothers, babies, and young children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). NWA provides education, guidance, and support to WIC staff; and drives innovation and advocacy to strengthen WIC as we work toward a nation of healthier families. For more information, visit www.nwica.org.

The **W.K. Kellogg Foundation (WKKF)**, founded in 1930 as an independent, private foundation by breakfast cereal innovator and entrepreneur Will Keith Kellogg, is among the largest philanthropic foundations in the United States. Guided by the belief that all children should have an equal opportunity to thrive, WKKF works with communities to create conditions for vulnerable children so they can realize their full potential in school, work and life.

The Kellogg Foundation is based in Battle Creek, Michigan, and works throughout the United States and internationally, as well as with sovereign tribes. Special attention is paid to priority places where there are high concentrations of poverty and where children face significant barriers to success. WKKF priority places in the U.S. are in Michigan, Mississippi, New Mexico and New Orleans; and internationally, are in Mexico and Haiti. For more information, visit www.wkkf.org.

NWA BOARD OF DIRECTORS

TABLE OF CONTENTS

PREFACE: A MESSAGE FROM THE NATIONAL WIC ASSOCIATION

FEBRUARY 10, 2021

It would be an understatement to say that WIC is the nation's premier public health nutrition program. Decades of evidence-based research and reviews confirm that well-earned recognition.

To America's families, though, WIC means so much more than science-based outcomes. To them, WIC is a safe and welcoming home where there is no shame or blame, where we share the joys and anxieties of parenting, where we celebrate with delight new babies and growing young children, and where we honor with pride moms and dads doing their best for their families. It is where families receive dependable health, nutrition, and social supports and guidance generously offered with love and care to the families we assist. With certainty, WIC families know that WIC is a hand up in the midst of a world of uncertainty.

For these reasons and many more, we are proud to share with you this inaugural *State of WIC Report*. It is published to help you appreciate the scope and depth of WIC services and our active engagement with families and communities. It is offered to share our gifts and strengths and to highlight our opportunities for growth. It is replete with recommendations to enhance the value and quality of WIC services. Why? There is so much more that we can do as public health nutrition experts and as a nation to transform lives and help our country continue to bend the moral arc of the universe towards health equity and justice.

Two essential traits that we invite you to know about WIC staff: We fall in love with the work that we do because we know we are making meaningful differences in the lives of the families we support; and second, we fall in love with the families we serve. So many of us dedicate our entire professional careers to being present for our young families. We are committed to helping them discover the importance of healthy nutrition, to buoy their health and wellbeing, and to helping them find their footing for their life's journey.

It is in that spirit of dedication and love of all things WIC that we offer this *State of WIC Report* as a blueprint for action to help make WIC even more responsive to the needs of mothers, dads, babies, and young children.

We are confident that you will agree with us that there are no Red or Blue babies and young children, only the faces of our nation's future. When we reach, teach, and keep families engaged with WIC, we know that their futures as individuals and families are healthier and brighter, and our future as a nation is healthier and brighter, too. We hope that this *State of WIC Report* will inspire you to action to help us strengthen WIC for all of our futures.

Yours Sincerely,
National WIC Association

Berry B. Kelly

BERRY KELLY
CHAIR, BOARD OF DIRECTORS

REV. DOUGLAS A. GREENAWAY
PRESIDENT & CEO

INTRODUCTION: THE STATE OF WIC

Since 1974, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has provided healthy food, quality nutrition services, breastfeeding support, health screenings, and healthcare and social services referrals for millions of expectant and new parents, babies, and young children. Administered by the U.S. Department of Agriculture (USDA), WIC's targeted, time-limited services are demonstrated to improve birth outcomes and support positive child growth and development, helping to grow a healthier next generation.

WIC stands at the intersection of food security and public health. First established to address the pernicious effects of early childhood malnutrition, WIC is distinguished from other federal nutrition programs through its integrated public health services and health screenings. These complementary supports are critical in achieving the improved health outcomes that set up WIC babies and young children for future life success. Since passage of the Patient Protection and Affordable Care Act, which reoriented the healthcare system toward preventive services, WIC's successful nutrition intervention and established rapport with families have been increasingly leveraged to address systemic national health concerns, including childhood obesity, diabetes prevention, maternal and infant mortality, opioid and substance use, and lead exposure.

This inaugural report on the state of WIC services recognizes that the program stands at a crossroads. Comprehensive reform and targeted investment are needed to modernize WIC's twentieth-century service delivery for new generations of twenty-first century expectant parents. Even in its earliest proposals, the Biden-Harris Administration has recognized this need with a call for $3 billion in multiyear investments for enhanced benefits, stronger outreach efforts, and program innovations. With necessarily amplified attention on the nation's persistently poor maternal and infant health outcomes, increasingly driven by sharp and systemic racial and ethnic disparities, streamlined access to WIC services can work in tandem with broader healthcare reforms to ensure that all children in the United States are afforded a healthy start.

RECOMMENDED POLICY ACTIONS

ACCESS TO WIC SERVICES

Expand program access to address nutrition gaps. WIC's effective nutrition intervention is demonstrated to improve dietary quality and access to healthy foods, prevent or mitigate chronic diet-related conditions, and strengthen subsequent pregnancy and child health outcomes. WIC should provide ongoing nutrition support until a child is eligible for the National School Lunch Program by extending eligibility to age six or the beginning of kindergarten. WIC should also improve overall adult health during the inter-pregnancy interval by extending postpartum eligibility to two years for both breastfeeding and non-breastfeeding participants. WIC's public health services are also critical for the families of those serving in our armed services, and expanded access for military families could help prepare the next generation of servicemembers.

Strengthen the nutritional quality of WIC-approved foods. NWA led a decades-long effort to partner with the National Academies of Sciences, Engineering, and Medicine (NASEM) to align the available WIC food packages with the Dietary Guidelines for Americans, offering science-based healthier options to families to positively address childhood obesity and other diet-related trends.[1] Increasing the value of the WIC food packages in a manner consistent with the 2017 NASEM recommendations will enhance access to fruits and vegetables, increase flexibility in the food packages to promote continued breastfeeding, and improve the overall dietary quality of WIC families.

Streamline certification processes. The annual certification appointment, which includes burdensome paperwork requirements, is one of the principal barriers to ongoing WIC participation. USDA has identified a 21 percent drop in coverage of eligible children at the one-year mark, and participation continues to decline until only one-fourth of eligible four-year-olds are certified in the program.[2] Clinic processes could be streamlined by extending certification periods to two years, making permanent a COVID-19 flexibility that would extend certification periods for up to three months to promote family alignment, and enhancing partnerships with early childhood providers by waiving the income test through adjunctive eligibility with Head Start, FDPIR, and CHIP.

Enable remote certifications. State-based waivers issued through the Families First Coronavirus Response Act permitted most WIC providers to implement remote certification

appointments throughout COVID-19. Although a necessary measure during a pandemic, remote appointments are a significant step forward in reducing barriers to access, such as transportation, reconciling work schedules, and arranging childcare. The statutory physical presence requirements should be altered to permit video certifications and allow for telephone appointments when there is a barrier to access.

Invest in WIC technology infrastructure. WIC providers made a significant technological advance by implementing electronic-benefit transfer (EBT), or e-WIC, transactions nationwide, and State WIC Agencies continue to innovate new service-delivery models to streamline the clinic and shopping experiences. By establishing annual funding for technology and Management Information Systems (MIS) grants, WIC could integrate new projects into their clinic computer networks, enabling innovations like web-based participant portals, prescreening tools, text-messaging features, and additional transaction models like online purchasing and mobile payments.[3]

COORDINATING WITH HEALTHCARE

Streamline WIC access to electronic health information. Families raising young children should have consistent access to health information from both their physician and WIC provider, enabling accurate growth charts and reducing duplicative tests for young children. A joint USDA-HHS project to streamline electronic health information sharing between WIC providers and physicians would be a significant step forward in streamlining patient data and integrating WIC into a family's overall healthcare experience.

Invest in WIC referrals and partnerships. As a critical point-of-contact, WIC plays an essential role in connecting families with healthcare services. Ongoing efforts to refer out from WIC should be enhanced by increased referrals to WIC, which will help connect the nearly 7 million eligible people who are not certified for WIC services.[4] Dedicated funding to support local referral networks with physicians and state-driven data projects with Medicaid, IHS, and SNAP would strengthen WIC participation, reducing overall healthcare expenditures. Additional funding for WIC's Breastfeeding Peer Counselor Program would support out-of-clinic placements with physicians, hospitals, and home visiting programs to deliver targeted breastfeeding support for new mothers.

Strengthen WIC funding for public health services. WIC's nutrition education and breastfeeding support are critical parts of assuring improved health outcomes, but they are consistently underfunded by an outdated funding formula that allocates resources to State WIC Agencies. Over the past decade, flaws in the funding formula have exposed this underinvestment, with WIC limited by regulatory barriers that prevent the program from strategically investing resources in these critical services. Thoughtful flexibilities to increase WIC's Nutrition Services & Administration (NSA) grant would assure investments in the wide range of nutrition services and related technology improvements needed to shape positive health outcomes in the current and next decade.

Leverage the WIC workforce to address chronic disease across populations. WIC's professional staff of Registered Dietitians (RDs) and credentialed lactation consultants are trained and have the skills to provide a range of clinical healthcare services, including diabetes prevention, medical nutrition therapy, and lactation support. To further WIC's documented health and nutrition success, Congress and the Administration should empower integrated healthcare services that bill to Medicaid, private health plans, and WIC to provide a full range of clinical nutrition services and breastfeeding support to both WIC participants and other families.

PRIORITIZE EQUITY IN WIC SERVICE DELIVERY

Modernize the WIC shopping experience. The rapid escalation of the SNAP online purchasing pilot has demonstrated the critical need to invest in WIC transaction models – including online purchasing, online ordering with curbside pickup, self-checkout, and mobile payments. These necessary technology innovations must also be paired with in-person supports at retail grocery stores to assist WIC participants with navigating the shopping experience and aid newly hired cashiers.

Address racial disparities in maternal health. Black and Indigenous women are more likely to face negative pregnancy outcomes – including a higher rate of mortality – than other racial and ethnic groups.[5] Expanding access to WIC's effective interventions can improve pregnancy outcomes overall. Anti-racism trainings for the WIC workforce and efforts to diversify the nutrition and lactation support fields can address the systemic racism in public health. The Administration should also reverse the public charge rule and take additional steps to assure that immigrants and mixed-status families have access to healthcare and other federal supports.

Support tribal administration of WIC services. WIC provides the option for tribes or inter-tribal organizations to administer WIC services as a State WIC Agency, with 33 Indian Tribal Organizations (ITOs) currently operating. Additional ITO funding and regulatory flexibilities could enhance the long-term viability of ITO State WIC Agencies, with specific vendor reforms related to food sovereignty enhancing the capacity of WIC to respond to historic inequities in agriculture, food production, and food access for Indigenous communities.

Resolve barriers to women's economic security. WIC's public health nutrition supports would be a beneficial service for families of any income, but 65 percent of current participants live below the federal poverty line.[6] Nutrition works in tandem with other factors – including investment in childcare, household income, workplace conditions, and access to healthcare – to assure positive pregnancy outcomes. WIC participants benefit when policymakers strengthen protections for and invest in women's economic security.

CHAPTER ONE: THE CASE FOR WIC

Since its inception, WIC's nutrition services have helped ensure a healthier next generation. WIC's food package, nutrition education, and breastfeeding support enhance the overall health of participants. From providing supplemental foods that meet the specific nutrient requirements of the life stage to the nutrition education and breastfeeding support targeted to the participant, WIC has a history of realizing positive nutrition and health outcomes.

FAST FACTS

45%

NEARLY HALF OF ALL INFANTS BORN IN THE UNITED STATES PARTICIPATE IN WIC[7]

$2.48

EVERY DOLLAR SPENT ON WIC MORE THAN DOUBLES THE RETURN ON INVESTMENT[8]

33%

PRENATAL WIC PARTICIPATION REDUCES RISK OF INFANT MORTALITY BY 33%[9]

OVERVIEW OF WIC'S COMPREHENSIVE NUTRITION SERVICES

WIC served nearly 6.4 million individuals in fiscal year 2019, the majority of which were children between ages one and five.[10] WIC reached over 1.6 million infants in fiscal year 2019,[11] which is estimated to be approximately 45 percent of all infants born in the United States.[12] WIC provides five core services to improve health and nutrition outcomes for participating families:

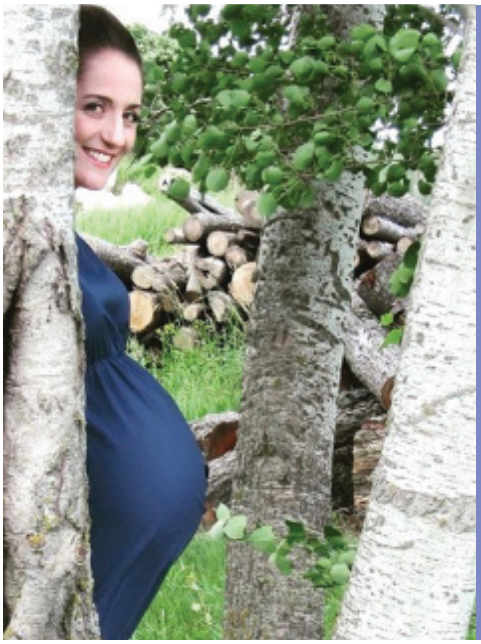
ACCESS TO HEALTHY FOOD

WIC provides a monthly benefit to purchase healthy foods that supplement the diets of WIC mothers and young children, with an average value of $40.90 per month.[13] There are seven core food packages, based on life stage and breastfeeding status, that are prescribed by WIC nutrition professionals and tailored to meet participants' individual nutritional needs.[14] Although WIC is a breastfeeding promotion program, two food packages provide infant formula for partially breastfed and fully formula-fed infants.[15] WIC benefits, with few exceptions, can be redeemed at retail grocery stores by an electronic benefit transfer (EBT), or e-WIC, card.[16]

WIC has the strongest nutrition requirements of any federal nutrition program, and the Healthy, Hunger-Free Kids Act of 2010 required an independent scientific review of the food package at least every decade.[17] The 2009 changes to the WIC food packages strengthened the nutritional quality of available WIC foods, including the introduction of a distinct Cash Value Benefit (CVB) that provides a small monthly benefit for the purchase of fruits and vegetables.[18]

NUTRITION EDUCATION

WIC provides individualized, participant-centered nutrition counseling that supports participants and their families in making healthy choices. Unlike other



"WHEN EXPECTING, MY DOCTOR MADE SURE MEDICAL THINGS WERE GOING WELL, BUT I NEVER REMEMBER HIM ASKING IF I WAS ABLE TO MAINTAIN A GOOD DIET AND WHAT FOODS WOULD HELP MY BABY AS HE GREW. WIC DID THAT. AND THEY DIDN'T JUST GIVE ME A HANDOUT TO READ. THEY TALKED TO ME, HELPED ME BUILD IDEAS, AND GAVE PRACTICAL, REALISTIC SUGGESTIONS."

WIC MOM,
LUDINGTON, MICHIGAN

federal nutrition programs, WIC's tailored nutrition education is core to the program's mission. It provides a consistent touchpoint for WIC families to receive advice and support from nutrition professionals. WIC nutrition education takes various forms, from online modules to group classes to one-on-one counseling, either in person or via a telehealth platform. WIC nutrition educators – including Registered Dietitians (RDs), nutritionists, and other professionals – help families navigate their capacities, strengths, and needs to shape positive dietary behaviors.

BREASTFEEDING SUPPORT

As the nation's leading breastfeeding promotion program, WIC provides individualized support, prenatal education, and access to breast pumps to encourage and strengthen a mother's choice to breastfeed. Structural and societal barriers, such as a rapid return to work after delivery, lack of workplace supports for breastfeeding, family and social pressures, and targeted marketing by the infant formula industry, create real and perceived barriers for low-income mothers as they consider breastfeeding.[19] To help mothers overcome these significant barriers, WIC has built, over three decades, strong incentives to breastfeed – including the introduction of an enhanced food package for exclusively breastfeeding participants in 1992,[20] an extension of program eligibility for breastfeeding participants in 2004,[21] and critical investments in WIC's Breastfeeding Peer Counselor Program in 2010[22] – all resulting in a 30 percent increase in breastfeeding initiation rates among WIC participants since 1998.[23]

HEALTH SCREENINGS

WIC eligibility is determined based on an assessment of nutrition risk, and WIC clinic staff routinely screen for height/length and weight to measure adequate growth. WIC has a rigorous anemia screening protocol, to account for the higher rates of iron-deficiency anemia among the WIC-eligible population.[24] WIC's anemia screenings are effective in tailoring nutrition-oriented interventions, with WIC infants now outpacing non-WIC infants in healthy iron intake.[25] For some families, these screenings have resulted in immediate life-saving medical interventions for vulnerable children. Select WIC agencies also partner with Medicaid to provide a range of other health screenings, including lead testing.[26]

REFERRALS

WIC screens for a range of other health factors and makes appropriate referrals, including for immunizations, tobacco cessation and substance use, prenatal or pediatric care, postpartum depression and mental health, dental care, and social services. WIC serves as a gateway to primary and preventative care, with the healthcare needs of children participating in both Medicaid and WIC found to be better met than low-income children who are not participating in WIC.[27] WIC participation is also associated with a higher likelihood of families showing up at well-child visits,[28] higher rates of childhood immunization than non-participating low-income children,[29] and higher rates of accessing dental care.[30]

PROGRAM IMPACTS ON HEALTH OUTCOMES

BIRTH OUTCOMES

Prenatal WIC participation has a marked effect on the success of a pregnancy, especially for high-risk pregnancies.[31] Recent research associates WIC participation with a 33 percent reduction in the risk of infant death within one year of delivery.[32] Successful pregnancy outcomes are driven by the supplemental foods provided by WIC, which are tailored to increase intake of vital nutrients, including protein, folate, vitamin D, and iron. WIC's nutrition support is vital in assuring healthy pregnancies by significantly reducing the risk of preterm birth[33] and low birthweight,[34] which are both associated with long-term health complications or infant mortality.[35]

It is critical to connect pregnant participants with WIC services as quickly as possible, with over half of pregnant participants enrolling in their first trimester.[36] Maternal nutrition before and during early pregnancy can significantly impact fetal development and the child's long-term health.[37] Maternal nutrition affects pregnancy outcomes both through micronutrient intake (e.g., folate intake affects the risk of neural tube defects[38]) and chronic diet-related conditions such as obesity, high blood pressure, or type-2 diabetes.[39]

Diet-related conditions like obesity are associated with several risk factors for maternal mortality, including preeclampsia[40] and cardiovascular conditions.[41] Since 39.7 percent of women in the United States between ages 20 and 39 have obesity,[42] WIC's individualized nutrition counseling and support is a critical intervention to strengthen nutrition outcomes during pregnancy, mitigate pre-conception barriers to healthy pregnancies, and ensure adequate nutrition as participants plan for a subsequent pregnancy.[43]

POLICY RECOMMENDATION:
WIC's postpartum eligibility should be extended to two years to strengthen inter-pregnancy nutrition outcomes.

BREASTFEEDING RATES

Dedicated program focus in promoting and supporting breastfeeding has led to a 30 percent increase in breastfeeding initiation rates for WIC infants since 1998.[44] The American Academy of Pediatrics recommends exclusive breastfeeding for the first six months, with continued breastfeeding as complementary foods are introduced through at least twelve months.[45] Over the past two decades, WIC has more than doubled the rate of breastfeeding at twelve months,[46] and WIC's successful Breastfeeding Peer Counselor Program is associated with increases in the three key metrics of breastfeeding: initiation, duration, and exclusivity.[47] WIC support – including peer counselors – are effective at addressing racial disparities in breastfeeding rates, especially among Black women.[48]

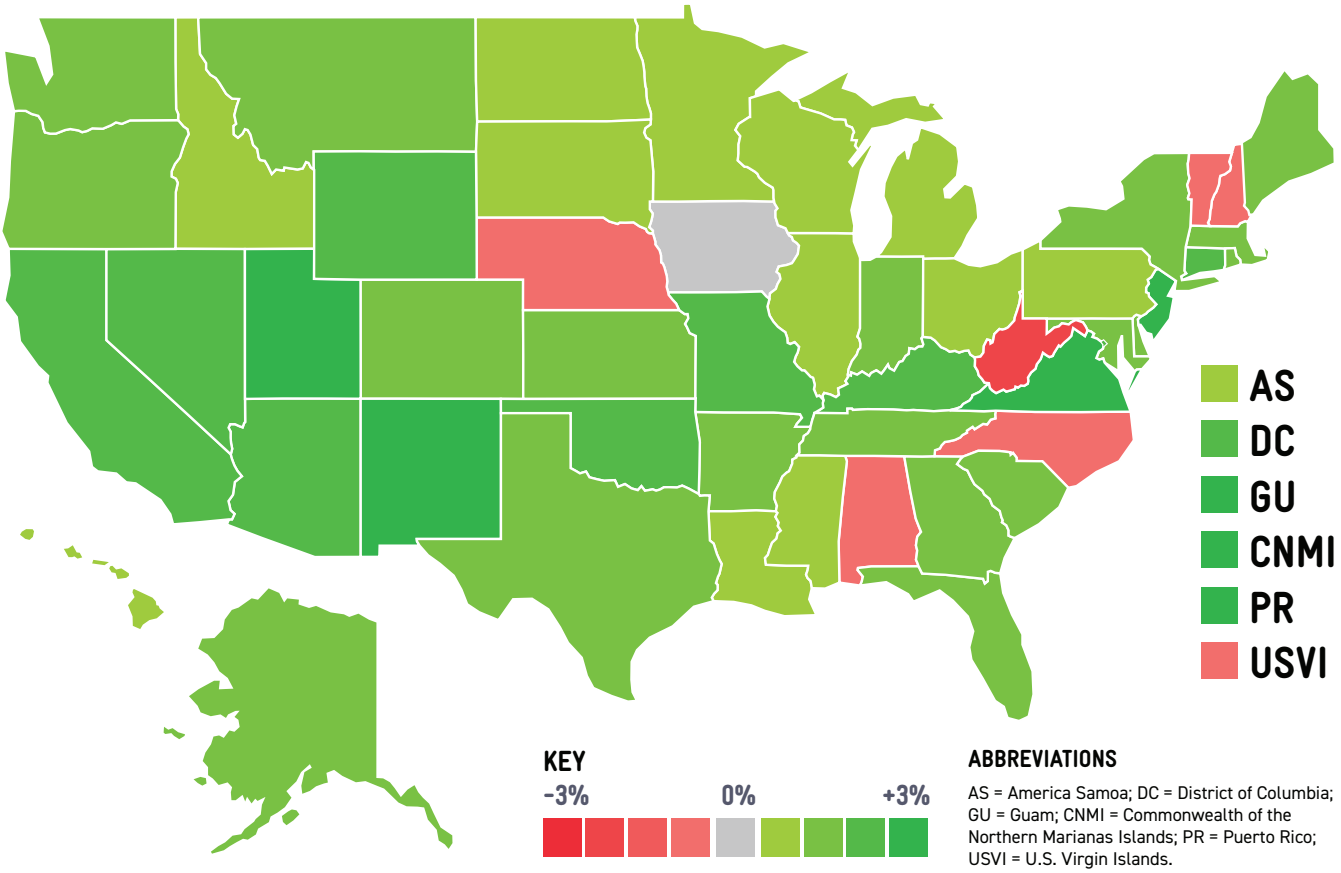
CHILD NUTRITION OUTCOMES

The National WIC Association promoted reforms to the WIC food packages in 2009 that have been instrumental in strengthening child nutrition outcomes for children ages one to five. A comprehensive analysis by the Centers for Disease Control and Prevention (CDC) indicates decreases in the prevalence of overweight and obese children participating in WIC, from 32.5 percent in 2010 to 29.1 percent in 2016, in part due to the food package reforms.[49] The childhood obesity rate for WIC toddlers is now aligned with the national childhood obesity rate for children age two to five.[50]

THE OBESITY RATE FOR WIC TODDLERS HAS DECLINED FROM 15.5% IN 2010 TO 13.9% IN 2016.[51]

WIC participation is also associated with improved diet quality,[52] with children who have participated in WIC for their first 24 months of life scoring higher on the Healthy Eating Index.[53] Enhanced options in the child food package after 2009 are also associated with higher dietary

PREVALENCE OF OBESITY AMONG CHILDREN AGED 2-4 ENROLLED IN THE WIC PROGRAM FROM 2010-2016[51]



ABBREVIATIONS

AS = America Samoa; DC = District of Columbia; GU = Guam; CNMI = Commonwealth of the Northern Marianas Islands; PR = Puerto Rico; USVI = U.S. Virgin Islands.

quality, as a longitudinal study following over 1,300 WIC participants found that children who continue to participate in WIC after their first birthday have healthier diets than children who cease participation by the first birthday.[54] WIC participation is associated with higher consumption of fruits, vegetables, and whole grains by participating children.[55]

Although WIC's food benefit is issued as an individual prescription, the food benefit and WIC's complementary nutrition education can shape family dietary behaviors. Research indicates that WIC participation is associated with healthier purchasing habits by the family[56] and increased availability of healthy foods in retail grocery stores, especially smaller retailers.[57]

Despite WIC's proven record of enhancing child nutrition, WIC eligibility ends on a child's fifth birthday. The majority of children do not enter school until at least age five-and-a-half, and are therefore not yet eligible for sustained nutrition assistance through the National School Lunch Program and National School Breakfast Program.[58]

POLICY RECOMMENDATION:
WIC's child eligibility should be extended until age six or the beginning of kindergarten to create a seamless transition to school meals.

This gap exacerbates food insecurity for children as families must search for alternate sources for food, resulting in meals that do not account for the child's nutritional needs or the family skipping meals all together.[59] These new stressors can inhibit a child's growth at the onset of entering the education system, an unfortunate outcome given WIC's sustained role in improving cognitive development and academic performance among children.[60]

RETURN ON INVESTMENT

HEALTHCARE COST SAVINGS

The United States spends 17.7 percent of its Gross Domestic Product on healthcare, almost twice as much as other developed countries.[61] Despite this high spending, life expectancy in the United States is shorter, while the prevalence of chronic conditions is higher.[62] WIC is a strong federal investment, with recent research indicating that every dollar spent on WIC services returns at least $2.48 in medical, education, and productivity costs.[63] This analysis was limited to cost savings associated with preterm birth, suggesting that the program's total cost savings are actually higher. This finding builds on decades of research, including landmark studies from the early 1990s, demonstrating Medicaid cost savings associated with prenatal WIC participation.[64]

Preterm birth and additional birth complications, including low birthweight, are associated with higher rates of infant mortality and significant health, cognitive, and developmental conditions.[65] Given the complexity of care for the first year after preterm birth, preterm births cost the United States over $26 billion each year, with average first-year medical cost estimated at $65,000 per infant.[66] Even small interventions can make a significant difference – an increase of one pound at birth for a very low birthweight baby can save approximately $28,000 in first-year medical costs.[67] WIC's effective nutrition intervention to assure healthy births ensures immediate healthcare cost savings by ensuring healthier birth outcomes, while also securing long-term savings by mitigating or preventing lifelong health conditions.

WIC's wide-ranging public health nutrition services reduce costs associated with additional healthcare efforts. Only 22 percent of infants in the United States are exclusively breastfed at six months as recommended.[68] WIC's breastfeeding promotion efforts are significant in

increasing breastfeeding rates among low-income infants[69] and reducing racial disparities in breastfeeding.[70] National efforts to improve breastfeeding are associated with significant healthcare savings, with $9.1 billion in estimated savings if 90 percent of WIC infants were breastfed for their first year.[71]

WIC's efforts to reduce childhood obesity have long-term effects on healthcare expenditures, as the additional incremental costs for medical care for each child with obesity is estimated at $19,000,[72] with overall annual medical costs in the United States estimated at $147 billion.[73] WIC also leads to additional Medicaid and healthcare cost savings, including lower dental-related Medicaid costs for participating children.[74]

ECONOMIC AND SOCIETAL IMPACTS

WIC has a direct economic benefit, channeling $4.8 billion in WIC food benefits to over 48,000 authorized retail grocery vendors in communities across the United States.[75] The majority of authorized stores are big box and larger retailers, but at least one-quarter of all WIC benefits are redeemed in small- and medium-sized stores.[76] Although smaller in reach than the Supplemental Nutrition Assistance Program (SNAP), WIC reforms to increase access to healthy foods in 2009 were associated with changes to store stocking practices, indicating that retailers will adapt to meet program requirements.[77] WIC's efficient cost containment efforts generated at least $1.7 billion in savings in fiscal year 2019, bringing in sufficient non-taxpayer revenue to support over one fourth of WIC participants.[78]

WIC PARTICIPATION REDUCES THE PREVALENCE OF CHILD FOOD INSECURITY BY AT LEAST 20 PERCENT.[79]

As with the other federal nutrition programs, WIC has a proven record in reducing food insecurity rates and expanding household access to foods.[79]

"WIC OFFICES SERVE AS A PLACE FOR PREGNANT AND POSTPARTUM MOTHERS TO ASK QUESTIONS WHILE THEIR SPOUSE IS DEPLOYED, FOR FIRST-TIME DADS TO ASK IF THAT NOISE THEIR BABY IS MAKING IS NORMAL, OR FOR THE NEW SOLDIER WHO JUST FOUND OUT SHE IS PREGNANT AND HAS NO CLUE WHAT THE NEXT STEPS ARE. WE ARE MORE THAN A SUPPLEMENTAL NUTRITION PROGRAM FOR OUR MILITARY FAMILIES, WE ARE THEIR SUPPORT SYSTEM."

RILEE SMITH, MA, CLC, CPA
WIC BREASTFEEDING COORDINATOR
ACTIVE-DUTY ALASKA NATIONAL GUARD AND ARMY SPOUSE
FAIRBANKS, ALASKA

Early WIC participation can also help children succeed in school, with demonstrated associations between WIC participation, cognitive development, and academic success.[80] The cognitive and academic impacts of WIC are long-lasting, with the persisting effects throughout school-age years similar in magnitude to other early childhood interventions, including Head Start.[81]

MILITARY READINESS

The federal child nutrition programs were first established to address military readiness and assure the civilian population was fit to serve.[82] The Department of Defense estimates that 71 percent of Americans aged 17 to 24 are ineligible for military service,[83] largely due to the increase in overweight and obesity.[84] Nutrition interventions for children from military families can be critical toward addressing national recruitment challenges, as parental service is a factor that may indicate future enlistment.[85]

WIC provides targeted support to military families on some military bases through co-located clinics or mobile units, but WIC providers often note challenges in outreach to military families and navigating special income rules for military families. Over half of the approximately 72,000 infants born to military families each year[86] are currently eligible for WIC benefits.[87]

Military families with young children report a level of food insecurity that is consistent with the civilian population, adding stressors that may be compounded as military spouses care for young children during deployment.[88] Enhanced access to WIC services for military families is a critical support and a meaningful investment in the country's future recruitment efforts.

POLICY RECOMMENDATION:
WIC adjunctive eligibility should be extended to waive the income test for all actively serving families, addressing national security preparedness while also reducing administrative barriers in serving active-duty parents, military spouses, and children.

SPOTLIGHT: WIC'S RESPONSE TO COVID-19

In 2020, the COVID-19 pandemic presented one of the most significant public health challenges in WIC's history. WIC providers adapted rapidly by modifying services to provide continued support for expectant and new parents, infants, and young children while minimizing risk of exposure to COVID-19 to participants, clinic staff, and their families. WIC providers had to act quickly, as access to WIC services typically requires physical presence at community-based clinics. These sweeping changes in WIC service delivery, including reliance on telehealth strategies and flexibilities around certification, have profound implications for the program's future.

FAST FACTS

WIC WAIVERS ARE APPROVED THROUGH 30 DAYS AFTER THE PUBLIC HEALTH EMERGENCY DECLARATION[89]

REMOTE APPOINTMENTS FUELED PARTICIPATION INCREASES IN THE MAJORITY OF STATES SINCE FEBRUARY 2020[90]

WIC FAMILIES LACK THE RANGE OF SHOPPING OPTIONS OF SNAP HOUSEHOLDS AND OTHER CONSUMERS[91]

EMERGENCY WAIVER AUTHORITY

In mid-March, as public concern about the spread of COVID-19 reached a critical point, WIC providers began to reschedule appointments and close clinic doors. The immediate threat of the virus and the prospect of long-term social distancing raised complications, as WIC providers are required by federal law to conduct certain program operations in person – including onboarding new participants.[92] Without legislative action, WIC providers could not have been responsive to the needs of existing participants, let alone the surge of newly eligible families due to the pandemic's disruption to the national economy and job market.

Within days, Congress passed Families First Coronavirus Response Act, which included unprecedented waiver authority of statutory physical presence requirements and other regulatory barriers to access.[93] State WIC Agencies swiftly applied for and received critical, though conditional, waivers necessary to adapt services, including waivers of the physical presence requirement for new participants.[94] Physical presence waivers were paired with delays in requirements to conduct health screenings and assessments, including measurements of height/length, weight, and hemoglobin levels. Although the waivers allowed for increased flexibility and ongoing services during the pandemic, WIC providers were put in a similar position as healthcare providers – the delays in testing, screening, and referrals were

"REMOTE TELEHEALTH WIC SERVICES DURING THE COVID-19 PANDEMIC HAS BEEN A GAME CHANGER. FAMILIES ARE EXCEPTIONALLY GRATEFUL FOR NOT HAVING TO BE PHYSICALLY PRESENT TO ENROLL, RECEIVE FOOD BENEFITS, OR ACCESS NUTRITION AND BREASTFEEDING SUPPORT."

SAFA HAMAD, MSC RD
WIC SECTION PROGRAM MANAGER
WAKE COUNTY, NORTH CAROLINA

leaving fewer children and families with the information necessary to assure optimal health.[95]

With waiver flexibilities, WIC providers were able to adapt and provide uninterrupted services for families, but providers were quickly challenged by the short-term nature of waivers. The Families First Coronavirus Response Act vested USDA with waiver authority through September 30, 2020,[96] but USDA only approved waivers through May 31, 2020.[97] USDA's short-term approach created barriers for State WIC Agencies as they simultaneously budgeted to scale up technology to sustain remote services, sought consistency in messaging oriented at participants and retail partners, and planned contingencies in case USDA failed to extend the waivers.

About two weeks before the waivers were set to expire, USDA extended the waivers until June 30 and rolled out a process to require State WIC Agencies to resubmit waiver requests with additional justification.[98] The requirement to reapply for waivers caused substantial paperwork burden on State WIC Agencies in the midst of the pandemic and raised public health concerns, as the Centers for Disease Control and Prevention (CDC) designated pregnant women as a population with increased risk of severe illness or adverse outcomes upon contracting COVID-19.[99] Under increased pressure, including a bipartisan letter from the Senate Agriculture Committee,[100] USDA extended the waivers without any further requests for justification through September 30, 2020, only one day before the waivers were set to expire.[101]

In late September, USDA continued to delay a decision on extending WIC flexibilities. Less than two weeks before the waivers were set to expire, with pressure from the National WIC Association, Congress, and other stakeholders, USDA extended waiver flexibilities until 30 days after the expiration of the public health emergency declaration promulgated by the Secretary of Health and Human Services.[102] Additionally, Congress included an extension of USDA's authority to issue waivers in the continuing resolution that passed in late September, allowing USDA to issue new waivers through September 30, 2021.[103] This long-term solution provided the clarity that WIC providers would have relied on from the start of the pandemic, allowing for consistent messages to participants that strengthen outreach and support ongoing WIC participation during the public health crisis.

PARTICIPATION IMPACTS OF REMOTE SERVICES

In March 2020, WIC providers swiftly implemented waiver flexibilities to ensure continued service for existing participants and onboard new families affected by the economic uncertainty related to the pandemic. The majority of State WIC Agencies instituted remote services, an effective and highly successful strategy to engage participants during the global pandemic. Initial evidence suggests that remote services are enabling increased participation, heightened engagement with existing participants, and greater flexibility and convenience for families. Building on earlier innovations to provide telephone or video conferencing for nutrition education, remote services are a success story of WIC efficiently adapting to meet the challenging circumstances of COVID-19.

POLICY RECOMMENDATION:
COVID-19 flexibilities should be made permanent to allow for remote certifications utilizing video conferencing technology or telephone appointments.

Remote services are most practical in states that have already implemented electronic-benefit transfer (EBT), or e-WIC. In those states, since participants already have access to an EBT/e-WIC card, State WIC Agencies or local providers are able to remotely load benefits onto the card each month. Any other contact with WIC staff, including nutrition education and recertification appointments, could be handled by phone or video conferencing technology. In the few states that have not begun the EBT/e-WIC transition, the waiver authority allowed agencies to mail paper vouchers directly to participants' homes.

As of October 2020, two-thirds of states are reporting an increase in participation since February 2020.[104] The distribution among State WIC Agencies is uneven, with many states reporting increases between one and seven percent, and some states reporting double-digit increases ranging as high as 20 percent. This is a stark departure from prior trends, with WIC participation rates declining consistently since reaching a record high

of 9.2 million in 2010 during the Great Recession.[105] WIC providers report that new participants include children who were previously certified but dropped off the program, families that were eligible before COVID-19 but not participating, and families that are newly eligible as a result of income loss during the pandemic.

There are two main indicators associated with the one-third of states that are still reporting declines in program participation. Over a dozen State WIC Agencies have offline EBT/e-WIC systems, which require that cards be manually reloaded at a clinic location.[106] Many offline WIC providers instituted curbside services, allowing participants to remain in their cars while clinic staff, garbed in personal protective equipment, would retrieve the EBT/e-WIC card and reload it at a distance.[107] USDA approved another set of waivers to allow benefit issuance for four months, instead of the more common three-month issuance, to reduce burdens on offline EBT/e-WIC states for both staff and participants.[108] Despite innovative strategies to reduce exposure, the majority of states that are still registering participation declines during COVID-19 have offline EBT/e-WIC systems.[109]

Additionally, several states were rolling out EBT/e-WIC systems in the midst of the pandemic, causing confusion and disruption for participants. At least one state, Hawaii, demonstrated participation increases after the EBT/e-WIC transition was completed over the summer.

In addition to the physical presence waivers, thirty-five State WIC Agencies were granted short-term extensions of child certification periods for up to 90 days.[110] With WIC's health assessments delayed, there is little to distinguish a recertification appointment from more frequent nutrition education touchpoints. Short-term extensions of child certification periods are useful for reducing administrative burden on overworked WIC clinic staff and, in some cases, aligning child certification periods with other family members' certification periods. The waiver demonstrates the complexity of enabling remote certifications in a post-COVID environment, when measurements for height and weight and screening for hemoglobin levels will be required again. An essential part of enabling remote certifications in the long term will be enhanced coordination between physicians and WIC providers to facilitate information sharing and ensure that relevant health assessments are being conducted without duplication.

POLICY RECOMMENDATION:
Technology investments should streamline electronic health information sharing between WIC providers and physicians to reduce needlessly duplicative testing and ensure accurate growth charts.

SHOPPING CHALLENGES

In March 2020, WIC participants reported increased challenges in navigating the shopping experience as the general public purchased excess groceries in fear of the pandemic and concerns about lockdowns or supply shortages. WIC's prescriptive food package limited the options for WIC shoppers, even if similar brands or products were otherwise available. WIC participants were increasingly concerned about shortages of WIC contract-brand infant formula, with some alarming reports in the first weeks of the pandemic around diluted or homemade formulas, which pose significant risks to infant health.

With passage of the Families First Coronavirus Response Act, State WIC Agencies swiftly requested food substitutions for many prescribed WIC food items to enhance available options for WIC shoppers. Each State WIC Agency was granted food substitutions based on reported shortages in their state, leading to significant variations in waiver flexibilities across the country. Food substitutions were granted in nearly every food category, permitting additional package sizes and options. State WIC Agencies also independently reviewed their Approved Product Lists to add additional brands and products that were otherwise available.

For the most part, food substitution waivers were consistent with the nutritional integrity of the food package, with USDA denying State WIC Agency

"IN AN EFFORT TO PREVENT SPREAD OF THE PANDEMIC AND PROTECT THEIR COMMUNITIES, MANY OF THE PUEBLOS INSTITUTED LOCKDOWNS AND ENFORCED SET SHOPPING TIMES. FIVE SANDOVAL INDIAN PUEBLOS WIC CONTINUES TO SERVE FAMILIES REMOTELY AND HAS EXPLORED ONLINE ORDERING, CURBSIDE PICKUP, AND PROXY SHOPPING TO ADDRESS THE HIGHER RISK OF ADVERSE HEALTH OUTCOMES FACED BY WIC FAMILIES DUE TO COVID-19."

KAREN GRIEGO-KITE,
FIVE SANDOVAL INDIAN PUEBLOS

requests to provide products that did not meet the whole-grain requirements. The one exception was fat content in milk and yogurt, with USDA permitting fifty-six State WIC Agencies to allow milk products with any fat content and seventeen State WIC Agencies to permit yogurt with any fat content. USDA did not approve any substitutions for infant formula, as State WIC Agencies enter into sole-source contracts with manufacturers and negotiate rebate prices independent of USDA.

In the early weeks of the pandemic, USDA took steps to scale up the online purchasing pilot for Supplemental Nutrition Assistance Program (SNAP). Authorized by the 2014 Farm Bill, the SNAP online purchasing pilot was already in the field when the pandemic worsened. USDA worked with Walmart, Amazon, and other retailers to rapidly escalate the pilot project to nearly all states. Although this action enhanced food access for millions of families, it exacerbated an inequity for WIC shoppers, who became the major population still required to conduct shopping in person. Although some stores have instituted special hours for pregnant shoppers and other at-risk customers, State WIC Agencies report that the disparity in transaction options between SNAP and WIC is having an effect both on participation and redemption of healthy WIC foods.

POLICY RECOMMENDATION:
USDA should partner with WIC providers and retailers to speedily implement online purchasing for WIC shoppers in all states no later than October 1, 2024.

USDA was hesitant to issue waiver flexibilities that would empower innovation for new transaction models. Under existing regulations, WIC participants must redeem their benefits by signing or entering their PIN in the presence of a cashier. Despite several State WIC Agency requests, USDA did not approve a waiver of this regulation for three months. In July 2020, USDA announced a series of small-scale pilot projects for online ordering that would explore online purchases, although the pilot projects are not expected to be completed until at least 2023.
In April 2020, in the absence of USDA engagement, the National WIC Association formed an Online Ordering Working Group comprised of WIC providers, retailers, EBT/e-WIC processors, and other stakeholders interested in exploring the steps necessary to operationalize safe transactions during COVID-19. Several promising models have emerged in recent months to strengthen self-checkout and build out online ordering systems that enable in-store or curbside pickup. The Working Group has also initiated conversations on the steps necessary to build out a system to enable WIC online purchasing.

ECONOMIC RELIEF

WIC waiver flexibilities provided by the Families First Coronavirus Response Act ensure that services can continue uninterrupted, but additional steps could be taken to enhance the federal economic response to COVID-19. Food insecurity rates in households with young children doubled in the initial months of the pandemic, from 14 percent to 28 percent.[111]

In January 2021, President Biden and Vice President Harris proposed a visionary investment of $3 billion in multi-year funding to strengthen WIC services, recognizing the program's importance in aiding families during the pandemic and resolving inequities during the nation's recovery. This funding would enhance food benefits, strengthen outreach, and drive innovation to modernize service delivery.

Enhanced benefits during the pandemic would complement efforts of SNAP and Pandemic-EBT to address the nation's worsening hunger crisis. WIC's Cash Value Benefit (CVB) allows for the purchase of fruits and vegetables, which had increased supply throughout the pandemic due to restaurant and school closures. The Biden-Harris proposal echos bipartisan efforts by Reps. Kim Schrier (D-WA) and Ron Wright (R-TX) to champion a short-term option that increases the value of the CVB in a win-win solution that supports WIC families and fruit and vegetable growers.

CHAPTER TWO: WIC'S ROLE IN IMPROVING NUTRITION

Since its inception, WIC's nutrition services have helped ensure a healthier next generation. WIC's food package, nutrition education, and breastfeeding support enhance the overall health of participants. From providing supplemental foods that meet the specific nutrient requirements of the life stage to the nutrition education and breastfeeding support targeted to the participant, WIC has a history of realizing positive nutrition and health outcomes.

FAST FACTS

$40.90

AVERAGE MONTHLY VALUE OF THE WIC FOOD BENEFIT[112]

FOOD PACKAGE CHANGES IN 2009 IMPROVED DIETARY INTAKE FOR WIC FAMILIES[113]

30%

WIC INCREASED BREASTFEEDING INITIATION RATES FROM 42% IN 1998 TO 72% IN 2018[114]

WIC FOOD PACKAGES

WIC's professional nutrition staff prescribe food benefits through seven distinct food packages, which reflect the life stage and breastfeeding status of individual participants. The seven food packages outline the variety and minimum nutritional content of supplemental foods approved for WIC shoppers and are designed by the U.S. Department of Agriculture in a science-based process undertaken in collaboration with the National Academies of Sciences, Engineering, and Medicine (NASEM). State WIC Agencies have a certain degree of flexibility in implementing the food packages, by developing Approved Product Lists for specific brands and package sizes that align with the federal regulations.[115]

FOOD PACKAGE REVIEW PROCESS

Under the Healthy, Hunger-Free Kids Act of 2010, the WIC food packages are subject to an independent, science-based review every decade.[116] Under federal law, USDA must conduct a scientific review of available foods and amend the regulations to reflect nutrition science, public health concerns, and cultural eating patterns.[117] This process is unique among the federal nutrition programs and has led to the strongest nutrition standards among any federal program.

Early in WIC's history, Congress mandated that WIC foods contain nutrients lacking in the program's target population and have relatively low levels of fat, sugar, and salt.[118] After the early food packages were established in federal regulations in 1980, USDA did not evaluate changes in the WIC food packages again until the 2000s. During that time period, the WIC food packages generally did not provide access to fruits and vegetables and was inflexible to variation in cultural food preferences, especially for tribal populations.

In 1999, the National WIC Association (then, the National Association of WIC Directors) issued a report calling for a revision of the WIC food packages to achieve consistency with the Dietary

Guidelines for Americans (DGAs).[119] This report formed the basis for a decade-long process to review and revise the food packages in alignment with the latest nutrition science.[120] USDA contracted with the National Academies' Institute of Medicine (IOM) to obtain an independent, science-based review.[121] The IOM report was published in 2005, taking into consideration the nutritional needs of the WIC population, embracing many of the National WIC Association's recommendations, and recommending changes to the foods then offered through the WIC food packages. In 2007, based on the IOM review and recommendations, USDA issued an interim rule that revised the WIC food packages, requiring State WIC Agencies to implement the changes by 2009.[122]

For the first time in the program's history, the 2009 food package changes made fruits, vegetables, whole-wheat bread, and additional whole-grain options available to WIC shoppers.[123] These additions were balanced with reductions in issuance of juice, eggs, milk, and formula, and the removal of whole milk for all participants except for one-year-old children.[124] State WIC Agencies were also afforded the ongoing opportunity to request substitutions within the food package to address cultural eating patterns.[125]

The 2009 food package changes are associated with improved inventory of healthier foods in WIC and non-WIC authorized retail grocery stores,[126] leading to improved access to healthy foods for WIC participants and the shopping public.[127] This has led to increased consumption of whole grains, fruits, and vegetables, and decreased consumption of whole milk,[128] as well as increased breastfeeding initiation among WIC participants.[129]

PENDING USDA REVIEW

In January 2017, the National Academies of Sciences, Engineering, and Medicine (NASEM) completed its most recent review of the WIC food packages. USDA has not yet acted on these recommendations, instead prioritizing completion of the 2020-2025 Dietary Guidelines for Americans (DGAs). For the first time, the DGAs will include specific recommendations for pregnancy, lactation, and early childhood through twenty-four months. In July 2020, the Dietary Guidelines Advisory Committee issued its scientific report.[130] The Committee does not independently evaluate the WIC food packages, but its general nutrition recommendations for pregnancy, lactation, and early childhood are consistent with the specific recommendations made in the 2017 NASEM report.

POLICY RECOMMENDATION:
USDA should swiftly undergo rulemaking to update the variety, quality, and value of WIC-approved foods, consistent with the 2017 NASEM recommendations and 2020 DGAs.

HIGHLIGHTS OF NASEM'S 2017 RECOMMENDATIONS FOR THE WIC FOOD PACKAGE[131]

- Increase dollar amount of Cash Value Benefit for fruit and vegetable purchases
- Require broader array of options in each food category consistent with cultural preferences and special dietary needs
- Individually tailor infant food packages to support continued breastfeeding
- Add fish for women and child food packages
- Reduce amounts of juice, milk, legumes, and peanut butter
- Reduce amounts of infant cereals, infant fruits and vegetables, and infant meats
- Improve alignment of all WIC foods with dietary guidance

In developing the 2017 report, NASEM was tasked to identify strategies to adjust available WIC foods that were cost-neutral to the current value of the food packages.[132] In 2019, the average value of the food package was $40.90 per month,[133] less than one-third of the average monthly benefit for the Supplemental Nutrition Assistance Program (SNAP).[134] The Cash Value Benefit for fruits and vegetables – one of the most redeemed elements of the food package – comes out to only $2.25

"THE NUTRITIONAL QUALITY OF THE WIC FOOD PACKAGE IS REALLY THE CORNERSTONE OF OUR PROGRAM. WE PROVIDE SPECIFIC, NUTRITIOUS FOODS AT A CRITICAL TIME FOR WOMEN AND CHILDREN. IN MY 23 YEARS WITH THE PROGRAM, THE SCIENCE-BASED FOOD PACKAGE CHANGES HAVE BEEN A WONDERFUL STEP FORWARD, BUT WE HAVE MORE WORK TO DO. BENEFITS DON'T STRETCH LIKE THEY USED TO, AND INCREASED VALUE FOR THE NUTRITIOUS FOODS WOULD GO A LONG WAY TOWARD SUPPORTING HEALTHY OUTCOMES."

TRACY KELLEY, BS, CLC
WIC PROGRAM DIRECTOR
HOME NURSING AGENCY, ALTOONA, PENNSYLVANIA

per week for adults and $2.75 per week for children. An increased value for the WIC food packages would both broaden access to nutritious foods and retain participants for the duration of program eligibility, shaping childhood dietary outcomes and setting the stage for future life success.

POLICY RECOMMENDATION:
The value of the WIC food packages should be increased to provide greater access to nutritious foods.

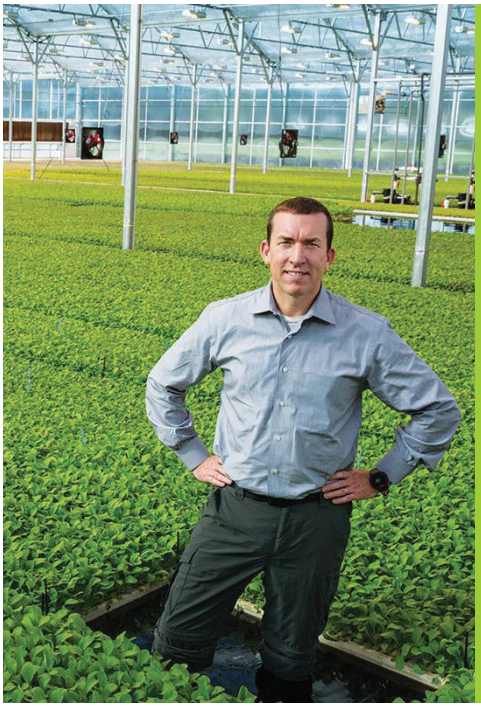
INFANT AND CHILD FOOD PACKAGES

The WIC packages ensure adequate nutrient intake for proper child growth, including macronutrients like carbohydrates and proteins that build healthy tissue and over a dozen micronutrients, among them vitamins and minerals that strengthen development of bones, teeth, vision, and the musculoskeletal, nervous, digestive, reproductive, and immune systems.[135]

USDA defines three distinct food packages for infants: fully formula-fed, partially (mostly) breastfed, and fully breastfed. At six months, all three food packages phase in infant foods – specifically, infant cereal and infant fruits and vegetables.[136] The fully breastfed package doubles the quantity of infant fruits and vegetables and provides for infant meats. Infant foods are the least-redeemed items in the food package, informing the NASEM recommendation to reduce issued quantities and allow substitution for canned fish or Cash Value Benefit for fruits and vegetables.[137]

The first two food packages provide for a prescribed amount of iron-fortified infant formula (either milk or soy), which can only be redeemed through the brand specified in a State WIC Agency's sole-source contract.[138] Iron fortification of formula is key for preventing iron-deficiency anemia, which can impact infant neurological development, cognitive function, and immune function.[139] WIC routinely screens for anemia, filling a significant gap in physician testing.[140] WIC may provide non-contract formula, certain nutritionals, or additional supplemental foods for infants with specific medical conditions, if documentation from a medical professional is provided.[141]

There is only one child food package, for participants aged one to four. The child food package includes prescribed amounts of juice, milk, eggs, whole grains, legumes, and peanut butter, as well as a $9 per month Cash Value Benefit for fruits and vegetables.[142] As a result of the 2009 food package changes, whole milk is only provided to one-year-old children, and older children and adults are prescribed lowfat (1%) or nonfat milks.[143] Reduced fat (2%) milk is only authorized for participants with certain conditions and upon an individualized nutrition assessment.[144]



"WIC HAS HELPED BRIDGE THE GAP FOR THE YOUNG FAMILIES STRUGGLING TO PUT HEALTHY FOODS ON THE TABLE. BUT WE MUST BE HONEST ABOUT THE FACT THAT $2.25 A WEEK IS NOT ENOUGH TO ENSURE KIDS ARE CONSUMING ENOUGH FRESH FRUITS AND VEGETABLES TO MEET THEIR DIETARY NEEDS. THE WIC FOOD PACKAGE SHOULD BE UPDATED TO REFLECT BOTH THE LATEST DIETARY GUIDANCE AND REALISTIC FOOD COSTS."

PAUL LIGHTFOOT
PRESIDENT, BRIGHTFARMS
IRVINGTON, NEW YORK

ADULT FOOD PACKAGES

The final three food packages are for adults: pregnant and partially breastfeeding participants; non-breastfeeding postpartum participants; and fully breastfeeding participants. Similar to the child food package, the adult food packages all provide specific quantities of juice, milk, cereal, eggs, legumes, and peanut butter,[145] as well as an $11 per month Cash Value Benefit for fruits and vegetables.[146] The WIC food packages include key micronutrients such as folate, vitamin C, calcium, and protein that contribute to healthy pregnancy outcomes, including extending the gestational period and assuring healthy birthweight.[147]

The fully breastfeeding food package was established in 1992 as part of a comprehensive effort initiated by Congress to reorient WIC as a breastfeeding promotion program.[148] The enhanced value of the package, intended to incentivize breastfeeding, includes cheese and canned fish, as well as additional quantities of milk, eggs, and whole grains.

NUTRITION EDUCATION

WIC supports families in making healthy changes to their lifestyles through nutrition education that can take various forms, from online modules to group classes to one-on-one counseling. The nutrition education in WIC helps families connect the dots among health, growth, and development. The nutrition counseling approach used by WIC staff is participant-centered and highlights

their capacities, strengths, and needs, rather than their problems or negative behaviors.

In 1978, early in WIC's history, nutrition education was established as a core component of WIC services.[149] Nutrition education programming was to be provided to all adult participants and made available to parents and caretakers of participating children, including fathers and grandparents.[150] Nutrition education is meant to be easily understood by participants and bears a practical relationship to the participant's nutritional needs, household situations, and cultural preferences, including information on how to select and prepare food for themselves and their families.[151] WIC nutrition education is a main factor in retaining families through a child's fourth birthday, as parents find value in the education, information, and advice provided by WIC's nutrition professionals.[152]

WIC nutrition education has been effective at empowering families to make informed decisions. Over the decades, WIC nutrition education has led to a decrease of over 40 percent in the families who introduced complementary foods earlier than six months (from 62 percent to 20 percent),[153] which is the timeframe recommended by the American Academy of Pediatrics.[154] Similarly, WIC nutrition education messages are critical in raising awareness about the 2009 food package changes, orienting participants toward healthier options, and influencing shopping behaviors that encourage better and more-educated choices.[155]

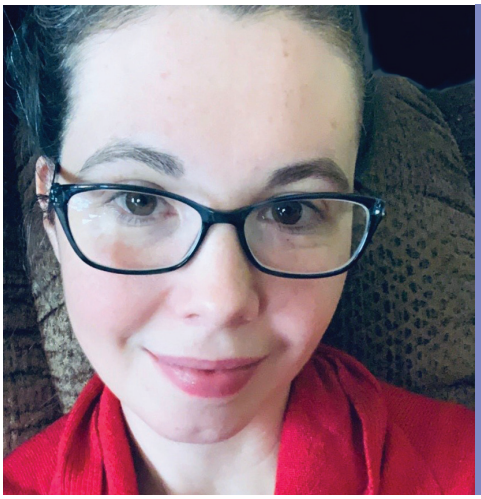
NEARLY 60 PERCENT OF WIC STAFF PROVIDING NUTRITION EDUCATION ARE REGISTERED DIETITIANS (RDS).[156] FOR MORE THAN TWO DECADES, STATE WIC AGENCIES HAVE NOTED THE INCREASED CHALLENGES OF RETAINING RDS, AS WIC SALARIES ARE NOT CURRENTLY COMPETITIVE WITH CLINICAL PLACEMENTS OR PRIVATE PRACTICE.[157] RD PLACEMENT WITHIN WIC MAY BECOME MORE DIFFICULT AS A NEW REQUIREMENT TO HAVE A GRADUATE DEGREE IN ORDER TO OBTAIN THE RD CREDENTIAL GOES INTO EFFECT IN 2024.[158]

Nutrition education is typically provided at a community-based WIC clinic, either in a one-to-one individualized counseling session or at a group class (e.g., a cooking demonstration). There is no statutory or regulatory requirement that nutrition education be provided at the WIC clinic. In recent years, State WIC Agencies have created alternatives to in-person counseling to promote convenience for participating families. Over 30 geographic State WIC Agencies have built out online nutrition education platforms to permit participants to access relevant messages and materials from their homes.[159] State WIC Agencies have explored additional strategies, including out-of-clinic food demonstrations, telephone and video conferencing appointments, video classes, and two-way texting platforms.[160]

Since the COVID-19 pandemic, nearly all State WIC Agencies have instituted remote nutrition education, primarily by telephone appointment. Some State WIC Agencies, such as Virginia, are building out longer-term platforms to continue online nutrition education sessions after the COVID-19 flexibilities expire. Consistent with findings from pre-COVID research into online nutrition education platforms,[161] WIC providers have reported higher attendance and engagement with nutrition education offered by phone or other remote means.[162]

BREASTFEEDING PROMOTION

After years of local and national activism and advocacy by the National WIC Association and other breastfeeding partners to elevate breastfeeding support within WIC's nutrition education curriculum, USDA issued the results of a three-year study in 1988 that outlined the range of creative and successful practice models at WIC sites across the country.[163] This report inspired Congressional action to establish WIC as a breastfeeding promotion program, including dedicated funding for breastfeeding promotion activities.[164] In 1992, following NWA's urging and Congressional directives, USDA



"PRIOR TO THE PANDEMIC, AN ARKANSAS PEER COUNSELOR CONDUCTED ROUNDS AT A LOCAL HOSPITAL. NOW, SHE USES ZOOM TO HELP BREASTFEEDING MOMS IN THE LABOR AND DELIVERY UNITS. IN 2020, WE'VE BEEN ABLE TO EXPAND OUR BREASTFEEDING SUPPORT BY CREATING THREE NEW PEER COUNSELOR POSITIONS IN NORTH ARKANSAS DUE TO INCREASED FUNDING. EVEN DURING COVID-19, WIC BREASTFEEDING STAFF PARTNER WITH LOCAL PHYSICIANS TO HELP MONITOR INFANT WEIGHT GAIN AND SUPPORT MOTHERS THROUGH THEIR BREASTFEEDING JOURNEY."

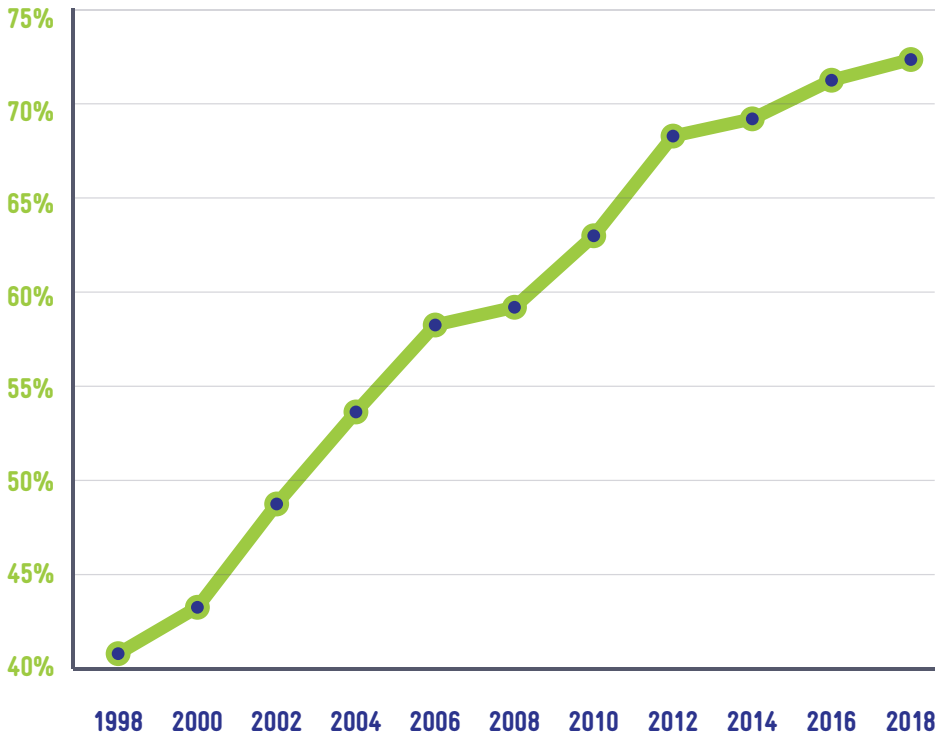
KAYLA FULLER, MS, RD, LD
WIC BREASTFEEDING PEER COUNSELOR COORDINATOR
ARKANSAS DEPARTMENT OF HEALTH

established the fully breastfeeding food package in the most substantive change to the WIC food packages between 1980 and the 2009 reforms. The 1992 fully breastfeeding food package included increased amounts of juice, cheese, legumes, and peanut butter, as well as canned fish and carrots, marking the first appearance of a vegetable in the WIC food packages.[165]

WIC's breastfeeding workforce – including International Board Certified Lactation Consultants (IBCLCs), Certified Lactation Educators (CLEs), Certified Lactation Consultants (CLCs), and peer counselors – is a trusted source of breastfeeding information, with a USDA study noting that WIC staff are the second-most-common group that women speak to regarding breastfeeding, after husbands or partners.[166] Women who attend WIC breastfeeding support groups are twice as likely to make a breastfeeding plan than those who do not.[167]

WIC supports breastfeeding through education, including classes, support groups and teaching tools, and hotlines, as well as peer and professional lactation support staff. Over the last two decades, in recognition of the mounting evidence demonstrating the health benefits of breastfeeding, WIC has established a number of breastfeeding initiatives, including a highly successful peer counselor program, evidence-based promotional campaigns, food package incentives, training curricula, provision of breast pumps, and partnerships with hospitals to both limit the distribution of infant formula and provide bedside support from WIC breastfeeding staff.[168]

BREASTFEEDING INITIATION RATES FOR WIC PARTICIPANTS[184]



Due to WIC's increased commitment and investments in breastfeeding promotion and support, the percentage of WIC moms who have initiated breastfeeding has increased 30 percent over two decades, from 42 percent in 1998 to 72 percent in 2018.[169] Breastfeeding duration has also improved as WIC's lactation professionals and peer counselors actively encouraged and supported continued breastfeeding. In 2017, 26 percent of WIC participants are still breastfeeding at seven months postpartum, as opposed to only 12 percent in 1997.[170] WIC's support is critical, as approximately 92 percent of mothers, across all socioeconomic lines, report feeding problems by day three postpartum.[171]

WIC's professional lactation support is provided by designated breastfeeding experts, with USDA recommending that

the role be held by IBCLCs.[172] The IBCLC designation is the highest credential in the field of lactation management, and IBCLCs are demonstrated to have a strong effect on breastfeeding outcomes, including for low-income Black and Latina women.[173] IBCLCs also reduce the utilization of healthcare resources for certain conditions, like otitis media (inner ear infections), presenting further healthcare cost savings in addition to high-value breastfeeding support.[174] Research consistently affirms WIC's breastfeeding model, with higher initiation rates when support is paired between IBCLCs and peer counselors.[175]

Due to the rigorous requirements for IBCLC credentialing, salaries that are not competitive with clinical practice, and the limited availability of IBCLCs in rural communities, only 71 percent of WIC agencies have an IBCLC on staff.[176] For the remainder of WIC agencies, other credentialed breastfeeding staff are designated as breastfeeding experts, including Certified Lactation Educators (CLEs) and Certified Lactation Consultants (CLCs). The diversity of credentialed breastfeeding staff ensures professional support for WIC mothers in every community, especially rural areas, immigrant communities, and communities of color.

IN 2020, CONGRESS INVESTED A 50% INCREASE IN WIC'S BREASTFEEDING PEER COUNSELOR PROGRAM.

BREASTFEEDING PEER COUNSELOR PROGRAM

One of WIC's most effective breastfeeding promotion strategies is the Breastfeeding Peer Counselor (BFPC) Program. Building on local models before being scaled up nationally in 2004, the BFPC Program uses an evidence-based peer-to-peer model that connects participants with paraprofessional breastfeeding counselors who come from the same neighborhoods and speak the same languages as WIC participants.[177] WIC peer counselors, who are often current or former WIC participants with experience breastfeeding their own children, provide counseling services in person, in groups, over the phone, via video call, through texting or chatting, and/or during home visits.

Peer counselors understand the difficulties surrounding breastfeeding and provide realistic and practical guidance as a result of shared personal backgrounds and experience in ways that most health professionals cannot. In addition, the use of peer counselors is more cost effective than professional lactation staff. WIC's breastfeeding support activities are strongest when credentialed lactation support professionals, peer counselors, and nutrition staff work together to provide a seamless continuum of care for WIC families.[178]

The BFPC Program is demonstrated to increase breastfeeding initiation, duration, and exclusivity among WIC participants.[179] Pregnant and postpartum participants with access to a peer counselor report that they highly value the peer support and are especially appreciative of the peer counselor's accessibility.[180] Peer counselors are particularly effective at increasing breastfeeding initiation and duration rates among Black WIC participants.[181]

WIC is well positioned to strengthen workforce development for peer counselors if adequate support is built into the program. Some State WIC Agencies had explored models to incentivize peer counselors in obtaining higher lactation support credentials, including Certified Lactation Consultant (CLC) and International Board Certified Lactation Consultant (IBCLC). The peer counselor experience could also encourage counselors to further their work and explore careers in nursing and healthcare. By creating a pipeline for peer counselors to pursue credentialing as an IBCLC, WIC could expand the program's access to credentialed staff while also strengthening the pipeline for a more diverse generation of lactation professionals.

POLICY RECOMMENDATION:
Increasing the annual investment in WIC's Breastfeeding Peer Counselor Program can enhance the number of available peer counselors and support out-of-clinic partnerships with hospitals, physician offices, and home visiting programs, while also supporting workforce development opportunities for peer counselors to obtain professional credentials.

Since its establishment in 2004, Congress has consistently increased the investment in the BFPC Program. The initial investment of $20 million was expanded in the Healthy, Hunger-Free Kids Act of 2010. The increased annual appropriations level at $60 million was finally elevated in 2020 to the full funding of $90 million authorized by the Healthy, Hunger-Free Kids Act.[182] This funding has been utilized by State WIC Agencies to address coverage gaps, increasing the number of local agencies with access to peer counselors while reducing disparities for rural participants.[183]

FAST FACTS

77 PERCENT OF WIC PARTICIPANTS ALSO RECEIVE MEDICAID[185]

THE SHARE OF ELIGIBLE INFANTS SERVED BY WIC DROPS 21 PERCENT BY THE FIRST BIRTHDAY[186]

ONLY 11 PERCENT OF WIC FUNDING IS APPORTIONED TO NUTRITION EDUCATION AND BREASTFEEDING SUPPORT[187]

CHAPTER THREE: CONNECTING FAMILIES WITH WIC AND HEALTHCARE

WIC's effective services are demonstrated to improve pregnancy, birth, and early childhood outcomes, but only 51.1 percent of eligible participants are certified for WIC.[188] Prior to the COVID-19 pandemic, WIC participation has declined since reaching an historic high of 9.2 million in 2010 at the height of the Great Recession.[189] With the majority of State WIC Agencies reporting participation increases during COVID-19, WIC providers are poised to reach a new generation of participants if they are empowered with the flexibilities and technology necessary to deliver quality services in the twenty-first century.

CERTIFICATIONS AND CLINIC PROCESSES

Even though WIC providers have implemented remote appointments during COVID-19, WIC traditionally provides in-person services at community-based clinics. Participants are required to physically come to the clinic at least once every six months for health screening and assessments, but participants are often more frequently present at their WIC clinic for nutrition counseling and other touchpoints. Over a dozen State WIC Agencies require more frequent in-person contact for program participation, as electronic-benefit transfer (EBT), or e-WIC, cards must be manually reloaded at the clinic every three months.[190] Appointments alternate between certification appointments and nutrition education sessions. WIC staff augment in-person visits with additional contact, through phone, texting, e-mail, and online platforms. These technologies are utilized during the COVID-19 pandemic to substitute for in-person services during the public health emergency.

PHYSICAL PRESENCE REQUIREMENTS

In 1998, Congress instituted requirements that WIC participants – including infant and child participants – be physically present for certification appointments.[191] At the time, certification periods only lasted six months. Participants quickly identified the physical presence requirement at certifications as a burden, with structural barriers such as scheduling, transportation, and obtaining childcare or time off work interfering with continued WIC participation.[192] Certification appointments have been shown to be as

long as two hours.[193] As a result, Congress extended certification periods from six months to one year for breastfeeding participants in 2004[194] and for children in 2010.[195]

When implemented in 1998, the physical presence requirement was specifically introduced as a program integrity measure, coupled with other punitive anti-fraud measures for participants and vendors.[196] Together, these provisions exceeded the boundaries necessary to protect the integrity of program services and sensationalized the extraordinarily low instances of participant fraud and abuse.[197] Unsurprisingly, the first recorded participation declines in WIC program history occurred in the years following introduction of physical presence.[198]

POLICY RECOMMENDATION:
Certification requirements should be streamlined by extending certification periods to two years for all participants and increased flexibility to promote family alignment of certification periods.

COVID-19 waivers of statutory physical presence requirements have enabled greater innovation as State WIC Agencies leverage telehealth options to reach WIC-eligible families.[199] The certification appointment includes four core components:

- **ELIGIBILITY SCREENING:** WIC staff reviews documents to verify an applicant's identity, residency, and income. These can be paper documents or photos of documents shown on a screen (e.g., a smartphone or WIC computer connected to state Medicaid or SNAP system).
- **HEALTH AND NUTRITION ASSESSMENT:** WIC nutrition professionals conduct an interview to assess health history, eating behaviors, and nutritional risks. A specific nutrition risk must be identified to be eligible for WIC services.[200] Participants are measured for height/length and weight and blood tested to screen for hemoglobin levels and iron-deficiency anemia.
- **NUTRITION EDUCATION:** Individualized nutrition education counseling is provided during a certification appointment, based on the health and nutrition assessments and the participant's concerns, interests, and priorities.
- **REFERRALS AND BENEFIT ISSUANCE:** Participants must agree to rights and responsibilities, a lengthy and burdensome recitation of terms of program participation.[201] Where appropriate, WIC staff will refer participants for healthcare or other services. WIC nutrition staff will assign a food package and tailor it to the participant's needs, and then issue an electronic benefit transfer (EBT)/e-WIC card.

Many of these steps can be accomplished through telehealth or online platforms, with over thirty State WIC Agencies already leveraging online nutrition education platforms to deliver education outside of the certification appointment.[202] WIC providers may explore strategies at the mid-certification appointment, which repeats many of these processes without the statutory physical presence requirements. Streamlining the initial and mid-certification appointments is a key priority for WIC providers, as repeated trips to the clinic can disincentivize continued participation. This is especially critical for families with multiple children participating in WIC, where the individual children's certification periods may not be aligned.

ONLINE CERTIFICATION TOOLS

The COVID-19 pandemic was a catalyst for WIC providers to invest in and build out technologies that streamline certification processes.[203] As WIC participants are already accustomed to utilizing technology in their daily lives and regular interactions with healthcare providers, technology platforms are critical in providing a modern, twenty-first century experience.[204] In addition, technology can enable more focused time on core nutrition content instead of administrative processes, as well as alleviate burdens such as bringing the correct documents to clinic, overcoming transportation barriers, and resolving staffing shortages, especially in rural communities.[205]

POLICY RECOMMENDATION:
WIC should provide annual funding to State WIC Agencies to enhance and improve technology platforms that streamline the clinic experience, especially state-based Management Information Systems (MIS).

Tools that streamline certifications vary in their scale and approach, from small process changes that improve clinic flow to more complex online participant portals where documents can be uploaded securely in advance of a certification appointment.[206] One of the core challenges of scaling up online certification tools is integrating the technology with existing WIC computer platforms, known as Management Information Systems (MIS).[207] WIC MIS are complex computer platforms that manage participant records, including demographic and anthropometric data, nutrition education touchpoints, food prescriptions, and remaining balance on an electronic benefit transfer (EBT), or e-WIC, card.

Many State WIC Agencies transitioned to new MIS platforms to enable the switch from paper vouchers to EBT/e-WIC cards.[208] Similar to online certification tools, EBT/e-WIC needed to integrate seamlessly with MIS software to enable participant-facing technologies that streamlined the WIC experience. Since online certification tools are more focused than the nationwide switch to EBT/e-WIC, State WIC Agencies lack the flexibility to overhaul their MIS systems to implement targeted clinic-oriented technology projects. Online certification tools must therefore integrate with existing MIS software, which may be older than systems used in the private sector. As states move beyond EBT/e-WIC implementation, both software and equipment may become outdated and require replacement, a costly endeavor that would deplete State WIC Agency Nutrition Services & Administration (NSA) funds.

Congress could revisit its strategy of the early 2010s to provide regular, dedicated set-aside funding for MIS projects that drive forward WIC innovation.

ONLINE CERTIFICATION TOOLS IMPLEMENTED BY WIC AGENCIES BEFORE AND DURING COVID-19[209]

- **Online Pre-Application Screener:** An applicant for WIC can enter basic information (name, address, initial income information, etc.) and expect a call from WIC staff to start the certification process.
- **Automated Chatbot:** WIC applicants, participants, or the general public can ask questions and get answers to common queries about the WIC program. Although only available in limited states, there is evidence that chatbots support a more streamlined participant experience.[210]
- **Two-way Texting:** WIC staff can send personalized or automated text messages to WIC participants and receive responses back. This technology can be used to remind participants about upcoming appointments, what to bring to appointments, and remaining benefits to use before the end of a month.
- **Document Uploader:** An applicant or participant in WIC can securely submit documents (e.g., income proofs) to WIC staff by uploading a file or taking a photo of the document from a personal device. This mitigates the need to bring documents to the WIC clinic for certification appointments.
- **Participant Portal:** An applicant or participant in WIC creates an account and can begin an online application for WIC, update information, complete nutrition education, and see the balance of their WIC food benefits.
- **Video Conferencing/Telehealth:** WIC participants and staff can interact face-to-face through two-way video conferencing platforms. Before COVID-19, it was widely used to provide breastfeeding support and nutrition education.

INCOME LIMITS AND ADJUNCTIVE ELIGIBILITY

WIC was piloted as a supplemental food program in 1972 and scaled up nationally in 1974, trusted with limited funding to reshape nutrition outcomes.[211] In 1978, Congress adopted an upper income limit to ensure that the limited appropriated funding was targeted at low-income individuals with the highest nutritional risk.[212] Even when implementing an income limit, Congress firmly instructed that "every effort should be made to ensure that the program reaches as many nutritionally and economically deprived individuals as possible."[213] WIC income thresholds were tied to the limits for free and reduced-price school meals, which are currently 185 percent above the federal poverty line[214] – currently estimated at $23,606 for a single parent or $48,470 for a family of four.[215]

In 1989, Congress instituted adjunctive eligibility to waive the income test for applicants who receive food stamps (now, the Supplemental Nutrition Assistance Program, or SNAP), who are part of a family that receives Aid to Families with Dependent Children (now, Temporary Assistance for Needy Families, or TANF), who receive Medicaid, or who are part of a family where a pregnant woman or infant receives Medicaid.[216] These provisions remain a critical method of streamlining certifications,[217] with 80.1 percent of participants reporting participation in either SNAP, TANF, or Medicaid.[218] More than three-quarters of WIC participants, 76.8 percent, are enrolled in Medicaid.[219] The lower recorded rates of SNAP and TANF participation suggest challenges in accurately measuring cross-enrollment between these programs.[220]

POLICY RECOMMENDATIONS:
To reduce burdens to ongoing child participation, adjunctive eligibility should be enhanced to include Head Start, the Children's Health Insurance Program (CHIP), and the Food Distribution Program on Indian Reservations (FDPIR).

Recognizing that the income test can be a significant barrier to participation, USDA provides an additional option to waive the income test for certain benefit programs that are at or below the prescribed income limits.[221] Some State WIC Agencies have succeeded in designating Head Start, the Children's Health Insurance Program (CHIP), or the Food Distribution Program on Indian Reservations (FDPIR) as adjunctively eligible programs, but the administrative burden of the process is significant and several states are unable to align income standards across programs.[222] As with the initial introduction of adjunctive eligibility in 1989, Congress could make the policy decision to align these programs to streamline certification and enhance collaboration between WIC and early childhood programs.

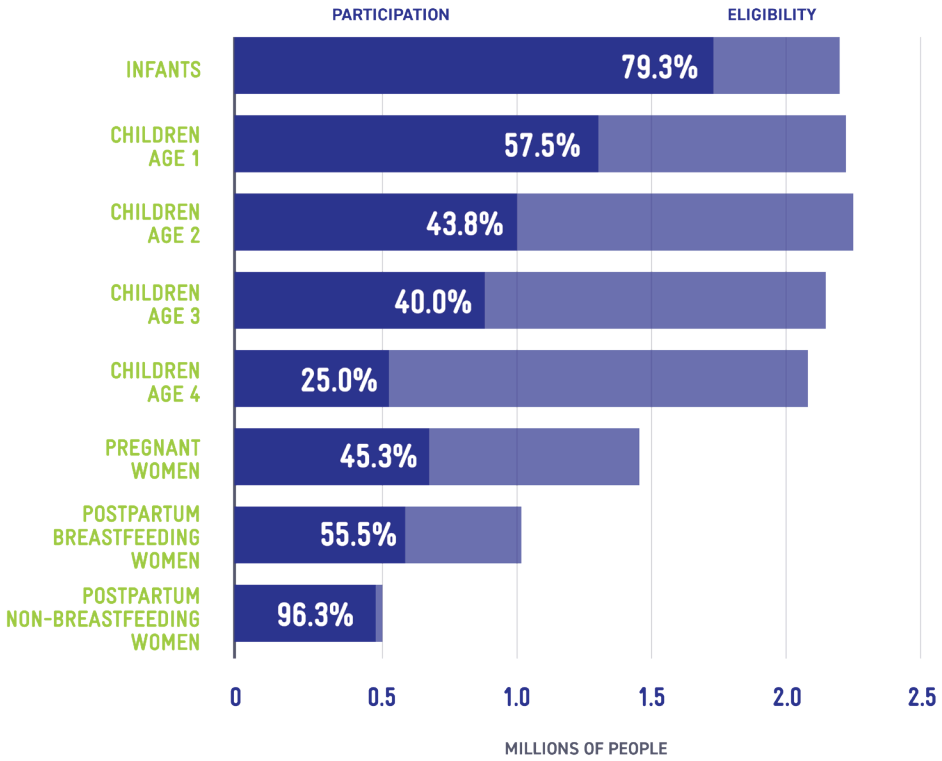
WIC PARTICIPATION AND FUNDING TRENDS

Consistent declines in participation since the program reached a record high of 9.2 million participations in 2010 pose one of the most significant challenges to WIC since its establishment in 1974.[223] WIC served approximately 6.4 million participants in fiscal year 2019, marking a decline of 2.8 million participants over nearly a decade.[224] This is the most pronounced decline in program history, with the only other recorded declines (totaling only 215,000 participants) occurring in 1998-2000, after implementation of physical presence and other burdensome certification requirements.[225]

In addition to participation declines, WIC is seeing the lowest coverage rate (51.1 percent in 2017) in over a decade.[226] WIC coverage rates are the percentage of estimated eligible individuals who are certified for and receiving WIC services. With the estimated eligible population relatively static, fluctuating between 13.8 million and 15 million over the past twelve years, the participation declines indicate that WIC is serving a smaller share of those who are eligible.[227]

In 2016, the National WIC Association (NWA) launched a National Recruitment and Retention Campaign, a multi-platform strategic marketing approach designed to raise awareness, drive enrollment, and improve public perceptions of WIC. The targeted, tested messages and branding used in the National Campaign are disseminated through digital advertisements, print advertisements in pregnancy and new-parent magazines, and point-of-care literature in OB/GYN offices, hospital maternity wards, and pediatrician offices. The National Campaign operates a web-based clinic locator, SignUpWIC.com, to connect families directly with their community WIC provider. NWA partners with 62 of the 89 State WIC Agencies to amplify the National Campaign and reach new eligible families.

NATIONAL WIC ELIGIBILITY, 2017[273]



BARRIERS TO WIC PARTICIPATION

Both initial access to WIC service and continued participation for the duration of eligibility are hindered by societal and structural factors. Although many barriers are consistent with challenges endured by other federal programs, WIC consistently has lower coverage rates than similar nutrition assistance programs like the Supplemental Nutrition Assistance Program (SNAP) (84 percent)[228] and means-tested health programs like Medicaid (93.7 percent for children in 2016).[229]

One of the most significant societal factors impacting WIC participation is anti-immigrant rhetoric and federal policy change surrounding immigrant access to public benefits. Since children born in the United States are citizens at birth,[230] the federal government has strong incentives to assure healthy births and positive child development. For these reasons, Congress consistently determined that WIC should continue to serve families regardless of citizenship and immigration status, even as severe restrictions were imposed on Medicaid and SNAP.[231]

In pursuing a deliberate strategy to reduce immigrant access to benefits, the Trump Administration ultimately came to the same conclusion and explicitly excluded WIC from review in public charge determinations.[232] The final result followed years of uncertainty,

"THE CHANGE TO THE PUBLIC CHARGE RULE WAS A GREAT CHALLENGE FOR OUR CLINICS. MANY OF THE FAMILIES WE SERVE COME TO WIC NOT JUST FOR SERVICES, BUT FOR THE HUMAN CONNECTION AND CRITICAL HEALTHCARE REFERRALS. ALTHOUGH WIC WAS NOT INCLUDED IN THE PUBLIC CHARGE RULE, WE SAW DEVASTATING EFFECTS ON OUR PARTICIPATION. FAMILIES BECAME FEARFUL OF SEEKING SERVICES."

ALIYA HAQ
INTERNATIONAL COMMUNITY HEALTH SERVICES
SEATTLE, WASHINGTON

where national outlets reported that WIC could be included in public charge.[233] The associated chilling effect discouraged participation by immigrants and mixed-status families, with the Hispanic coverage rate sharply falling by 6.3 percent in 2017.[234] In the face of unrelenting attacks on immigrants and the repeated threats to immigration policy, WIC has struggled to reassure immigrant and mixed-status families of the safety of WIC participation.

Social stigma also plays a significant role in accessing WIC services.[235] White, non-Hispanic families participate in WIC at rates that are nearly 20 percent lower than Black and Hispanic families.[236] This may reinforce societal misconceptions about WIC, with reported confusion about eligibility and ingrained concern about taking services from someone who is more in need, even though WIC is funded to serve all eligible families.[237] This concern is reinforced when federal spending bills are not passed in a timely manner, as at least three State WIC Agencies limited access to WIC during the 2013 government shutdown.[238] Historic use of waiting lists and priority risk systems continue to undermine messaging to eligible participants.[239] Structural factors and program requirements can also deter participation, especially the yearly certification appointments. In-person requirements for certification appointments implicate a range of barriers, including scheduling difficulties, access to transportation, and obtaining childcare or time off work.[240] The certification appointment at the first birthday is especially burdensome, as it aligns with transitions in infant feeding habits and the expiration of infant formula benefits. The first-year certification appointment is associated with a 21 percent reduction in the coverage rate, from 79 percent of eligible infants to 58 percent of eligible one-year-old children.[241] Child coverage rates continue to decline as the children age and additional certification appointments must be held, until only one-quarter of eligible four-year-olds are served.[242] Additional efforts to streamline certification and clinic ser vices, including introducing online tools and platforms, can mitigate other barriers at the clinic, including wait times at clinics.[243]

POLICY RECOMMENDATION:
The public charge rule should be reversed to address the chilling effect on immigrant participation in federal programs like WIC.

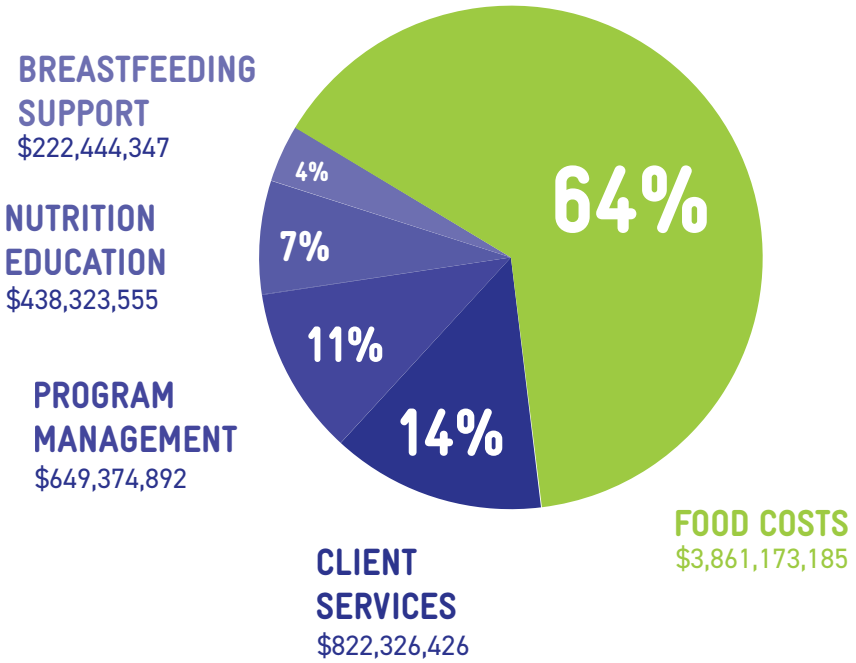
Stigma and program requirements intersect in presenting challenges in the shopping experience. Due to the prescriptive nature of the food package, participants must often navigate the store on their own to select approved items that will not complicate the final transaction.[244] Cashier attitudes, turnover, and unfamiliarity with WIC can be significant barriers to assuring a smooth shopping experience.[245] Recent technology innovations, including the transition to electronic-benefit transfer (EBT), or e-WIC, cards, as well as shopping apps that can help identify approved items at the shelf, are helpful tools to mitigate difficulties for WIC shoppers.[246]

INCREASED PRESSURE ON WIC FUNDING

WIC is a discretionary program funded through the annual appropriations process in Congress. Participation declines throughout the 2010s spotlighted structural flaws in the funding formula that apportions federal funds to State WIC Agencies. State WIC Agencies receive two grants each year: the Food grant and the Nutrition Services & Administration (NSA) grant.[247] The Food grant is limited to the issuance of benefits to participants for the purchase of supplemental foods.[248] The only exception, instituted in 1998, permits Food funds to cover the purchase of breast pumps.[249]

The NSA grant covers all WIC costs that are not associated with direct food benefits, including a wide range of expenses such as nutrition education, breastfeeding support, technology procurement and administration, outreach and partnerships, clinic rent and management costs, and salaries for the entire WIC workforce.[250] Program administration costs are kept fairly low, constituting only 11 percent of the overall WIC budget,[251] even as core management costs, such as retaining credentialed professional staff like Registered Dietitians (RDs) and International Board Certified Lactation Consultants (IBCLCs), continue to rise.

WIC FUNDING ALLOCATIONS IN FY 2018[274]



POLICY RECOMMENDATION:
Thoughtful flexibility to increase WIC's Nutrition Services & Administration (NSA) grant will enhance WIC funding for nutrition education and breastfeeding support. Without enhanced investment in NSA, WIC's track record of success will be jeopardized.

Despite its essential role in providing for WIC's core mission, the NSA grant comprises only 36.2 percent of WIC spending,[252] leaving limited funding to invest in strengthening WIC's nutrition education and breastfeeding programming. Only 11.2 percent of WIC spending goes to these critical services (7.4 percent for nutrition education and 3.8 percent for breastfeeding support),[253] leaving WIC providers in a position of stretching every dollar to the fullest extent.

Concurrent with participation declines, State WIC Agencies assumed new costs in transitioning from paper vouchers to electronic-benefit transfer (EBT), or e-WIC, transaction systems. WIC providers estimate that the cost of running an EBT/e-WIC system, including transaction fees and targeted subsidies to retailers for transaction devices, can run at about twice the costs associated with a paper voucher model.[254] Although Congress appropriated funding to support the transition to EBT/e-WIC systems, no new flexibilities in the funding formula accounted for the long-term costs of maintaining the new systems. While EBT/e-WIC is undoubtedly a step forward for the program in modernizing the shopping transaction and providing convenience for participants, the additional costs have fallen on the NSA budget and exhausted limited resources even further.

PARTNERSHIPS WITH HEALTHCARE

As the Patient Protection and Affordable Care Act realigned the healthcare system toward prevention, WIC's targeted intervention at the earliest stages positions the program as a critical support for positive lifelong health outcomes. Increased collaboration between WIC and physicians reinforces messages

"I AM FROM A SMALLER RURAL NORTH DAKOTA AGENCY AND WE'VE SEEN A SIGNIFICANT REDUCTION IN OUR BUDGET THE PAST COUPLE OF YEARS. EVEN AS OUR PARTICIPANT NUMBERS DECLINE, OUR COSTS CONTINUE TO INCREASE TO PAY FOR QUALIFIED STAFF TIME AND TRAVEL TO PROVIDE ACCESSIBLE WIC SERVICES TO OUR SEVEN-COUNTY SERVICE AREA. 'OLD' COSTS, LIKE THOSE ASSOCIATED WITH MANAGING INCREASINGLY MORE COMPLEX MIS SYSTEMS, AND 'NEW' COSTS LIKE SHOPPER APPS, ONLINE NUTRITION EDUCATION SERVICES AND EBT HAVE ADDED MORE COMPETITION FOR THE LIMITED NSA DOLLARS COMING TO THE STATE."

SHERI HATTEN, RD, LRD, CLC
LAKE REGION WIC DIRECTOR
DEVILS LAKE, NORTH DAKOTA

"WIC IS A CRITICALLY IMPORTANT PROGRAM PROVIDING NUTRITIONAL SUPPORT IN THE FIRST YEARS OF LIFE AS WELL AS LINKAGES WITH HEALTHCARE PROVIDERS. PEDIATRICIANS AND WIC WORK CLOSELY TOGETHER TO ENSURE THE NUTRITIONAL NEEDS OF CHILDREN AND THEIR FAMILIES ARE MET, ESPECIALLY NOW AS FAMILIES FACE CHALLENGES DUE TO THE COVID-19 PANDEMIC. THIS COLLABORATION COULD BE STRENGTHENED THROUGH BETTER DATA SHARING OF HEALTH-RELATED INFORMATION. BOTH PRIMARY CARE AND WIC CAN BE MORE EFFECTIVE AT PROVIDING EDUCATION AND SERVICES IF THEY ARE ABLE TO EASILY SHARE INFORMATION LIKE THE PATIENT'S WEIGHT, LENGTH OR OTHER MEASUREMENTS, INCLUDING THE BLOOD COUNTS ROUTINELY MEASURED DURING IN-PERSON WIC VISITS."

STEVEN ABRAMS, MD, FAAP
CHAIR, AAP COMMITTEE ON NUTRITION
AUSTIN, TEXAS

about preventive health, guiding families toward healthier choices that will avert or manage chronic conditions and reduce overall healthcare expenditures. With the renewed emphasis on prevention, WIC's professional workforce can be better integrated into the healthcare system and utilized in innovative ways to more efficiently provide preventive care.

STRENGTHENING REFERRALS

One of the core services provided by WIC is to conduct health screenings and make referrals to healthcare and other social services. WIC clinics routinely screen for food insecurity, healthcare coverage, immunizations, access to dental care, tobacco cessation, opioid and substance use, postpartum depression, and other health issues, resulting in appropriate referrals to Medicaid, SNAP, Head Start, pediatricians, dentists, mental health providers, and other programs and services. WIC is a vital point-of-contact for many services, as WIC staff's consistent contact with WIC families provides a critical opportunity to raise awareness about available programs and services.

WIC makes referrals in a variety of ways, including by providing information directly to participants, asking participants to directly follow-up with the service, hiring patient navigators or family support coordinators to assist WIC families in connecting with services, or integrating data systems with other programs to generate automated referrals.
With WIC participation declining, similarly strong referral policies from other programs could have a pronounced effect on breaking through societal misconceptions about the availability of WIC services and reinforce the continued value of WIC services as children grow older. Trusted medical professionals – including physicians, OB/GYNs, pediatricians, and nurses – can have a significant impact on influencing patient decisions to follow up on a referral to specific services.[255]

In 2015, the National WIC Association utilized funding from the Centers for Disease Control and Prevention (CDC) to strengthen referral networks at WIC clinics in Illinois, Michigan, New Jersey, Texas, and Virginia. WIC providers created green prescription pads to screen for food insecurity, breastfeeding support, or medical risk. The pads were distributed to community partners, including healthcare providers, Head Start, grocery stores, and military bases. The low-cost, effective tool was utilized to refer families to their local WIC provider.[256]

Community partnerships will look different for each WIC provider, and strong referral networks depend on consistent collaboration between WIC and healthcare providers. In some states, the State WIC Agency will establish or facilitate an advisory council to provide a regular forum for coordination and partnership with the medical community, including maternal health, pediatric health providers, and HMO providers.[257] This can lead to innovative partnership, such as Medicaid covering the costs of transportation for WIC participants to get to the WIC clinic.[258]

State governments can also partner on a broad range of projects that promote cross-enrollment between programs like WIC, SNAP, and Medicaid. State-driven projects to develop universal applications or screening tools are effective at reducing paperwork burdens for applicants, although states must account for the challenge of WIC's in-person requirements.[259] Even more limited partnerships, such as New Hampshire's efforts to design a WIC dashboard within the SNAP online application tool,[260] can connect families with WIC services or provide WIC with relevant information to conduct follow-up outreach to eligible families.

POLICY RECOMMENDATION:
WIC should be provided dedicated funding to enhance collaboration with physicians, Medicaid, SNAP, IHS, and other maternal and early childhood partners to strengthen WIC participation.

Some State WIC Agencies have explored more ambitious data-sharing projects to identify eligible families through Medicaid or SNAP administrative data.[261] More than three-quarters of WIC participants, 76.8 percent, are enrolled in Medicaid,[262] suggesting that eligible individuals who are not certified may also be accessing Medicaid. Federal data indicates that only 33.3 percent of WIC participants access SNAP,[263] which suggest challenges in accurately measuring cross-enrollment between WIC and SNAP and offers opportunities for greater collaboration with SNAP administrators.[264] To address inequities in serving Indigenous communities, future collaborations should also be inclusive of the Indian Health Service (IHS) and other tribal services.

One of the key challenges to enhanced data sharing is the need for robust memorandums of understanding (MOUs) between relevant agencies that govern data management. In several states, SNAP, Medicaid, and WIC are positioned in three different state departments. Complex agreements that may implicate data privacy laws like the Health Insurance Portability and Accountability Act (HIPAA) take time to negotiate before any data sharing can commence.[265] Many states – including small, rural states – lack resources to manage complex data-sharing projects or capacity to analyze the data in a meaningful manner.

GO-TO WIC: COMMUNITY-CLINICAL LINKAGES

WIC clinics are operated by nearly 1,800 local agencies and can be located in a variety of venues, including hospitals, federally qualified health centers (FQHCs), county health departments, and standalone clinics.[266] No matter the venue, WIC providers have routinely partnered with medical and public health stakeholders in the community to raise awareness about WIC and address community health concerns, including providing services to low-income and vulnerable populations.[267]

As a result of the Patient Protection and Affordable Care Act's emphasis on prevention, WIC providers, especially those co-located at hospitals or FQHCs, have strengthened community-clinical linkages to partner more effectively with the healthcare system and public health agencies. Community-clinical linkages are more formal partnerships that support community access to resources that help prevent, manage, or reduce risks of chronic disease.[268] Integrated care is essential during pregnancy, as families often receive support from a range of healthcare providers and community groups, especially if there are underlying chronic conditions such as type-2 diabetes.

POLICY RECOMMENDATION:
USDA and the Department of Health and Human Services (HHS) should explore opportunities that leverage the WIC workforce to provide clinical nutrition and breastfeeding services that can be billed to Medicaid and private health plans, efficiently streamlining the provision of clinical healthcare services while facilitating collaboration and cost-sharing between WIC and health centers.

WIC providers in Washington State and California have implemented effective models to leverage the WIC workforce in providing preventive services. At a FQHC in Washington State, WIC splits the time for Registered Dietitians with other clinical nutrition and chronic disease management services that bill Medicaid, including diabetes prevention programs and medical nutrition therapy.[269] An agency in California formed a coalition with hospitals and physician groups to coordinate breastfeeding support across Los Angeles, ensuring consistent, quality support through numerous entry points.[270]

Under the Patient Protection and Affordable Care Act, health plans were required to cover chronic disease management and preventive services.[271] The WIC workforce is rich in nutrition and breastfeeding expertise and in some states, is the largest employer of breastfeeding and nutrition support staff.[272] As the healthcare system adjusts toward prevention, the WIC workforce is well positioned to provide additional services that can be billed to Medicaid or private insurance plans to improve overall health outcomes.

CHAPTER FOUR: HEALTHY AND MODERN OPTIONS FOR WIC SHOPPERS

In nearly every state, WIC families have increased access to healthy foods through a traditional retail grocery shopping experience. With $4.8 billion in WIC food benefits flowing to over 48,000 authorized vendors each year,[278] WIC shoppers are an essential customer base for many stores and have a demonstrated impact on shaping retail grocer behaviors, including on product stock, pricing, and healthy food access.[279] Increased attention has been paid to reducing challenges in the shopping experience, especially through streamlined and more modern transaction options.[280] Substantial efforts driven by the Healthy, Hunger-Free Kids Act of 2010 phased out paper vouchers in nearly all states,[281] and retailers are already partnering with WIC providers to strengthen both technology systems and in-person supports that address structural barriers to program access.

FAST FACTS

48,000 RETAIL VENDORS PROVIDE WIC FOODS[275]

NEARLY ALL STATES PROVIDE E-WIC TRANSACTIONS[276]

$1.7 BILLION

FEDERAL SAVINGS FROM INFANT FORMULA COST CONTAINMENT[277]

NEW OPTIONS AT CHECKOUT

Over the past decade, WIC streamlined transactions at retail grocery stores with the introduction of electronic-benefit transfer (EBT) technology, also known as e-WIC. Even with this progress, significant barriers remain to a quality shopping experience equivalent to non-WIC consumers, as participants continue to report stigma, inadequate cashier training, and difficulty finding approved foods.[282] These challenges were exacerbated during the COVID-19 pandemic, with WIC shoppers unable to access modern shopping options like online purchasing and home delivery.[283] Enhanced partnerships between WIC providers and retailers are critical to implementing additional innovations that will provide a quality shopping experience for all WIC families.

THE WIC TRANSACTION AND ELECTRONIC BENEFIT TRANSFER/ E-WIC

For decades, WIC participants redeemed benefits with paper vouchers that

prescribed certain quantities of approved foods. Since WIC purchases are tied to quantities of redeemed products instead of the store's actual sale point, the transaction is more complicated to account for the appropriate reimbursement levels to credit to the retailer.[284] WIC transactions must confirm that the product being purchased is within the WIC food package, prescribed specifically to the participant, and not yet redeemed in that month.[285] For this reason, paper vouchers required participants to redeem all listed items or otherwise forfeit prescribed foods.[286]

EBT/e-WIC is a major improvement that resolves several of the challenges of redeeming paper vouchers for participants and retailers. The paper voucher model was often stigmatizing, requiring participants to divide their WIC and non-WIC purchases at checkout.[287] Cashier turnover and inadequate cashier training could delay timely processing of WIC transactions, leading to shaming of WIC customers by cashiers or other store patrons.[288] EBT/e-WIC transactions are simpler and more discreet, reducing stigma by electronically processing the WIC transaction.[289] When a cashier scans a product's barcode, the point-of-sale system matches an item's Price Look-Up Code (PLU) or Universal Product Code (UPC) to the WIC State Agency's Approved Product List (APL) and Management Information System (MIS), verifying that a specific item is approved for redemption by the cardholder.[290]

The transition to EBT/e-WIC ensures greater program integrity by streamlining vendor monitoring and providing significant electronic data.[291] Since WIC transactions still reimburse based on quantity as opposed to a store's sales point,[292] EBT/e-WIC simplifies the vendor reimbursement process, reducing burden on retailers to document and request reimbursement by creating a technology interface that resolves transactions and promptly reimburses WIC retailers.[293]

EBT/e-WIC systems are often integrated with other point-of-sale software within a single device, allowing for split-tender transactions with SNAP EBT and credit/debit cards.[294] In some cases, smaller local vendors and retailers necessary to ensure participant access in food deserts, rural areas, and underserved communities may have a stand-beside device that exclusively processes WIC EBT/e-WIC transactions. Retailers do not have to assume the cost of stand-beside devices, deferring instead to State WIC Agencies to assume new costs if retailers are unable to implement an integrated system.[295]

EBT/e-WIC is a more efficient transaction system than paper vouchers, but the complicated technology has required State WIC Agencies to assume new technology costs. State contracts with technology vendors generally stipulate monthly transaction processing fees that are calculated based on participation, with some states paying millions of dollars in fees each year. State WIC Agencies estimate that the cost of operating an EBT/e-WIC system is approximately double the administrative costs of running a paper voucher system, diminishing funds under WIC's Nutrition Services & Administration (NSA) grant for other public health services.[296]

Wyoming became the first state to adopt EBT/e-WIC in 2002, with seven other state agencies adopting the technology by 2009: Michigan, Nevada, New Mexico, Texas, Cherokee Nation, the Inter-Tribal Council of Nevada, and Pueblo of Isleta.[297] Inspired by NWA and stakeholder advocacy, drawing from the proactive efforts of these agencies, and recognizing the inequities posed by a nationwide mandate for SNAP EBT that went into effect in 2002,[298] the Healthy, Hunger-Free Kids Act of 2010 required that all WIC agencies implement WIC EBT/e-WIC by October 1, 2020.

The process of implementing EBT/e-WIC was not straightforward. Many state agency computer systems could not interface with the new EBT technology, requiring an overhaul of state Management Information Systems (MIS) that store participant records and manage clinic processes. As a result, a few State WIC Agencies received an exemption to continue to use paper vouchers beyond October 2020 until their MIS and/or EBT/e-WIC projects are completed in the near future.[299]

THE NEED FOR ONLINE PURCHASING

Online purchasing, paired with home delivery, is a convenient and flexible model well suited for the busy lives of WIC participants – who share many of the same time challenges as non-WIC families. Online purchasing – available to non-WIC households, including those participating in SNAP – could reduce burdens on the shopping experience related to childcare responsibilities, accessibility for pregnant participants on bed rest, and the convenience of being able to reconcile shopping needs with home food inventory.[300] Although online purchasing would be a significant step forward for the program, home delivery is not unprecedented in WIC and is an acceptable food delivery method under current program rules.[301] Between the program's inception in 1974 and EBT/e-WIC implementation in 2016, Vermont operated a home delivery model where WIC trucks would deliver foods directly to participants' homes.[302]

USDA WILL CONVENE A TASK FORCE AND ISSUE RECOMMENDATIONS ON HOW TO IMPLEMENT ONLINE PURCHASING BY SEPTEMBER 30, 2021.

One of USDA's earliest efforts to address the COVID-19 pandemic was to rapidly expand the online purchase pilot for the Supplemental Nutrition Assistance Program (SNAP), allowing over 90 percent of SNAP households to access remote purchasing options through Walmart, Amazon, and other retailers.[303] This decision was a public health imperative to reduce exposure

to COVID-19, but was also revolutionary in resolving food-access inequities and promoting options for SNAP shoppers. USDA was only able to scale up this pilot program to a national level given years of prior planning, after Congress required development of this technology in the 2014 farm bill.[304]

USDA has not sought similarly bold solutions to simplify the WIC shopping experience during COVID-19, despite the Centers for Disease Control and Prevention (CDC) identifying heightened health risks during pregnancy. In the initial months, USDA resisted issuing emergency waivers of program rules that prohibit online purchases and require participants to redeem benefits in the presence of a cashier.[305] In the absence of USDA action, the National WIC Association convened a workgroup of WIC providers, retailers, and technology vendors to identify steps necessary to implement online purchasing technology in WIC, including intelligent online ordering to account for appropriate food substitutions within the scope of allowable WIC foods.[306]

POLICY RECOMMENDATION:
In addition to implementing online purchasing by 2024, additional funding should be provided to empower State WIC Agencies to quickly implement other modern transaction models, like mobile payments, curbside pickup, and self-checkout.

In July 2020, after months of pressure, USDA announced a multi-year pilot project of alternative transaction models in five states that would extend through 2023.[307] Especially since there are only four EBT/e-WIC processing companies serving State WIC Agencies, parallel USDA-led action is needed to coordinate the appropriate stakeholders to swiftly implement national-scale solutions. In December 2020, Congress authorized a short-term task force on alternative transaction models to issue actions and recommendations by no later than September 30, 2021.

ALTERNATIVE CHECKOUT MODELS

Even before the COVID-19 pandemic, retailers were already exploring integrating WIC into existing models that simplify the shopping experience and modernize the WIC transaction in accordance with general business practices. With pressing public health concerns during the COVID-19 pandemic and no imminent solution on online purchasing, WIC providers and retailers collaborated in 2020 to advance alternative transaction models that reduced in-store time. Unlike online purchasing, these innovations did not require regulatory flexibility to enact.

In 2020, WIC retailers took steps to increase self-checkout lanes and enhance online ordering platforms paired with in-store or curbside pickup.[308] These measures build on the success of EBT/e-WIC to reduce typical barriers to successful WIC shopping experiences and mitigate stigmatizing delays at checkout.[309] In-store or curbside pickup is an area of particular interest, as it sets the foundation for online purchasing models and is more readily operationalized by smaller grocers who may not wish to invest in online purchasing platforms.[310] Although curbside pickup is especially effective at reducing in-store time and minimizing exposure to COVID-19, curbside models require additional costs to grocers, who must procure handheld point-of-sale devices to conduct the transaction while shoppers remain in their car.[311]

With many retailers imposing special shopping hours for vulnerable groups like pregnant people,[312] State WIC Agencies have also highlighted proxy shopping as an effective strategy for safe shopping. Participants or caretakers of participating children are permitted to designate another individual to conduct shopping on their behalf, which can reduce barriers such as transportation, childcare, or when pregnant participants are on bed rest.[313] Although proxies were often encouraged at the individual level, some states – such as Nevada – partnered with community health stakeholders like Catholic Charities and food banks to leverage proxy shopping to enable home delivery models during COVID-19.[314]

"THE COVID-19 PANDEMIC HAS ACCELERATED THE NEED TO CREATE AN EQUITABLE WIC SHOPPING EXPERIENCE. THAT IS WHY NEW MEXICO WIC IS PARTNERING WITH FTS SOLUTIONS TO OFFER A STATEWIDE SHOPPING SOLUTION THAT WILL ENABLE WIC FAMILIES TO PLACE ORDERS ONLINE AND PICK UP THEIR PRODUCTS AT A PARTICIPATING RETAIL STORE. FLEXIBILITY AND PEACE OF MIND SHOULD BE AVAILABLE FOR ALL, INCLUDING WIC SHOPPERS."

SARAH FLORES-SIEVERS, BS, MPA
WIC AND FARMERS MARKET DIRECTOR
NEW MEXICO DEPARTMENT OF HEALTH

FINDING WIC FOODS IN THE STORE

Although checkout can be the most stigmatizing part of the WIC shopping experience,[315] the prescriptive nature of the WIC food package can cause challenges in identifying WIC-approved products in the store.[316] Unsuccessful shopping trips can limit the effect of WIC participation, driving families to underutilize the benefit or even exit the program.[317] Both in-person and technology strategies can streamline the WIC shopping experience, guiding families toward approved foods without isolating WIC participants from the general shopping public.

STORE PLACEMENT

Each State WIC Agency establishes an Approved Product List (APL) that identifies specific brands and package sizes of WIC-approved foods.[318] State APLs specify particular product barcodes, known as Universal Product Codes (UPCs) or Price Look-Up Codes (PLUs), that are programmed into the EBT/e-WIC system and enabled for redemption by WIC shoppers.[319] State WIC Agencies update the APL regularly, sometimes daily, to account for reformulation of products and inclusion of new items.[320] State WIC Agencies consistently communicate with retailers and food manufacturers to assure all stakeholders have up-to-date PLUs and UPCs, a necessary step to ensure that WIC items are appropriately stocked and labeled in the store.

Retail stores may apply shelf tags, labels, or stickers to identify specific products as WIC-approved.[321] State policy varies significantly, with some states requiring specific labels and others requiring that all items are labeled on the shelf.[322] Within states, there may also be variation as retailers adopt corporate-branded shelf tags. While shelf tags can help focus shoppers on approved items on the shelf,[323] they can also result in confusion when shelf tags are relocated by customers or when shelves are restocked differently without accounting for the tag.

In some cases, retail stores have adopted WIC aisles or corners that combine approved items across food categories. While some stores explicitly mention WIC, others have used broader framing such as "healthy corner" to decrease perceived stigma for WIC shoppers. Recent research suggests that the convenience of finding approved items may quickly outweigh the stigma associated with shopping in a WIC-designated space of a retail grocery store.[324]

SHOPPER EDUCATION

The complexity of navigating the shopping experience, and the importance of reducing barriers at checkout, requires partnership between retailers and local WIC providers to support current and new participants. State WIC Agencies generally develop a shopping guide that is provided to participants during their certification visit, highlighting the specific products by food category that can be purchased at approved WIC vendors.[325] Preparing participants for the shopping experience during certification is limited by the other elements of the appointment, including health screenings, nutrition education, and the paperwork requirements to screen for identity and income.

Recognizing the need for additional support, State WIC Agencies were increasingly exploring in-person shopping support at retail grocery locations before the COVID-19 pandemic.[326] WIC staff – sometimes in partnership with former participants – will conduct walkthroughs of retail locations with a new participant to explain the placement of approved WIC foods and troubleshoot any issues

"SOUTH DAKOTA'S VENDOR LIAISONS ARE WIC STAFF WHO ARE POINTS-OF-CONTACT FOR WIC VENDORS IN THEIR COMMUNITY AND ARE AVAILABLE TO HELP OUR WIC FAMILIES AND VENDORS WITH RESOLVING SHOPPING ISSUES. OUR VENDOR LIAISONS ALSO ASSIST WITH GETTING NEW FOODS ADDED TO OUR APPROVED PRODUCT LIST AND MAKE SUCH A POSITIVE IMPACT IN OUR LOCAL COMMUNITIES!"

WENDY SPEAECT AND MELISSA MAYER,
SOUTH DAKOTA WIC

with a WIC transaction. The increased WIC presence at store locations is also beneficial for the retailer, enhancing limited cashier training and providing a contact at the local WIC site separate from program monitors.

POLICY RECOMMENDATION:
WIC should fund state-driven vendor liaison programs to provide in-person shopping support for new participants.

The high level of technology literacy among new parents has led many State WIC Agencies to explore shopping apps. There are at least a dozen apps, including a few specifically contracted with or developed by State WIC Agencies, to provide in-person support for WIC shoppers by listing approved WIC retail locations, providing real-time updates on the participant's EBT/e-WIC balance, and using the mobile phone to scan barcodes to identify whether a product is WIC-approved.[327] WIC shopping apps can be paired with clinic-driven innovations, such as remote nutrition education or appointment reminders.[328] Although WIC shopping apps can make the shopping experience easier and are associated with higher redemptions,[329] economic and structural factors such as limited access to mobile data, phone memory, and phone sharing among household members may reduce participant utilization during shopping.

ENSURING PROGRAM EFFICIENCY AND INTEGRITY

WIC's strong return on investment is driven by a commitment to efficient, targeted services. Over the past several decades, WIC has taken innovative steps to reduce overall costs and hold retailers and food manufacturers accountable for administrative requirements. Through strong partnerships with the retail community, WIC saves taxpayers billions of dollars without reducing services by ensuring effective delivery of food benefits.

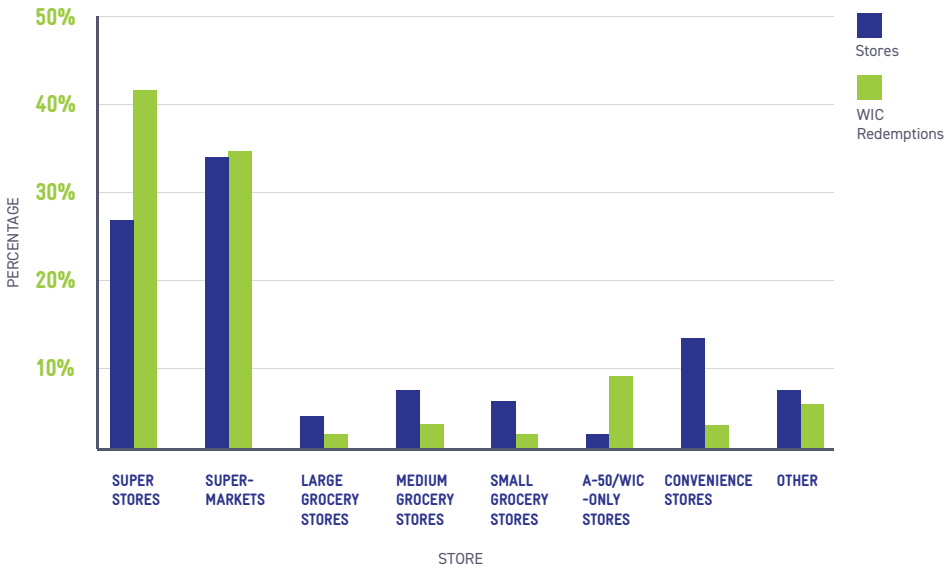
HOLDING VENDORS ACCOUNTABLE

WIC partners with approximately 48,000 unique vendors to ensure that WIC participants can shop in traditional retail settings.[330] Although 98 percent of WIC vendors are also authorized to conduct SNAP transactions, there are significant differences in vendor authorization and management between the two federal nutrition programs.

WIC vendors are more likely to be large retailers and national chains, with larger stores constituting 63 percent of all WIC vendors and conducting 77 percent of all WIC sales.[331] National chains can more readily meet the administrative requirements to become approved WIC vendors, although one-quarter of WIC vendors are smaller retailers.[332] This is a different dynamic from SNAP, which authorizes a greater percentage of smaller vendors and convenience stores.[333]

WIC requires retailers to maintain a minimum stock of WIC-approved products.[334] Although the federal regulations only require stores to carry fruits, vegetables, and whole-grain cereals, many State WIC Agencies will require vendors to carry additional items – including infant-specific items like formula and baby foods.[335] The 2009 food package changes positively shaped

PERCENTAGE OF STORES VS WIC REDEMPTIONS[350]



retailer stocking practices,[336] increasing access to healthy foods and improving social determinants of health in low-income neighborhoods and food swamps – areas with a high-density of restaurants or stores selling high-calorie fast foods or junk food, which is associated with higher rates of obesity.[337]

Over the past few decades, USDA program integrity efforts have found little evidence of fraud in WIC transactions. A comprehensive study in 2013 identified only a small number of retailers with improper payments, with only 0.30 percent of WIC funds involved in an overcharge of WIC foods.[338] In addition to WIC compliance activities, State WIC Agencies may disqualify vendors that have been assessed penalties for SNAP violations, even if the adverse action only resulted in a civil money penalty.[339] State WIC Agencies manage vendor authorization and monitoring activities, ranging from in-person store visits to compliance buys. WIC vendor authorization contracts are generally termed at three years, as opposed to five-year contracts for SNAP vendors.[340]

POLICY RECOMMENDATION:
WIC vendor contracts should be extended to five years to promote alignment with SNAP, as well as other reforms to streamline vendor authorization between the two programs.

In response to instances of vendor fraud uncovered in the 1990s, the National WIC Association supported legislative action to strengthen regulation of vendors that predominately catered to WIC participants, including banning incentives for WIC shoppers in these WIC-only/Above-50-percent (A-50) stores. The Child Nutrition and WIC Reauthorization Act of 2004 created a balanced approach that appropriately regulated A-50 stores.[341] In recent years, promising new models of A-50 stores that establish partnerships with WIC providers while balancing program integrity concerns have emerged in California, Oklahoma, Texas, and a select few other states.[342]

CONTAINING COSTS

Since the WIC food package operates as a prescription, WIC shoppers are not limited by specific product costs when redeeming their benefits at a retail grocery location. However, WIC's status as a discretionary program funded by annual appropriations requires that State WIC Agencies adopt measures to contain overall food costs. Federal legislative action and state-based policies have successfully reined in costs, leading to significant savings that have, in recent years, returned funds to the Treasury.

Federal law requires State WIC Agencies to contain costs by establishing vendor peer groups, which set different reimbursement rates based on a range of factors, including size of the retailer, geography, and total number of registers to conduct transactions.[343] State WIC Agencies may set a ceiling for the cost of items based on each vendor's peer group, known as the maximum allowable redemption levels (MARLs), to ensure that vendors are not charging significantly higher prices than other vendors of a similar size.[344] Vendor peer groups are key to ensuring that small vendors can remain on the program, as their products are generally more expensive than national chains, but they are often more accessible to WIC participants.[345]

In addition to the peer-group structure, State WIC Agencies have implemented a range of policies to contain costs. These include efforts to limit the options for WIC shoppers by limiting allowable package sizes, allowing only least-cost or store-brand products, or reducing the number of brands or flavors available for purchase.[346] Although these policies may be helpful in curbing overall food costs, they can have an adverse effect on the program by complicating the in-store shopping experience, confusing participants, and undermining the perceived quality of the WIC food package by removing trusted or desired brands from the reach of WIC shoppers.[347]

The most notable cost-containment measure was WIC's adoption of sole-source contracting with infant formula manufacturers, implemented in the Child Nutrition and WIC Reauthorization Act of 1989. As the infant formula market is highly concentrated, the small number of manufacturers will bid aggressively for the WIC contracts, which have a spillover effect in prominent store placement and sales to non-WIC consumers.[348] After over three decades of cost containment, State WIC Agencies are reporting significant rebates in excess of 90 percent of the wholesale price – generating over $1.7 billion in program savings in fiscal year 2019.[349]

SINCE 1989, STATE WIC AGENCIES HAVE FORMED ALLIANCES TO JOINTLY BID ON INFANT FORMULA CONTRACTS AND FURTHER REDUCE PROGRAM COSTS.

Infant formula cost containment is extraordinarily cost efficient, not only reducing overall costs, but generating enough savings to serve approximately one-quarter of WIC's total caseload. The entire process relies on voluntary bidding by infant formula manufacturers, and increased reliance on the system to sustain WIC funding may have significant implications should rebate trends reverse or State WIC Agencies be unable to promptly secure a competitively bid contract. Additionally, Congress rescinded unspent funds in recent years that largely originate as infant formula rebates. State WIC Agencies are restricted by the statutory funding formula from reallocating that funding for Nutrition Services & Administration purposes, and Congress has rarely elected to reinvest that funding into other WIC priorities. These dynamics, taken together, raise serious concerns about the sustainability of the infant formula cost containment process and the continued disinvestment of Nutrition Services & Administration priorities.

CHAPTER FIVE:
ENHANCING EQUITY IN WIC

WIC is designed and administered to remedy health equity disparities in pregnancy, birth, and early childhood. Motivated by infant and child malnutrition in both rural and urban areas with extreme poverty, the rapid escalation of WIC services across the country demonstrated the widespread need for targeted nutrition support and increased education for expectant parents and their children. Over 45 years later, WIC continues to tackle contemporary barriers to healthy child development, including systemic racial disparities and social determinants of health.

FAST FACTS

3X

BLACK WOMEN ARE THREE TIMES AS LIKELY TO DIE OF PREGNANCY-RELATED COMPLICATIONS AS WHITE WOMEN[351]

THE 2009 FOOD PACKAGE CHANGES INCREASE ACCESS TO HEALTHY FOODS IN LOW-INCOME NEIGHBORHOODS[352]

33

INDIAN TRIBAL ORGANIZATIONS ADMINISTER WIC DIRECTLY TO INDIGENOUS POPULATIONS[353]

NATIONAL WIC ASSOCIATION HEALTH EQUITY STATEMENT

Health equity is the ability of all individuals and families to achieve optimal health, irrespective of their identity, race, ability or class. This requires equitable access to nutritious foods, breastfeeding support, chronic disease prevention and management services, safe living environments, and good jobs with fair pay. It necessitates removing obstacles to families' short- and long-term health and wellbeing including poverty, discrimination, and institutional racism and other forms of bias expressed through housing, healthcare, education, labor, and other public policies.

WIC'S EQUITY ROOTS

WIC was established in 1974 in the midst of a decade of social reform, driven by the civil rights movement and Poor People's Campaign, to end poverty and create opportunity for all Americans.[354] In 1967, then-NAACP Legal Defense Fund attorney Marian Wright (later Edelman) accompanied Senators Robert Kennedy (D-NY), Joseph Clark (D-PA), and George Murphy (R-CA) on a tour to three Mississippi Delta counties to understand the nature of poor birth outcomes, child malnutrition, and the "shocking, widespread, and unconscionable" poverty that existed in the United States.[355]

That trip led to the creation of a Select Committee on Nutrition and Human Needs and the 1969 White House Conference on Food, Nutrition, and Hunger. Wright Edelman's forceful focus on the needs of infants and children led the White House

"DURING MY TIME AS CHAIR OF NWA'S MATERNAL MORTALITY IN WIC TASK FORCE, I WORKED WITH COLLEAGUES ACROSS THE NATION TO DEVELOP RECOMMENDATIONS FOR IMMEDIATE IMPLEMENTATION BY WIC AGENCIES. IT WILL TAKE A CONCERTED EFFORT TO MOVE THE NEEDLE AND IMPROVE MATERNAL HEALTH OUTCOMES. TO QUOTE A SENTENCE FROM THE TASK FORCE REPORT, 'WIC IS A VITAL MECHANISM TO HELP REDUCE MATERNAL MORTALITY [BUT] IT WILL INVOLVE A COLLABORATIVE EFFORT FROM INDIVIDUALS, ORGANIZATIONS, AND LEGISLATORS NATIONWIDE.' WE ARE READY AND WILLING. WILL YOU JOIN US?"

TONCÉ JACKSON, ED.D., MPH, RDN, CLE
SENIOR HEALTH EQUITY MANAGER, PHFE WIC
LOS ANGELES, CA

Conference to issue a recommendation that "special attention be given to the nutritional needs of low-income pregnant women and preschool children."[356]

Advocates, legislators and USDA officials, and physicians soon crafted plans to build food commissaries attached to neighborhood clinics to enhance access to healthy foods.[357] Simultaneous projects emerged through a USDA commissary established in Atlanta and a voucher program designed by Dr. David Paige of Johns Hopkins University in Baltimore.[358] By the time the first WIC clinic was established in Pineville, Kentucky, in January 1974, WIC's critical role in addressing health and food access disparities was already firmly established. WIC carries this strong tradition of public health activism today in delivering critical nutrition and breastfeeding support that addresses present challenges, including high rates of childhood obesity and persistent racial and systemic barriers to optimal health.

RACIAL DISPARITIES IN MATERNAL AND CHILD HEALTH

MATERNAL AND INFANT MORTALITY

Between 1990 and 2015, the maternal mortality rate in the United States increased by 56 percent.[359] The increased rates demonstrated persistent racial disparities, with Black women at least three times as likely and Indigenous women at least twice as likely to die of pregnancy-related complications than white women between 2011 and 2016.[360] These disparities are even more concerning since the Centers for Disease Control and Prevention (CDC) estimates that approximately 60 percent of maternal deaths should be preventable.[361]

Racial disparities, especially for Black women, are driven by systemic racism, both in the provision of maternal care and in social determinants of health.[362] Racism and racial discrimination – including implicit or unconscious bias – can lead providers to overlook the pain of a pregnant or birthing woman, ignore or misdiagnose symptoms, and delay care.[363] The toxic stress of chronic exposure to racism, accumulated over time resulting in weathering, is a critical factor in Black maternal deaths in the United States.[364]

Direct causes of maternal death, often resulting from weathering, include cardiovascular conditions, infection or sepsis, hemorrhaging, and hypertensive disorders and preeclampsia.[365] The 2009 food package reforms and WIC's individualized nutrition counseling lead to improved maternal nutrition, including increased vitamin D and iron intake, which reduces the risk of pregnancy-induced hypertension and preeclampsia.[366] Diet-related conditions like obesity are associated with additional risk factors for maternal mortality, such as cardiovascular conditions.[367]

Although WIC's time-limited intervention cannot reverse years of toxic stress and weathering, improved maternal nutrition could address some of the risk factors for poor pregnancy outcomes.

WIC providers, as a consistent point-of-contact throughout pregnancy, refer families to appropriate healthcare services and reinforce positive messages about ongoing prenatal care.[368] WIC's nutrition intervention is complemented by comprehensive prenatal care, including access to prenatal vitamins, ultrasound screenings, genetic counseling, amniocentesis, and other core services that support healthy pregnancies.[369] The combined effect of WIC participation and access to prenatal care is especially critical for the nearly one-quarter of pregnant participants who are assessed to have general obstetrical risks.[370]

Racial disparities persist in the perinatal period and beyond. Black infants are more than twice as likely as white infants to die in their first year of life, and Indigenous children face similarly high rates of infant mortality.[371] WIC's prenatal support is an effective intervention to extend the length of pregnancies and ensure healthy birthweights for Black infants.[372] WIC reduces the risk of infant mortality by 33 percent for the overall population,[373] but is particularly effective at closing racial disparities for Black infants.[374]

BREASTFEEDING RATES

WIC's balanced approach between professional lactation support and peer counseling is effective at increasing breastfeeding rates,[375] providing tailored support that navigates racial and ethnic disparities, lack of information, and intergenerational trauma that may inhibit successful breastfeeding. Although low-income mothers breastfeed at lower rates than the general population,[376] WIC has made significant progress over the past two decades by increasing initiation rates by 30 percent[377] and doubling the duration rate at 12 months.[378] Strengthening WIC's breastfeeding programming is a core piece of closing racial gaps in breastfeeding initiation, duration, and exclusivity.

Nationally, Black and Indigenous women have lower rates across all three breastfeeding metrics than other racial and ethnic groups and are the only two racial groups with less than 80 percent breastfeeding initiation.[379] Higher rates for Hispanic and Asian populations may not fully account for the impact of higher breastfeeding rates among immigrant women.[380] While 83.2 percent of infants are breastfed nationally,[381] only 71.8 percent of WIC infants are ever breastfed.[382] The racial gaps are narrower among WIC participants, with Black WIC participants over 5 percent closer to the national average than the overall Black population.[383]

WIC'S COMBINATION OF PROFESSIONAL AND PEER SUPPORT CLOSES RACIAL DISPARITIES IN BREASTFEEDING INITIATION AND DURATION.

Racial disparities are shaped by historic trauma and the emergence of commercial formula in the early twentieth century. Traditional breastfeeding practices for Indigenous women were disrupted by assimilation policies, including boarding schools for Indigenous children that separated mothers from their children.[384] For Black women, the historic legacy of slavery and wet-nurse practices were coupled with higher rates of maternal employment in the early twentieth century that disincentivized breastfeeding, paving the way for decades of targeted and deceptive marketing by infant formula manufacturers.[385] Black women were especially susceptible to infant formula marketing in hospital settings, with samples given out at maternity wards to influence feeding behaviors.[386] In-hospital formula feeding is associated with significantly reduced breastfeeding duration and earlier weaning.[387]

In 1991, the Baby Friendly Hospital Initiative (BFHI) was established to improve breastfeeding support in maternity care settings, including hospitals. BFHI is effective at reshaping hospital policies to ban infant formula marketing at the bedside and prioritize time in the recovery room for breastfeeding initiation.[388] However, BFHI accreditation is voluntary and may not be prioritized by hospitals associated with underserved communities, including Black neighborhoods shaped by decades of redlining, housing discrimination, and underinvestment.[389] Between 2011 and 2014, every hospital administered by the Indian Health Service received BFHI status.[390]

Without WIC's education and support, intergenerational patterns will only reinforce existing racial disparities. The choice to breastfeed or pursue alternative infant feeding practices is often shaped by personal experience and family history.[391] Prior family experience, support, and engagement from partners or parents is an important factor in addressing common concerns that inhibit or cease breastfeeding,[392] including stress about breast milk supply and difficulty latching.[393] WIC counseling and encouragement navigates through a participant's prior experiences and perceptions,[394] and WIC staff consistently engage family members – including fathers, grandparents, and siblings – to support a participant's choice to breastfeed.

ADDRESSING ANTI-BLACK AND ANTI-INDIGENOUS RACISM AND IMPLICIT BIAS

Higher risk of adverse outcomes, persistent disparities, and historical traumas of abusive medical practices erode trust in the healthcare system among people of color, especially Black and Indigenous women.[395] Black and Indigenous patients' high level of distrust of physicians[396] can be especially acute during prenatal care due to specific history of abusive gynecological practices, including forced or coerced sterilization, on Black[397] and Indigenous women.[398]

Black and Indigenous patients' high level of distrust for physicians may be ameliorated when there is greater interaction with medical professionals of the same demographic background, raising dual priorities of diversifying the medical profession while also improving the ability of white providers to establish trust with patients across racial lines.[399] In recent years, medical providers are increasingly evaluating the effectiveness of anti-racism and implicit bias trainings to identify and remedy problematic behaviors in service delivery that fuel outcome disparities.[400]

POLICY RECOMMENDATION:
The WIC workforce, especially frontline providers of nutrition and breastfeeding support, should, in addition to acquiring cultural competencies, undergo anti-racism and implicit bias trainings to enhance WIC service delivery.

WIC providers are exploring similar strategies to both diversify the workforce and enhance the provision of nutrition education and breastfeeding support by implementing diversity, inclusion, and equity trainings at clinic sites. Credentialed nutrition and breastfeeding professionals are overwhelmingly white – including an estimated 81.1 percent of Registered Dietitians (RDs).[401] Although International Board Certified Lactation

Consultants (IBCLCs) are predominantly white,[402] there is a greater range of diversity among Certified Lactation Educators (CLEs) and Certified Lactation Consultants (CLCs).[403]

POLICY RECOMMENDATION:
USDA and State WIC Agencies should partner with credentialing programs and universities to enhance degree programs and professional development opportunities that incentivize diversity in the fields of dietetics, nutrition, and lactation support.

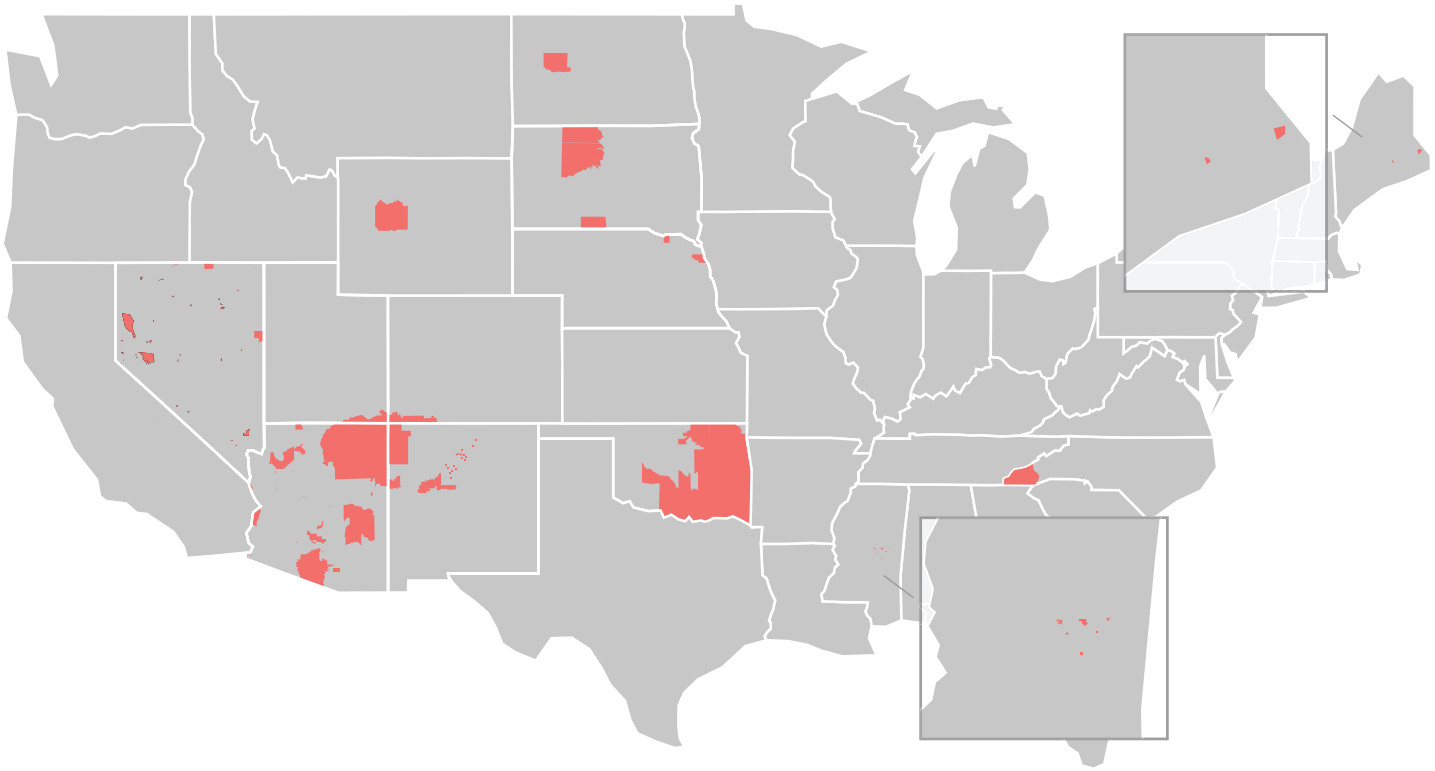
A successful model of WIC workforce diversification is best exemplified by the Breastfeeding Peer Counselor Program established in 2004. It necessarily includes a paraprofessional subset of the WIC workforce that is drawn from the same neighborhoods and communities as current participants and better reflects the lived experience of the people served by WIC, including shared challenges, backgrounds, and languages.[404] Increased efforts to create professional pathways for peer counselors, including higher credentialing in lactation support or healthcare, is an effective strategy toward further diversifying the workforce pipeline in WIC and the broader public health sector.

EMPOWERING TRIBAL SERVICES

The 2010 decennial Census reported that 5.2 million people identified as American Indian or Alaska Native alone or in combination with another race.[405] There are 574 federally recognized American Indian Tribes and Alaska Native Villages, all inherently sovereign entities with their own political and tribal structure, entitled to a government-to-government relationship with the United States.[406]

Even before the first WIC clinic opened, Congress prioritized the rights of tribes and inter-tribal groups to scale up their own WIC programs at equivalent status

INDIAN TRIBAL ORGANIZATIONS DIRECTLY OPERATING WIC SERVICES



INDIAN TRIBAL ORGANIZATIONS

Acoma, Canoncito & Laguna
Cherokee Nation of Oklahoma
Cheyenne River Sioux Tribe
Chickasaw Nation
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation
Eastern Band of Cherokee Indians
Eastern Shoshone
Eight Northern Indian Pueblo Council
Five Sandoval Indian Pueblos
Indian Township Passamaquoddy Reservation
Inter Tribal Council of Arizona
Inter Tribal Council of Nevada
Inter Tribal Council of Oklahoma
Mississippi Band of Choctaw Indians
Muscogee Creek Nation
Navajo Nation
Northern Arapaho
Omaha Nation
Osage Nation
Otoe-Missouria Tribe
Pleasant Point Passamaquoddy Reservation
Pueblo of Isleta
Pueblo of San Felipe
Pueblo of Zuni
Rosebud Sioux Tribe
Santee Sioux Tribe
Santo Domingo WIC Program
Standing Rock Sioux Tribe
Three Affiliated Tribes
Ute Mountain Ute Tribe
Wichita, Caddo, and Delaware Tribes
Winnebago

"A LOT OF OUR MOMS ARE YOUNG, FIRST TIME MOMS WHO ARE OFTEN NERVOUS TO SEEK HEALTH SERVICES. THEY MAY NOT REACH OUT TO ANY ONE FOR SERVICES EXCEPT FOR WIC. WINNEBAGO WIC BEING HERE REALLY HELPS NEW MOMS FEEL COMFORTABLE BECAUSE WE ARE ALSO NATIVE AMERICAN, WHICH HELPS ESTABLISH A SENSE OF TRUST AND SUPPORT. AS WIC PROVIDERS, WE HELP BRIDGE THE GAP BETWEEN OUR FAMILIES AND PRIMARY HEALTH CARE THROUGH OUR REFERRALS. OUR FAMILIES COME TO WIC THINKING THEY ARE JUST GOING TO RECEIVE SUPPLEMENTAL FOOD, BUT THEN THEY REALIZE ALL THE SERVICES THAT WINNEBAGO WIC PROVIDES AND THE SUPPORTIVE ENVIRONMENT WE HAVE FOSTERED."

BENITA PAYER,
WIC PROGRAM DIRECTOR
WINNEBAGO TRIBE OF NEBRASKA

to geographic states.[407] Designated as Indian Tribal Organizations (ITOs), tribal WIC programs partner with federal programs like the Indian Health Service (IHS) and the Food Distribution Program on Indian Reservations (FDPIR) to enhance nutrition and health outcomes on tribal lands. In addition to tribally operated programs, geographic State WIC Agencies may contract with local providers that support the needs of urban and rural Indigenous populations.[408] In 2018, both ITOs and other State WIC Agencies served over 696,000 Indigenous participants, approximately 9 percent of all WIC participants.[409]

Thirty-three tribes or inter-tribal councils currently operate as ITO State WIC Agencies, representing only a fraction of the federally recognized tribal nations.[410] ITO status is an important step in tribal exercise of sovereignty, empowering tribes to manage their own programs and tailor services for Indigenous families in a culturally appropriate manner.[411] This responsibility is not without challenges, as tribal agencies report financial and staffing difficulties, onerous reporting requirements, and high operating costs, especially with the increased technology infrastructure needed to implement electronic-benefit transfer (EBT), or e-WIC, systems.[412] For example, Seneca Nation discontinued operations independent of the New York State WIC Agency in 2019 as a result of financial and staffing challenges.[413]

POLICY RECOMMENDATION:
Additional funding and regulatory flexibilities should be explored to support Indian Tribal Organizations (ITOs) and empower tribal administration of WIC services.

Targeted services tailored to Indigenous populations are critical to alleviating high rates of food insecurity[414] and chronic health conditions like type-2 diabetes,[415] lower rates of breastfeeding initiation,[416] and challenges accessing healthcare services.[417] Indigenous populations may lack trust in federal programs and healthcare providers given historical trauma rooted in displacement from ancestral lands and coercive or abusive practices, including high rates of sterilization of Indigenous women,[418] which could drive the higher rates of Indigenous maternal mortality and poor birth outcomes.[419] Indigenous women are more than twice as likely as white women,[420] and perhaps as much as four times as likely,[421] to die from pregnancy-related complications.

Tribally managed services tailored to Indigenous cultural perspectives are critical to achieving optimal health outcomes.[422] Early peer counselor programs, drawn from Indigenous communities and able to navigate cultural sensitivities and practices, were demonstrated to improve breastfeeding initiation and duration for Indigenous participants and helped build the evidence base to scale up peer services nationally.[423] ITO State WIC Agencies were also critical in driving the National WIC Association's advocacy to reform the WIC food packages and provide culturally appropriate substitutions,[424] an option enacted in the 2009 regulatory changes and that, in 2017, the National Academies for Sciences, Engineering, and Medicine (NASEM) recommended strengthening.[425]

Tribes are increasingly taking steps to strengthen local food systems and environments to empower local investment and address high rates of food insecurity and chronic disease.[426] Increased efforts to assert tribal sovereignty over food systems improves production of and access to foods that are historically and culturally preferred,[427] many of which are nutrient-rich.[428] Greater variety of food options, when paired with nutrition education grounded in Indigenous cultural practices, can positively impact children's diet quality.[429] WIC, FDPIR, and other federal programs can be partners in elevating and strengthening tribal-led movements to enhance traditional and culturally appropriate food access and attain food sovereignty.

POLICY RECOMMENDATION:
Increased vendor flexibilities and deliberate efforts to encourage smaller tribal retailers and producers to seek authorization for WIC or WIC Farmers Market Nutrition Program would complement broader food sovereignty efforts.

SOCIAL DETERMINANTS OF HEALTH

WIC's effective nutrition intervention must be considered in the context of comprehensive measures to address children's health, development, and future opportunity. Health outcomes are so often shaped by social determinants of health, geography, and community conditions that control access to social and economic opportunities, including access to healthy foods, healthcare, and safe workplaces. WIC providers consistently collaborate with community partners to strengthen local food systems and supports, but broader policy change is needed to address structural racism, alleviate poverty, and provide opportunity regardless of rural or urban settings, neighborhood, or ZIP code.

ENSURING FAMILY ECONOMIC SECURITY

The modern economy is not structured to account for the realities of raising children. Women constituted a majority of the workforce before the COVID-19 pandemic,[430] but more women exited the workforce as a result of childcare responsibilities and the economic disruption throughout 2020.[431] Even if not a majority, the substantial number of working women of childbearing age requires strong labor and workplace policies that balance health and familial considerations with job responsibilities. The American College of Obstetricians and Gynecologists recommend work flexibilities or accommodations to account for the range of precautions for high-risk jobs, shift work, and physically demanding tasks.[432] These accommodations are necessary to avert negative pregnancy outcomes, including health risks to the mother, preterm birth, and miscarriage.[433]

The United States is the only industrialized country that does not provide paid family leave for new parents.[434] The initial weeks of an infant's life are critical for bonding, establishing parent-child relationships, and laying the foundation for how children learn.[435] In addition to these key cognitive and developmental milestones, the initial weeks are also critical for breastfeeding success, with rapid return to work shortening breastfeeding duration.[436] In addition to positive health outcomes, paid parental leave models also ensure ongoing employment and family income, reducing stressors on new parents and ensuring greater productivity when parents return to work.[437]

Healthy pregnancies must also be complemented with long-term family economic security, as even temporary experiences of child poverty can have long-term developmental and health effects.[438] 17.4 percent of children under the age of six lived in poverty in 2018 – over four million children.[439] Younger adults are having a harder time accumulating the financial resources needed to support families than past generations, in part driven by stagnating wages, underemployment, and substantial student debt.[440] Broader economic reforms to raise wages and targeted measures for low-income families, like the Child Tax Credit, strengthen family economic security and enhance children's overall health and development.[441]

PRIORITIZING COMMUNITY HEALTH

Community determinants shape children's development and family supports, with an association between a child's ZIP code and risk factors for adverse birth outcomes.[442] A history of underinvestment in rural and certain urban communities, in part driven by segregation and racial discrimination in housing practices, can impact the prevalence of food security and health outcomes.[443] Food swamps – areas with a high-density of restaurants or stores selling high-calorie fast food or junk food – are associated with higher rates of obesity and may lack a broad range of available healthy foods.[444] The 2009 food package changes – which shaped stocking practices in authorized WIC retail grocery stores – are associated with expanded access to healthy foods in low-income neighborhoods.[445]

Other metrics of community development, including broadband

"INTERNET CONNECTIVITY PRESENTS CHALLENGES IN REMOTE OR RURAL COMMUNITIES FOR BOTH CLIENTS AND CLINICS, ESPECIALLY AS STAFF WORKS FROM HOME DURING THE PANDEMIC. WIC HAD TO INVEST IN NEW TECHNOLOGY, SUCH AS MOBILE HOTSPOTS, TO SUPPORT ONGOING OPERATIONS. SOME CLINICS WERE COMPLETELY CLOSED WITHOUT THE ABILITY TO PROVIDE REMOTE SERVICES, AND ITCA HAD TO STEP IN AND PROVIDE DIRECT SERVICES TO ENSURE NO DISRUPTION TO BENEFITS."

MINDY JOSSEFIDES,
WIC PROGRAM DIRECTOR
INTER-TRIBAL COUNCIL OF ARIZONA

access, can affect community development and shape health outcomes for young children. Approximately 18.3 million people in the United States lack access to fixed broadband service, with nearly one-fourth of rural communities (22 percent) lacking access to this critical utility.[446] Rural tribal lands are disproportionately impacted, with 28 percent unable to access broadband.[447] Rural broadband access is especially critical as healthcare providers utilize telehealth technologies to deliver care and resolve barriers to access like transportation and social distancing during COVID-19.[448] WIC retailers will increasingly need to demonstrate internet connectivity to operate electronic-benefit transfer (EBT)/e-WIC systems and new transaction models, like online purchasing.[449] As State WIC Agencies increasingly rely on alternative service delivery models for remote access, nutrition education, and client consultations, internet connectivity will be essential to assure quality access to these essential services.

Environmental factors pose specific risks for pregnancies and child development. In 2015, 7 percent of communities had unsafe water systems, but approximately 12 percent of all children live in communities with unsafe water.[450] Low-income children are at risk of increased intake of contaminants through water, with children participating in WIC being three to four times more likely to have unsafe blood lead levels than the general child population.[451] Safe water systems are especially critical for the health of formula-fed WIC infants.[452] Similarly, maternal or early exposure to air pollutants can impact fetal development and pregnancy outcomes, including higher risk of preterm birth or miscarriage,[453] while also contributing to long-term health conditions in children, such as asthma and respiratory conditions.[454]

DURING THE FLINT WATER CRISIS, MICHIGAN WIC TESTED FOR LEAD EXPOSURE, DISTRIBUTED BOTTLED WATER, AND COUNSELED ON SAFE INFANT FORMULA PREPARATION.

Community safety influences child development and may impact family stability and economic security. Racist policing practices and police brutality have significant impacts on the mental health and social development of Black children,[455] and punitive immigration policies have led to mental health conditions in young children from immigrant and mixed-status families, especially when a parent has been detained or separated from the family.[456] Comprehensive reforms to policing and immigration enforcement that address abusive or dangerous practices, ensure accountability, and prioritize justice for affected families are needed to promote family stability and assure positive child development.

Within households, intimate partner violence is associated with increased risks to pregnancy, including low birthweight and preterm birth,[457] as well as negative health effects for children and even infants who witness violence.[458] Intimate partner violence is often tied to economic control, and ending the violence may leave the affected parent and any children vulnerable to poverty and economic insecurity.[459] WIC providers make referrals to domestic violence shelters and other social services that support families in ending violence and assuring the safety of young children.

Community safety is also at increased risk if there are firearms present. The presence of firearms in the house escalates the risk of injury or death in intimate partner violence cases for both women[460] and children.[461] Children discovering and playing with unsecured firearms in the home is the most common form of unintentional firearm-related death.[462] The National WIC Association concurs with the 2015 Call to Action from health professional organizations identifying firearm-related injury and death as a major public health problem.[463]

CHAPTER SIX: PARTNERSHIPS WITH FARMERS

WIC purchases are the last link in a dedicated food supply chain that grows, produces, and distributes healthy foods to retail grocery locations across the country. As with other federal nutrition programs, WIC retail purchases flow back to the farm sector and invest in America's agricultural production. The partnership between agriculture and WIC participants is a vital underpinning to the program's success, but further collaboration is needed to open the WIC market to small farmers.

FAST FACTS

$1.3 BILLION

WIC RETURNS REVENUES DIRECTLY TO FARMERS[464]

10,155

FULL-TIME FARM JOBS ARE CONNECTED TO WIC FOOD PRODUCTION[465]

16,049

FARMERS IN THE WIC FARMERS MARKET NUTRITION PROGRAM DIRECTLY INTERACT WITH WIC FAMILIES[466]

WIC'S IMPACT ON THE FARM SECTOR

WIC's historic connections with agriculture were revitalized by the 2009 changes to the WIC food package, which expanded the food products available for purchase by WIC consumers to include fruits, vegetables, and whole-grain foods. These expanded options brought in a greater variety of farmers and producers to the WIC supply chain, ensuring that federal funding flowed back to different sectors of the farm economy.

USDA estimated that the 2009 food package changes resulted in an annual revenue of $1.3 billion for the farm sector based on $4.6 billion in WIC retail purchases.[467] The changes to the WIC food package and greater variety of available foods were estimated to increase farm revenues connected to WIC by $331 million each year.[468]

Farm revenues are evenly split between livestock and crop producers, with the dairy industry drawing 45 percent of WIC-related revenues.[469] Dairy producers benefitted the most from the 2009 food package changes, with an estimated additional $147.4 million in annual revenues, even though the changes reduced the allowances of milk and cheese for WIC shoppers.[470] The second-largest increase in revenues was associated with fruit and vegetable producers, who are estimated to claim nearly $300 million in annual revenues due to the introduction of WIC's Cash Value Benefit.

WIC fuels a segment of the farm workforce, with over 10,000 full-time farm positions needed to produce foods for WIC consumers, including an increased 2,600 jobs connected to the 2009 changes to the food package.[471] This may underestimate the total number of workers, as many farm jobs – including those related to fruit and vegetable production – are seasonal and part-time. Additionally, WIC intersects with other areas of the farm economy, bringing $177 million in annual revenues to farm

"AS SOMEONE WHO WORKS WITH THE FULL FRESH PRODUCE SUPPLY CHAIN, WIC INCREASES ACCESS TO FLAVORFUL FRUITS AND VEGETABLES FOR MANY FAMILIES. THE CASH VALUE BENEFIT STRENGTHENS THE ENTIRE SUPPLY CHAIN FROM GROWER TO CONSUMER."

GARLAND PERKINS
SENIOR MANAGER OF INSIGHTS & INNOVATION, OPPY
CHARLOTTE, NC

production commodities, such as feed for dairy cows and poultry and seed for grain production.[472]

WIC-related food production affects several additional sectors of the food supply chain. The majority of foods require at least one stage of processing, bringing revenues to food processors.[473] Distributors also play a vital role in connecting foods to retail grocery locations. The introduction of fruits and vegetables to the food package – and the requirement that WIC-approved vendors carry two varieties of each[474] – have led smaller vendors to invest in capital improvements, such as acquiring refrigeration and display units.[475] Nonetheless, distributors may face challenges in connecting small farmers with the WIC market, given the high proportion of large grocery chains with national distributor networks among WIC-approved vendors.[476]

WIC AT FARMERS MARKETS

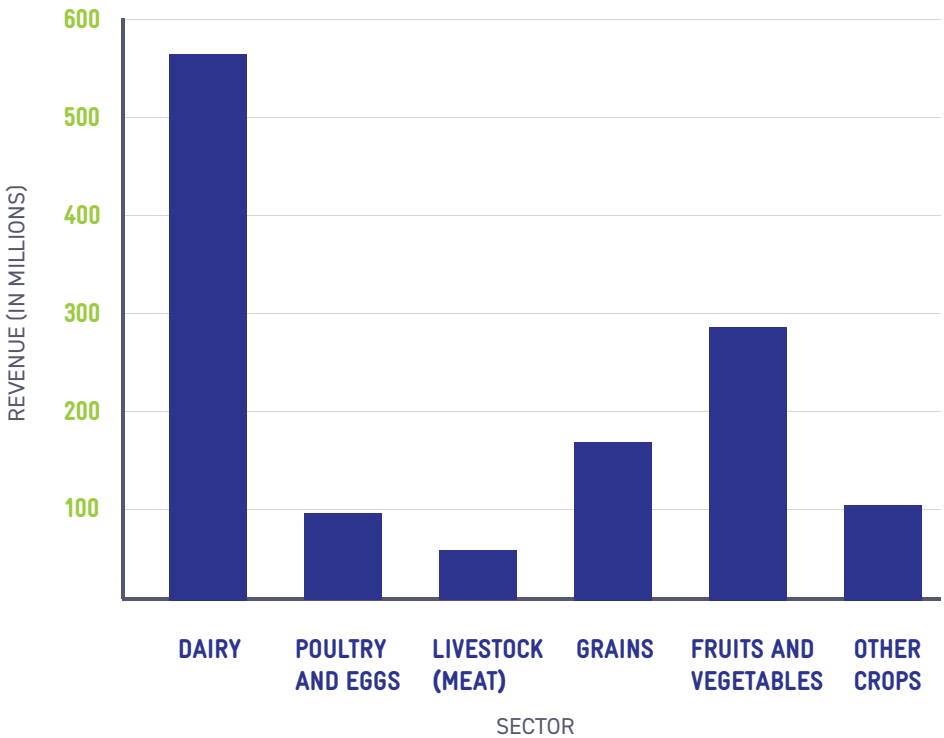
For nearly three decades, WIC has worked to strengthen connections with farmers markets to enhance access to local produce and healthy foods. Farmers markets are critical opportunities for smaller farmers and producers to offer their products to WIC shoppers, and opportunities for collaboration have only expanded with the introduction of the Cash Value Benefit in 2009.

Twenty-two State WIC Agencies – including 15 geographic states – allow for the Cash Value Benefit to be redeemed at farmers markets.[477] The Cash Value Benefit – which provides $9 or $11 per month for fruit and vegetable purchases – can also be redeemed in traditional retail locations that are approved as WIC vendors.

POLICY RECOMMENDATION
USDA should move forward solutions to streamline electronic transactions at farmers markets between WIC Cash Value Benefits, WIC FMNP, and SNAP.

Farmers markets met immediate challenges in allowing for redemption of the Cash Value Benefit, as State WIC Agencies began implementing electronic-benefit transfer (EBT), or e-WIC, transactions. The transition to an EBT/e-WIC system meant that individual farmers would have to procure handheld EBT/e-WIC transaction devices with reliable internet access at the market location. Although some State WIC Agencies have facilitated the procurement of this equipment for farmers, many states have deemed this process too costly and burdensome for farmers. Unlocking a solution that integrates an EBT/e-WIC transaction with a scalable, affordable transaction

FARM REVENUES BY SECTOR (IN MILLIONS)[480]



"THIS YEAR, WITH COVID, WE HAD TO GET CREATIVE ON HOW WE SOLD THINGS. WE DECIDED TO REALLY DOUBLE DOWN ON FARMERS MARKETS AND VALUE THE DIRECT CONNECTION WITH THOSE WHO EAT THE FOOD WE WORKED SO HARD TO GROW. I LOVE WHEN WIC PARTICIPANTS COME UP WITH THEIR FMNP CHECKS! GETTING TO SEE A KID'S EYES LIGHT UP WHEN THEY CAN CHOOSE A VEGETABLE IS SO HEARTWARMING AND ENCOURAGING. WE TRY TO KEEP ITEMS AT A PRICE POINT TO MATCH UP WITH THE FMNP CHECKS AND, ON THE LAST DAY OF THE SEASON, THE PROGRAM WAS A LARGE PERCENT OF OUR MARKET SALES FOR THE DAY. ANY PERCENTAGE MAKES A DIFFERENCE TO OUR BUSINESS. WITHOUT WIC FMNP, WE'D LOSE A WHOLE GROUP OF PEOPLE WE GET TO INTERACT WITH AROUND FOOD, AND THAT WOULD STING."

NICKI PASSARELLA
AMICA FARM
GRESHAM, OR

device for farmers is a critical step toward strengthening farmers market partnerships with WIC.

Even before the Cash Value Benefit was introduced, Congress instituted the WIC Farmers Market Nutrition Program (FMNP) in 1992. WIC FMNP, a separate program that is funded through the Commodity Assistance Program, provides over 1.5 million WIC participants at 49 of the 89 State WIC Agencies with an additional voucher to redeem fruits, vegetables, and herbs at a farmers market or farm stand.[478] WIC FMNP benefits are capped at $30 per year,[479] which limits the reach of the program and its ability to incentivize shopping by WIC families at farmers markets.

POLICY RECOMMENDATION:
Congress should double the upper limit for WIC FMNP benefits to $60 per year to support both WIC families and individual farmers.

As USDA evaluates opportunities to enhance WIC redemptions at farmers markets, an integrated approach should be inclusive of both WIC FMNP and SNAP transactions. As in retail settings, current WIC regulations are more restrictive than SNAP, precluding some market models that allow for centralized terminals or shopping via token.

Further collaboration between WIC and WIC FMNP is an important step toward enhancing WIC purchases of local produce. WIC FMNP programs are not necessarily administered by state health departments, but could also be placed in state agriculture or aging departments – especially when paired with the Senior FMNP.

The National WIC Association has consistently supported stronger funding for WIC FMNP, especially as additional State WIC Agencies voice interest in expanding the program to new markets or even new states. WIC collaborations with farmers markets demonstrate the intertwined relationship between local farmers and WIC shoppers.

APPENDIX: STATE PROFILES OF WIC SERVICES

HOW WIC HELPS
THE UNITED STATES OF AMERICA

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response

WIC State Agencies received at least 697 waivers to operate during the pandemic, including flexibilities to implement remote services and substitutions within the food package to ensure access to nutritious foods.

45% of infants born in the United States participated in WIC in 2017

51% of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

7,837,672 WIC PARTICIPANTS

National WIC participation in 2018

Pregnant women	675,227
Breastfeeding women	628,152
Postpartum women	514,009
Infants	1,868,344
Children	4,151,940

BREASTFEEDING IN WIC

National WIC breastfeeding initiation rates increased by **7 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in the United States in 2018, **23 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN THE UNITED STATES

The obesity rate among WIC toddlers in the United States decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN THE UNITED STATES

Maternal mortality per 100,000 births, 2017	**17.3**
Infant mortality per 1,000 live births, 2017	**5.8**
Preterm birth rates, 2017	**10%**

UNITED STATES OF AMERICA WIC PARTICIPANT CHARACTERISTICS

$19,355 average family income in 2018

77% received Medicaid in 2018

$40.90 average monthly food cost in FY 2019

HOW WIC SUPPORTED THE UNITED STATES ECONOMY IN FY 2019

$3.1B to spend at food retailers

$1.7B formula rebates received

$2.0B nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
INDIAN TRIBAL ORGANIZATIONS

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response

Indian Tribal Organization State Agencies received at least 184 waivers during the pandemic, including flexibilities to implement remote services and substitutions within the food package to ensure access to nutritious foods.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

59,284
WIC PARTICIPANTS

WIC participation in Indian Tribal Organizations in 2018

Pregnant women	4,872
Breastfeeding women	3,377
Postpartum women	3,998
Infants	13,253
Children	33,784

BREASTFEEDING IN WIC

Breastfeeding initiation rates among WIC infants in Indian Tribal Organizations increased by approximately **20 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Indian Tribal Organizations in 2018, approximately **24 percent** continued breastfeeding at 6 months.

INDIAN TRIBAL ORGANIZATION WIC PARTICIPANT CHARACTERISTICS

$14,963
average family income in 2018

68%
received Medicaid in 2018

$52.17
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ECONOMY OF INDIAN TRIBAL ORGANIZATIONS IN FY 2019

$22.0M
to spend at food retailers

$11.2M
formula rebates received

$29.8M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS

ACOMA, CANONCITO, AND LAGUNA INDIAN TRIBAL ORGANIZATION

State WIC Director
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New Laguna, NM 87038-0310

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
ACL WIC received at least 6 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

427
WIC PARTICIPANTS

ACL WIC participation in 2018

Pregnant women	34
Breastfeeding women	36
Postpartum women	24
Infants	83
Children	250

BREASTFEEDING IN WIC

ACL WIC breastfeeding initiation rates increased by **19 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in ACL in 2018, **26 percent** continued breastfeeding at 6 months.

ACL WIC PARTICIPANT CHARACTERISTICS

$16,397
average family income in 2018

88%
received Medicaid in 2018

$46.86
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ACL ECONOMY IN FY 2019

$204,889
to spend at food retailers

$219,852
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
ALABAMA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Alabama WIC received at least 7 waivers, including physical presence and larger package sizes for whole grains.

60%
of infants born in Alabama participated in WIC in 2017

53%
of eligible individuals in Alabama participated in WIC in 2017

WHO PARTICIPATES IN WIC?

130,739
WIC PARTICIPANTS

Alabama WIC participation in 2018

Pregnant women	14,393
Breastfeeding women	4,044
Postpartum women	13,992
Infants	35,438
Children	62,872

BREASTFEEDING IN WIC

Alabama WIC breastfeeding initiation rates increased by **3 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Alabama in 2018, **23 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN ALABAMA

The obesity rate among WIC toddlers in Alabama increased by **<1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN ALABAMA

Maternal mortality per 100,000 births, 2010–2015	**11.9**
Infant mortality per 1,000 live births, 2017	**8.2**
Preterm birth rates, 2017	**12%**

ALABAMA WIC PARTICIPANT CHARACTERISTICS

$17,111
average family income in 2018

71%
received Medicaid in 2018

$44.32
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ALABAMA ECONOMY IN FY 2019

$61.4M
to spend at food retailers

$33.2M
formula rebates received

$27.6M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
ALASKA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Alaska WIC received at least 10 waivers, including physical presence and flexibility for mailed food packages.

39%
of infants born in Alaska participated in WIC in 2017

39%
of eligible individuals in Alaska participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Alaska WIC participation in 2018

18,963
WIC PARTICIPANTS

Pregnant women	1,591
Breastfeeding women	1,988
Postpartum women	813
Infants	4,037
Children	10,534

BREASTFEEDING IN WIC

Alaska WIC breastfeeding initiation rates increased by **15 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Alaska in 2018, **7 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN ALASKA

The obesity rate among WIC toddlers in Alaska decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **20%**

MORTALITY AND BIRTH OUTCOMES IN ALASKA

Infant mortality per 1,000 live births, 2017 **5.5**

Preterm birth rates, 2017 **9%**

ALASKA WIC PARTICIPANT CHARACTERISTICS

$26,638
average family income in 2018

$54.52
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ALASKA ECONOMY IN FY 2019

$10.5M
to spend at food retailers

$2.5M
formula rebates received

$7.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
AMERICAN SAMOA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
American Samoa WIC received at least 3 waivers, including physical presence and extended certification periods for children.

79%
of infants born in American Samoa participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

5,396
WIC PARTICIPANTS

American Samoa WIC participation in 2018

Pregnant women	406
Breastfeeding women	460
Postpartum women	125
Infants	768
Children	3,637

BREASTFEEDING IN WIC

American Samoa WIC breastfeeding initiation rates increased by **4 percentage points** between 2000 and 2016.

Among WIC infants who initiated breastfeeding in American Samoa in 2018, **56 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN AMERICAN SAMOA

The obesity rate among WIC toddlers in American Samoa decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **14%**

AMERICAN SAMOA WIC PARTICIPANT CHARACTERISTICS

$26,768
average family income in 2018

$68.12
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE AMERICAN SAMOA ECONOMY IN FY 2019

$4.1M
to spend at food retailers

$1.0M
formula rebates received

$1.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
ARIZONA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Arizona WIC received at least 12 waivers, including physical presence and relief from in-person monitoring requirements.

37%
of infants born in Arizona participated in WIC in 2017

46%
of eligible individuals in Arizona participated in WIC in 2017

WHO PARTICIPATES IN WIC?

151,081
WIC PARTICIPANTS

Arizona WIC participation in 2018

Pregnant women	12,349
Breastfeeding women	5,406
Postpartum women	13,871
Infants	30,174
Children	89,281

BREASTFEEDING IN WIC

Arizona WIC breastfeeding initiation rates increased by **4 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Arizona in 2018, **39 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN ARIZONA

The obesity rate among WIC toddlers in Arizona decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN ARIZONA

Maternal mortality per 100,000 births, 2010–2015	**18.8**
Infant mortality per 1,000 live births, 2017	**5.5**
Preterm birth rates, 2017	**9%**

ARIZONA WIC PARTICIPANT CHARACTERISTICS

$21,213
average family income in 2018

87%
received Medicaid in 2018

$35.63
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ARIZONA ECONOMY IN FY 2019

$60.7M
to spend at food retailers

$39.5M
formula rebates received

$41.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
ARKANSAS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Arkansas WIC received at least 15 waivers, including physical presence and extended certification periods for children.

59%
of infants born in Arkansas participated in WIC in 2017

49%
of eligible individuals in Arkansas participated in WIC in 2017

WHO PARTICIPATES IN WIC?

79,859
WIC PARTICIPANTS

Arkansas WIC participation in 2018

Pregnant women	8,463
Breastfeeding women	3,268
Postpartum women	9,012
Infants	22,042
Children	37,074

BREASTFEEDING IN WIC

Arkansas WIC breastfeeding initiation rates increased by **11 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Arkansas in 2018, **23 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN ARKANSAS

The obesity rate among WIC toddlers in Arkansas decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN ARKANSAS

Maternal mortality per 100,000 births, 2010–2015	**34.8**
Infant mortality per 1,000 live births, 2017	**8.2**
Preterm birth rates, 2017	**11%**

ARKANSAS WIC PARTICIPANT CHARACTERISTICS

$18,589
average family income in 2018

70%
received Medicaid in 2018

$37.22
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ARKANSAS ECONOMY IN FY 2019

$30.0M
to spend at food retailers

$23.3M
formula rebates received

$21.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
CALIFORNIA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
California WIC received at least 17 waivers, including physical presence and extended certification periods for children.

52%
of infants born in California participated in WIC in 2017

61%
of eligible individuals in California participated in WIC in 2017

WHO PARTICIPATES IN WIC?

1,194,194
WIC PARTICIPANTS

California WIC participation in 2018

Pregnant women	100,047
Breastfeeding women	90,986
Postpartum women	62,899
Infants	244,943
Children	695,319

BREASTFEEDING IN WIC

California WIC breastfeeding initiation rates increased by **1 percentage point** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in California in 2018, **13 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN CALIFORNIA

The obesity rate among WIC toddlers in California decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	16%

MORTALITY AND BIRTH OUTCOMES IN CALIFORNIA

Maternal mortality per 100,000 births, 2010–2015	4.5
Infant mortality per 1,000 live births, 2017	4.2
Preterm birth rates, 2017	9%

CALIFORNIA WIC PARTICIPANT CHARACTERISTICS

$21,363
average family income in 2018

80%
received Medicaid in 2018

$44.09
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CALIFORNIA ECONOMY IN FY 2019

$491.5M
to spend at food retailers

$219.8M
formula rebates received

$324.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
CHEROKEE NATION OF OKLAHOMA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Cherokee Nation WIC received at least 12 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

8,250
WIC PARTICIPANTS

Cherokee WIC participation in 2018

Pregnant women	814
Breastfeeding women	392
Postpartum women	534
Infants	2,098
Children	4,412

BREASTFEEDING IN WIC

Cherokee WIC breastfeeding initiation rates increased by **19 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Cherokee in 2018, **11 percent** continued breastfeeding at 6 months.

CHEROKEE WIC PARTICIPANT CHARACTERISTICS

$19,495
average family income in 2018

80%
received Medicaid in 2018

$36.81
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CHEROKEE ECONOMY IN FY 2019

$2.7M
to spend at food retailers

$1.7M
formula rebates received

$3.1M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE CHEYENNE RIVER SIOUX TRIBE

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Cheyenne River Sioux WIC received at least 5 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

784
WIC PARTICIPANTS

Cheyenne River Sioux WIC participation in 2018

Pregnant women	60
Breastfeeding women	40
Postpartum women	43
Infants	135
Children	506

BREASTFEEDING IN WIC

Cheyenne River Sioux WIC breastfeeding initiation rates increased by **18 percentage points** between 2000 and 2018.

Among WIC infants who initiated breastfeeding in Cheyenne River Sioux in 2018, **13 percent** continued breastfeeding at 6 months.

CHEYENNE RIVER SIOUX WIC PARTICIPANT CHARACTERISTICS

$10,960
average family income in 2018

65%
received Medicaid in 2018

$59.53
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CHEYENNE RIVER SIOUX ECONOMY IN FY 2019

$519,477
to spend at food retailers

$60,562
formula rebates received

$554,113
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
CHICKASAW NATION

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Chickasaw Nation WIC received at least 9 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

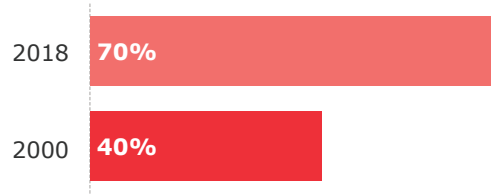
3,850
WIC PARTICIPANTS

Chickasaw WIC participation in 2018

Pregnant women	352
Breastfeeding women	219
Postpartum women	336
Infants	901
Children	2,042

BREASTFEEDING IN WIC

Chickasaw WIC breastfeeding initiation rates increased by **30 percentage points** between 2000 and 2018.



Among WIC infants who initiated breastfeeding in Chickasaw in 2018, **23 percent** continued breastfeeding at 6 months.

CHICKASAW WIC PARTICIPANT CHARACTERISTICS

$22,247
average family income in 2018

71%
received Medicaid in 2018

$33.94
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CHICKASAW ECONOMY IN FY 2019

$1.4M
to spend at food retailers

$942,859
formula rebates received

$2.9M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE CHOCTAW NATION OF OKLAHOMA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Choctaw Nation WIC received at least 4 waivers, including physical presence and vendor-related flexibilities.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

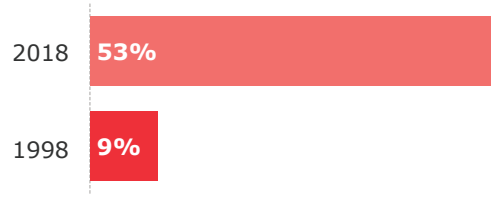
3,921
WIC PARTICIPANTS

Choctaw WIC participation in 2018

Pregnant women	295
Breastfeeding women	196
Postpartum women	350
Infants	984
Children	2,096

BREASTFEEDING IN WIC

Choctaw WIC breastfeeding initiation rates increased by **44 percentage points** between 1998 and 2018.



Among WIC infants who initiated breastfeeding in Choctaw in 2018, **14 percent** continued breastfeeding at 6 months.

CHOCTAW WIC PARTICIPANT CHARACTERISTICS

$19,068
average family income in 2018

77%
received Medicaid in 2018

$29.64
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CHOCTAW ECONOMY IN FY 2019

$1.5M
to spend at food retailers

$1.3M
formula rebates received

$1.5M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE CITIZEN POTAWATOMI NATION

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Citizen Potawatomi WIC received at least 7 waivers, including physical presence and vendor-related flexibilities.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

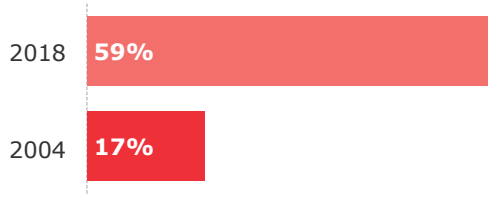
1,740
WIC PARTICIPANTS

Citizen Potawatomi WIC participation in 2018

Pregnant women	203
Breastfeeding women	94
Postpartum women	119
Infants	410
Children	914

BREASTFEEDING IN WIC

Citizen Potawatomi WIC breastfeeding initiation rates increased by **42 percentage points** between 2004 and 2018.



Among WIC infants who initiated breastfeeding in Citizen Potawatomi in 2018, **20 percent** continued breastfeeding at 6 months.

CITIZEN POTAWATOMI WIC PARTICIPANT CHARACTERISTICS

$27,817
average family income in 2018

84%
received Medicaid in 2018

$32.53
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CITIZEN POTAWATOMI ECONOMY IN FY 2019

$564,067
to spend at food retailers

$420,605
formula rebates received

$2.8M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
COLORADO

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Colorado WIC received at least 16 waivers, including physical presence and food substitutions for dairy products.

37%
of infants born in Colorado participated in WIC in 2017

41%
of eligible individuals in Colorado participated in WIC in 2017

WHO PARTICIPATES IN WIC?

94,470
WIC PARTICIPANTS

Colorado WIC participation in 2018

Pregnant women	8,347
Breastfeeding women	7,938
Postpartum women	6,488
Infants	23,879
Children	47,818

BREASTFEEDING IN WIC

Colorado WIC breastfeeding initiation rates increased by **5 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Colorado in 2018, **36 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN COLORADO

The obesity rate among WIC toddlers in Colorado decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**8%**

MORTALITY AND BIRTH OUTCOMES IN COLORADO

Maternal mortality per 100,000 births, 2010–2015	**11.3**
Infant mortality per 1,000 live births, 2017	**4.6**
Preterm birth rates, 2017	**9%**

COLORADO WIC PARTICIPANT CHARACTERISTICS

$22,290
average family income in 2018

56%
received Medicaid in 2018

$37.00
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE COLORADO ECONOMY IN FY 2019

$36.4M
to spend at food retailers

$15.2M
formula rebates received

$25.4M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
CNMI WIC received at least 5 waivers, including physical presence and extended certification periods for children.

89%
of infants born in CNMI participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

CNMI WIC participation in 2018

3,087
WIC PARTICIPANTS

Pregnant women	278
Breastfeeding women	171
Postpartum women	111
Infants	322
Children	2,205

BREASTFEEDING IN WIC

CNMI WIC breastfeeding initiation rates increased by **30 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in CNMI in 2018, **37 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN CNMI

The obesity rate among WIC toddlers in CNMI decreased by **6 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **8%**

CNMI WIC PARTICIPANT CHARACTERISTICS

$18,270
average family income in 2018

79%
received Medicaid in 2018

$60.63
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CNMI ECONOMY IN FY 2019

$2.2M
to spend at food retailers

$0.6M
formula rebates received

$1.4M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
CONNECTICUT

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Connecticut WIC received at least 6 waivers, including physical presence and larger package sizes for whole grains.

37%
of infants born in Connecticut participated in WIC in 2017

49%
of eligible individuals in Connecticut participated in WIC in 2017

WHO PARTICIPATES IN WIC?

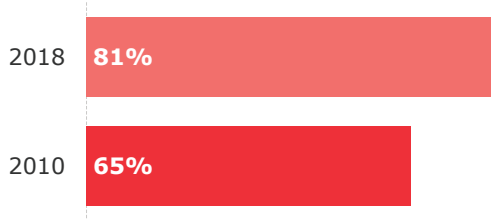
54,509
WIC PARTICIPANTS

Connecticut WIC participation in 2018

Pregnant women	5,123
Breastfeeding women	3,753
Postpartum women	2,592
Infants	12,962
Children	30,079

BREASTFEEDING IN WIC

Connecticut WIC breastfeeding initiation rates increased by **16 percentage points** between 2010 and 2018.



CHILDHOOD OBESITY IN WIC IN CONNECTICUT

The obesity rate among WIC toddlers in Connecticut decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN CONNECTICUT

Maternal mortality per 100,000 births, 2010–2015	**13.2**
Infant mortality per 1,000 live births, 2017	**4.7**
Preterm birth rates, 2017	**10%**

CONNECTICUT WIC PARTICIPANT CHARACTERISTICS

$18,558
average family income in 2018

86%
received Medicaid in 2018

$44.56
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE CONNECTICUT ECONOMY IN FY 2019

$24.5M
to spend at food retailers

$13.4M
formula rebates received

$14.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
DELAWARE

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Delaware WIC received at least 8 waivers, including physical presence and larger package sizes for eggs.

54%
of infants born in Delaware participated in WIC in 2017

43%
of eligible individuals in Delaware participated in WIC in 2017

WHO PARTICIPATES IN WIC?

19,766
WIC PARTICIPANTS

Delaware WIC participation in 2018

Pregnant women	1,590
Breastfeeding women	1,421
Postpartum women	1,318
Infants	5,838
Children	9,599

BREASTFEEDING IN WIC

Delaware WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Delaware in 2018, **20 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN DELAWARE

The obesity rate among WIC toddlers in Delaware decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN DELAWARE

Maternal mortality per 100,000 births, 2010–2015	**14.0**
Infant mortality per 1,000 live births, 2017	**7.1**
Preterm birth rates, 2017	**10%**

DELAWARE WIC PARTICIPANT CHARACTERISTICS

$17,324
average family income in 2018

42%
received Medicaid in 2018

$33.89
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE DELAWARE ECONOMY IN FY 2019

$6.7M
to spend at food retailers

$5.3M
formula rebates received

$5.4M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE DISTRICT OF COLUMBIA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
DC WIC received at least 6 waivers, including physical presence and extended certification periods for children.

46%
of infants born in the District of Columbia participated in WIC in 2017

46%
of eligible individuals in the District of Columbia participated in WIC in 2017

WHO PARTICIPATES IN WIC?

15,539
WIC PARTICIPANTS

District of Columbia WIC participation in 2018

Pregnant women	1,161
Breastfeeding women	1,623
Postpartum women	1,039
Infants	4,399
Children	7,317

BREASTFEEDING IN WIC

The District of Columbia WIC breastfeeding initiation rates increased by **23 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in the District of Columbia in 2018, **33 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN THE DISTRICT OF COLUMBIA

The obesity rate among WIC toddlers in the District of Columbia decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**11%**

MORTALITY AND BIRTH OUTCOMES IN THE DISTRICT OF COLUMBIA

Maternal mortality per 100,000 births, 2010–2015	**36.1**
Infant mortality per 1,000 live births, 2017	**7.7**
Preterm birth rates, 2017	**11%**

THE DISTRICT OF COLUMBIA WIC PARTICIPANT CHARACTERISTICS

$8,958
average family income in 2018

60%
received Medicaid in 2018

$43.23
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE DISTRICT OF COLUMBIA ECONOMY IN FY 2019

$6.1M
to spend at food retailers

$3.4M
formula rebates received

$5.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE EASTERN BAND OF CHEROKEE INDIANS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Eastern Band of Cherokee WIC received at least 3 waivers, including physical presence and remote benefit issuance.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Eastern Band of Cherokee Indians WIC participation in 2018

665
WIC PARTICIPANTS

Pregnant women	53
Breastfeeding women	38
Postpartum women	31
Infants	122
Children	421

EASTERN BAND OF CHEROKEE INDIANS WIC PARTICIPANT CHARACTERISTICS

$7,144
average family income in 2018

97%
received Medicaid in 2018

$34.20
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE EASTERN BAND OF CHEROKEE INDIANS ECONOMY IN FY 2019

$230,803
to spend at food retailers

$104,447
formula rebates received

$354,854
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE EASTERN SHOSHONE TRIBE

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Eastern Shoshone WIC received at least 2 waivers, including physical presence and remote benefit issuance.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

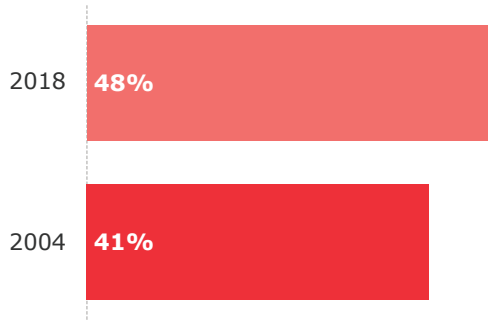
154
WIC PARTICIPANTS

Eastern Shoshone WIC participation in 2018

Pregnant women	16
Breastfeeding women	6
Postpartum women	8
Infants	39
Children	85

BREASTFEEDING IN WIC

Eastern Shoshone WIC breastfeeding initiation rates increased by **7 percentage points** between 2004 and 2018.



EASTERN SHOSHONE WIC PARTICIPANT CHARACTERISTICS

$4,911
average family income in 2018

52%
received Medicaid in 2018

$64.15
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE EASTERN SHOSHONE ECONOMY IN FY 2019

$120,544
to spend at food retailers

$249,417
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS EIGHT NORTHERN INDIAN PUEBLOS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Eight Northern WIC received at least 5 waivers, including physical presence and relief from in-person monitoring requirements.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

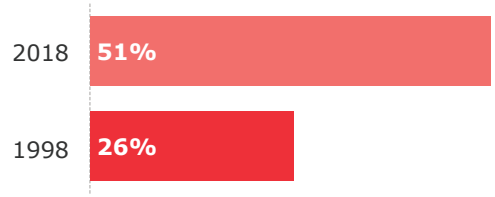
247
WIC PARTICIPANTS

Eight Northern Indian Pueblos WIC participation in 2018

Pregnant women	23
Breastfeeding women	11
Postpartum women	14
Infants	51
Children	148

BREASTFEEDING IN WIC

Eight Northern Indian Pueblos WIC breastfeeding initiation rates increased by **25 percentage points** between 1998 and 2018.



Among WIC infants who initiated breastfeeding in Eight Northern Indian Pueblos in 2018, **23 percent** continued breastfeeding at 6 months.

EIGHT NORTHERN INDIAN PUEBLOS WIC PARTICIPANT CHARACTERISTICS

$21,252
average family income in 2018

77%
received Medicaid in 2018

$59.53
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE EIGHT NORTHERN INDIAN PUEBLOS ECONOMY IN FY 2019

$183,602
to spend at food retailers

$217,439
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
FIVE SANDOVAL INDIAN PUEBLOS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Five Sandoval WIC received at least 9 waivers, including physical presence and additional options for eggs and cheese.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

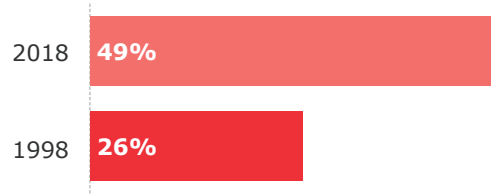
267
WIC PARTICIPANTS

Five Sandoval Indian Pueblos WIC participation in 2018

Pregnant women	17
Breastfeeding women	21
Postpartum women	17
Infants	65
Children	147

BREASTFEEDING IN WIC

Five Sandoval Indian Pueblos WIC breastfeeding initiation rates increased by **23 percentage points** between 1998 and 2018.



Among WIC infants who initiated breastfeeding in Five Sandoval Indian Pueblos in 2018, **36 percent** continued breastfeeding at 6 months.

FIVE SANDOVAL INDIAN PUEBLOS WIC PARTICIPANT CHARACTERISTICS

$18,957
average family income in 2018

77%
received Medicaid in 2018

$50.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE FIVE SANDOVAL INDIAN PUEBLOS ECONOMY IN FY 2019

$139,543
to spend at food retailers

$19,431
formula rebates received

$235,696
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
FLORIDA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Florida WIC received at least 10 waivers, including physical presence and extended certification periods for children.

57%
of infants born in Florida participated in WIC in 2017

51%
of eligible individuals in Florida participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Florida WIC participation in 2018

543,711
WIC PARTICIPANTS

Pregnant women	48,246
Breastfeeding women	56,339
Postpartum women	24,893
Infants	128,481
Children	285,752

BREASTFEEDING IN WIC

Florida WIC breastfeeding initiation rates increased by **9 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Florida in 2018, **10 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN FLORIDA

The obesity rate among WIC toddlers in Florida decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN FLORIDA

Maternal mortality per 100,000 births, 2010–2015	**23.8**
Infant mortality per 1,000 live births, 2017	**6.1**
Preterm birth rates, 2017	**10%**

FLORIDA WIC PARTICIPANT CHARACTERISTICS

$20,551
average family income in 2018

86%
received Medicaid in 2018

$45.87
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE FLORIDA ECONOMY IN FY 2019

$236.4M
to spend at food retailers

$116.9M
formula rebates received

$106.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
GEORGIA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Georgia WIC received at least 12 waivers, including physical presence and larger package sizes for whole grains.

50%
of infants born in Georgia participated in WIC in 2017

47%
of eligible individuals in Georgia participated in WIC in 2017

WHO PARTICIPATES IN WIC?

241,407
WIC PARTICIPANTS

Georgia WIC participation in 2018

Pregnant women	24,739
Breastfeeding women	17,252
Postpartum women	18,094
Infants	64,550
Children	116,772

BREASTFEEDING IN WIC

Georgia WIC breastfeeding initiation rates increased by **10 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Georgia in 2018, **19 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN GEORGIA

The obesity rate among WIC toddlers in Georgia decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN GEORGIA

Maternal mortality per 100,000 births, 2010–2015	**46.2**
Infant mortality per 1,000 live births, 2017	**7.3**
Preterm birth rates, 2017	**11%**

GEORGIA WIC PARTICIPANT CHARACTERISTICS

$15,200
average family income in 2018

70%
received Medicaid in 2018

$40.51
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE GEORGIA ECONOMY IN FY 2019

$98.6M
to spend at food retailers

$60.9M
formula rebates received

$63.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
GUAM

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Guam WIC received at least 11 waivers, including physical presence and extended certification periods for children.

38%
of infants born in Guam participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Guam WIC participation in 2018

7,175
WIC PARTICIPANTS

Pregnant women	542
Breastfeeding women	455
Postpartum women	374
Infants	1,269
Children	4,535

BREASTFEEDING IN WIC

Guam WIC breastfeeding initiation rates increased by **21 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Guam in 2018, **26 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN GUAM

The obesity rate among WIC toddlers in Guam decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **8%**

GUAM WIC PARTICIPANT CHARACTERISTICS

$17,940
average family income in 2018

53%
received Medicaid in 2018

$71.09
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE GUAM ECONOMY IN FY 2019

$5.6M
to spend at food retailers

$1.8M
formula rebates received

$3.0M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
HAWAII

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Hawaii WIC completed EBT/e-WIC rollout during the pandemic. Hawaii received at least 11 waivers, including physical presence and extended certification periods for children.

42%
of infants born in Hawaii participated in WIC in 2017

43%
of eligible individuals in Hawaii participated in WIC in 2017

WHO PARTICIPATES IN WIC?

32,197
WIC PARTICIPANTS

Hawaii WIC participation in 2018

Pregnant women	2,479
Breastfeeding women	3,455
Postpartum women	1,388
Infants	7,276
Children	17,599

BREASTFEEDING IN WIC

Hawaii WIC breastfeeding initiation rates increased by **4 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Hawaii in 2018, **35 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN HAWAII

The obesity rate among WIC toddlers in Hawaii decreased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**10%**

MORTALITY AND BIRTH OUTCOMES IN HAWAII

Maternal mortality per 100,000 births, 2010–2015	**11.7**
Infant mortality per 1,000 live births, 2017	**5.7**
Preterm birth rates, 2017	**10%**

HAWAII WIC PARTICIPANT CHARACTERISTICS

$26,215
average family income in 2018

69%
received Medicaid in 2018

$54.82
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE HAWAII ECONOMY IN FY 2019

$16.8M
to spend at food retailers

$5.8M
formula rebates received

$9.2M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
IDAHO

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Idaho WIC received at least 8 waivers, including physical presence and extended certification periods for children.

39%
of infants born in Idaho participated in WIC in 2017

42%
of eligible individuals in Idaho participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Idaho WIC participation in 2018

37,264
WIC PARTICIPANTS

Pregnant women	3,131
Breastfeeding women	3,388
Postpartum women	1,893
Infants	8,680
Children	20,172

BREASTFEEDING IN WIC

Idaho WIC breastfeeding initiation rates increased by **4 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Idaho in 2018, **43 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN IDAHO

The obesity rate among WIC toddlers in Idaho decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**11%**

MORTALITY AND BIRTH OUTCOMES IN IDAHO

Maternal mortality per 100,000 births, 2010–2015	**21.2**
Infant mortality per 1,000 live births, 2017	**5.2**
Preterm birth rates, 2017	**9%**

IDAHO WIC PARTICIPANT CHARACTERISTICS

$22,406
average family income in 2018

75%
received Medicaid in 2018

$32.74
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE IDAHO ECONOMY IN FY 2019

$12.2M
to spend at food retailers

$6.4M
formula rebates received

$8.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
ILLINOIS

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Illinois WIC completed EBT/e-WIC rollout during the pandemic. Illinois received at least 9 waivers, including physical presence and larger package sizes for whole grains.

42%
of infants born in Illinois participated in WIC in 2017

42%
of eligible individuals in Illinois participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Illinois WIC participation in 2018

232,543
WIC PARTICIPANTS

Pregnant women	19,362
Breastfeeding women	17,452
Postpartum women	20,014
Infants	62,601
Children	113,114

BREASTFEEDING IN WIC

Illinois WIC breastfeeding initiation rates increased by **9 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Illinois in 2018, **22 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN ILLINOIS

The obesity rate among WIC toddlers in Illinois decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN ILLINOIS

Maternal mortality per 100,000 births, 2010–2015	**16.6**
Infant mortality per 1,000 live births, 2017	**6.3**
Preterm birth rates, 2017	**10%**

ILLINOIS WIC PARTICIPANT CHARACTERISTICS

$17,342
average family income in 2018

86%
received Medicaid in 2018

$48.76
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ILLINOIS ECONOMY IN FY 2019

$106.7M
to spend at food retailers

$61.7M
formula rebates received

$52.2M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE INDIAN TOWNSHIP PASSAMAQUODDY RESERVATION

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MISSION OF WIC
Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Indian Township Passamaquoddy WIC received at least 2 waivers, including physical presence and remote benefit issuance.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

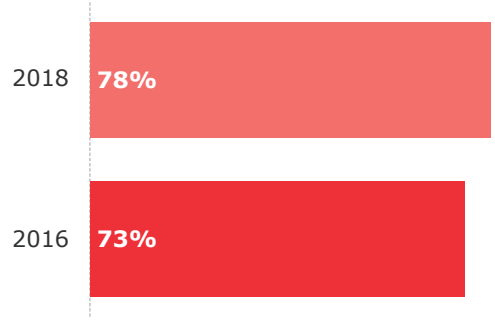
66
WIC PARTICIPANTS

Indian Township Passamaquoddy WIC participation in 2018

Women	22
Infants	16
Children	28

BREASTFEEDING IN WIC

Indian Township Passamaquoddy WIC breastfeeding initiation rates increased by **5 percentage points** between 2016 and 2018.



INDIAN TOWNSHIP PASSAMAQUODDY WIC PARTICIPANT CHARACTERISTICS

$11,600
average family income in 2018

68%
received Medicaid in 2018

$72.31
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE INDIAN TOWNSHIP PASSAMAQUODDY ECONOMY IN FY 2019

$56,690
to spend at food retailers

$45,389
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
INDIANA

State WIC Director
Laura Chavez
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Indianapolis, IN 46204

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Indiana WIC received at least 8 waivers, including larger package sizes for whole grains and eggs.

51%
of infants born in Indiana participated in WIC in 2017

48%
of eligible individuals in Indiana participated in WIC in 2017

WHO PARTICIPATES IN WIC?

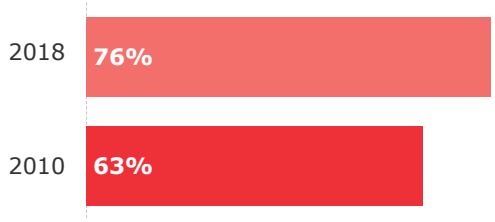
Indiana WIC participation in 2018

168,412
WIC PARTICIPANTS

Pregnant women	12,935
Breastfeeding women	12,210
Postpartum women	12,907
Infants	41,940
Children	88,420

BREASTFEEDING IN WIC

Indiana WIC breastfeeding initiation rates increased by **13 percentage points** between 2010 and 2018.



CHILDHOOD OBESITY IN WIC IN INDIANA

The obesity rate among WIC toddlers in Indiana decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN INDIANA

Maternal mortality per 100,000 births, 2010–2015	**41.4**
Infant mortality per 1,000 live births, 2017	**7.3**
Preterm birth rates, 2017	**10%**

INDIANA WIC PARTICIPANT CHARACTERISTICS

$18,653
average family income in 2018

68%
received Medicaid in 2018

$33.06
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE INDIANA ECONOMY IN FY 2019

$55.0M
to spend at food retailers

$39.5M
formula rebates received

$38.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
IOWA

State WIC Director
Kimberly Stanek
321 E 12th St,
Des Moines, IA 50319

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Iowa WIC received at least 5 waivers, including physical presence and relief from in-person monitoring requirements.

41%
of infants born in Iowa participated in WIC in 2017

51%
of eligible individuals in Iowa participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Iowa WIC participation in 2018

70,601
WIC PARTICIPANTS

Pregnant women	5,316
Breastfeeding women	4,636
Postpartum women	5,771
Infants	15,659
Children	39,219

BREASTFEEDING IN WIC

Iowa WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Iowa in 2018, **19 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN IOWA

The obesity rate among WIC toddlers in Iowa decreased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN IOWA

Maternal mortality per 100,000 births, 2010–2015	**17.9**
Infant mortality per 1,000 live births, 2017	**5.6**
Preterm birth rates, 2017	**9%**

IOWA WIC PARTICIPANT CHARACTERISTICS

$26,141
average family income in 2018

67%
received Medicaid in 2018

$31.71
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE IOWA ECONOMY IN FY 2019

$22.1M
to spend at food retailers

$17.0M
formula rebates received

$16.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
PUEBLO OF ISLETA

State WIC Director
Mary Dominguez
4 Sagebrush,
Albuquerque, NM 87105

Phone: 505-869-2662
Email: POI30001@isletapueblo.com

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Isleta Pueblo WIC received at least 7 waivers, including physical presence and larger package sizes for whole grains, cereals, and cheese.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

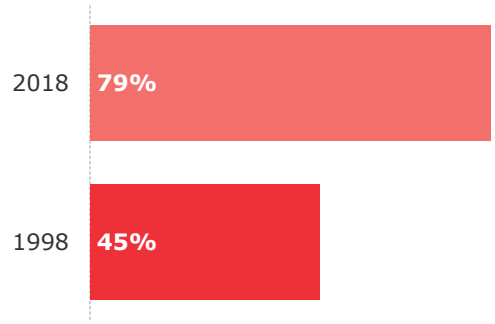
1,723
WIC PARTICIPANTS

Isleta WIC participation in 2018

Pregnant women	102
Breastfeeding women	205
Postpartum women	91
Infants	496
Children	829

BREASTFEEDING IN WIC

Isleta WIC breastfeeding initiation rates increased by **34 percentage points** between 1998 and 2018.



ISLETA WIC PARTICIPANT CHARACTERISTICS

$20,651
average family income in 2018

84%
received Medicaid in 2018

$44.60
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ISLETA ECONOMY IN FY 2019

$607,612
to spend at food retailers

$212,468
formula rebates received

$468,354
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE INTER-TRIBAL COUNCIL OF ARIZONA

State WIC Director
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MISSION OF WIC
Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
ITCA WIC received at least 15 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

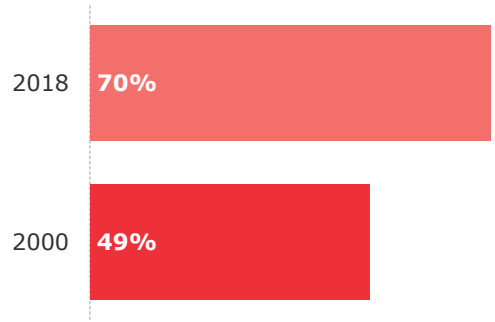
10,729
WIC PARTICIPANTS

Pregnant women	715
Breastfeeding women	576
Postpartum women	794
Infants	2,288
Children	6,356

The Inter-Tribal Council of Arizona WIC participation in 2018

BREASTFEEDING IN WIC

The Inter-Tribal Council of Arizona WIC breastfeeding initiation rates increased by **21 percentage points** between 2000 and 2018.



INTER-TRIBAL COUNCIL OF ARIZONA WIC PARTICIPANT CHARACTERISTICS

$18,773
average family income in 2018

83%
received Medicaid in 2018

$31.92
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE INTER-TRIBAL COUNCIL OF ARIZONA ECONOMY IN FY 2019

$2.9M
to spend at food retailers

$2.0M
formula rebates received

$3.3M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE INTER-TRIBAL COUNCIL OF NEVADA

State WIC Director
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Sparks, NV 89431-3100

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MISSION OF WIC
Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
ITCN WIC received at least 7 waivers, including physical presence and extension of medical documentation for special infant formulas.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

1,736
WIC PARTICIPANTS

The Inter-Tribal Council of Nevada WIC participation in 2018

Pregnant women	125
Breastfeeding women	104
Postpartum women	137
Infants	404
Children	966

BREASTFEEDING IN WIC

The Inter-Tribal Council of Nevada WIC breastfeeding initiation rates increased by **5 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in the Inter-Tribal Council of Nevada in 2018, **10 percent** continued breastfeeding at 6 months.

INTER-TRIBAL COUNCIL OF NEVADA WIC PARTICIPANT CHARACTERISTICS

$19,490
average family income in 2018

33%
received Medicaid in 2018

$29.85
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE INTER-TRIBAL COUNCIL OF NEVADA ECONOMY IN FY 2019

$440,191
to spend at food retailers

$325,493
formula rebates received

$623,202
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE INTER-TRIBAL COUNCIL OF OKLAHOMA

State WIC Director
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Miami, OK 74354

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MISSION OF WIC
Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
ITCO WIC received at least 5 waivers, including physical presence and vendor-related flexibilities.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

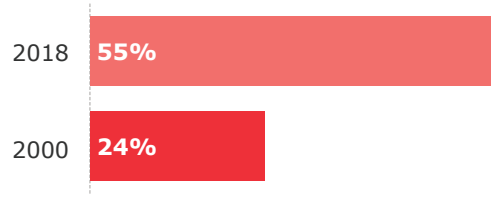
786
WIC PARTICIPANTS

Pregnant women	55
Breastfeeding women	47
Postpartum women	81
Infants	196
Children	407

The Inter-Tribal Council of Oklahoma WIC participation in 2018

BREASTFEEDING IN WIC

The Inter-Tribal Council of Oklahoma WIC breastfeeding initiation rates increased by **31 percentage points** between 2000 and 2018.



Among WIC infants who initiated breastfeeding in the Inter-Tribal Council of Oklahoma in 2018, **16 percent** continued breastfeeding at 6 months.

INTER-TRIBAL COUNCIL OF OKLAHOMA WIC PARTICIPANT CHARACTERISTICS

$23,164
average family income in 2018

31%
received Medicaid in 2018

$53.93
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE INTER-TRIBAL COUNCIL OF OKLAHOMA ECONOMY IN FY 2019

$478,207
to spend at food retailers

$73,715
formula rebates received

$345,704
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
KANSAS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Kansas WIC received at least 8 waivers, including physical presence and extended certification periods for children.

40%
of infants born in Kansas participated in WIC in 2017

41%
of eligible individuals in Kansas participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Kansas WIC participation in 2018

62,761
WIC PARTICIPANTS

Pregnant women	5,241
Breastfeeding women	4,483
Postpartum women	4,341
Infants	14,674
Children	34,022

BREASTFEEDING IN WIC

Kansas WIC breastfeeding initiation rates increased by **8 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Kansas in 2018, **22 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN KANSAS

The obesity rate among WIC toddlers in Kansas decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN KANSAS

Maternal mortality per 100,000 births, 2010–2015	**17.7**
Infant mortality per 1,000 live births, 2017	**6.0**
Preterm birth rates, 2017	**10%**

KANSAS WIC PARTICIPANT CHARACTERISTICS

$22,213
average family income in 2018

65%
received Medicaid in 2018

$34.36
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE KANSAS ECONOMY IN FY 2019

$20.0M
to spend at food retailers

$13.5M
formula rebates received

$17.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
KENTUCKY

State WIC Director
Nicole Nicholas
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Frankfort, KY 40621-0001

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Kentucky WIC received at least 7 waivers, including physical presence and relief from in-person monitoring requirements.

57%
of infants born in Kentucky participated in WIC in 2017

49%
of eligible individuals in Kentucky participated in WIC in 2017

WHO PARTICIPATES IN WIC?

113,382
WIC PARTICIPANTS

Kentucky WIC participation in 2018

Pregnant women	11,169
Breastfeeding women	5,259
Postpartum women	10,117
Infants	31,358
Children	55,479

BREASTFEEDING IN WIC

Kentucky WIC breastfeeding initiation rates increased by **11 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Kentucky in 2018, **12 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN KENTUCKY

The obesity rate among WIC toddlers in Kentucky decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN KENTUCKY

Maternal mortality per 100,000 births, 2010–2015	**19.4**
Infant mortality per 1,000 live births, 2017	**6.7**
Preterm birth rates, 2017	**11%**

KENTUCKY WIC PARTICIPANT CHARACTERISTICS

$21,603
average family income in 2018

89%
received Medicaid in 2018

$38.93
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE KENTUCKY ECONOMY IN FY 2019

$44.1M
to spend at food retailers

$28.9M
formula rebates received

$27.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
LOUISIANA

State WIC Director
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Email: Jennifer.Nicklas@la.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Louisiana WIC received at least 8 waivers, including physical presence and extended benefit issuance periods.

62%
of infants born in Louisiana participated in WIC in 2017

47%
of eligible individuals in Louisiana participated in WIC in 2017

WHO PARTICIPATES IN WIC?

127,365
WIC PARTICIPANTS

Louisiana WIC participation in 2018

Pregnant women	12,160
Breastfeeding women	5,038
Postpartum women	14,981
Infants	37,779
Children	57,407

BREASTFEEDING IN WIC

Louisiana WIC breastfeeding initiation rates increased by **17 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Louisiana in 2018, **11 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN LOUISIANA

The obesity rate among WIC toddlers in Louisiana decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	13%

MORTALITY AND BIRTH OUTCOMES IN LOUISIANA

Maternal mortality per 100,000 births, 2010–2015	44.8
Infant mortality per 1,000 live births, 2017	7.5
Preterm birth rates, 2017	13%

LOUISIANA WIC PARTICIPANT CHARACTERISTICS

$14,262
average family income in 2018

89%
received Medicaid in 2018

$46.85
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE LOUISIANA ECONOMY IN FY 2019

$58.0M
to spend at food retailers

$35.0M
formula rebates received

$34.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MAINE

State WIC Director
Ginger Roberts-Scott
286 Water St 4th Floor,
Augusta, ME 04333-0001

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Maine WIC completed EBT/e-WIC rollout during the pandemic. Maine received at least 5 waivers, including physical presence and larger package sizes for eggs.

35%
of infants born in Maine participated in WIC in 2017

50%
of eligible individuals in Maine participated in WIC in 2017

WHO PARTICIPATES IN WIC?

20,172
WIC PARTICIPANTS

Maine WIC participation in 2018

Pregnant women	1,675
Breastfeeding women	1,455
Postpartum women	1,297
Infants	4,288
Children	11,457

BREASTFEEDING IN WIC

Maine WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Maine in 2018, **30 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MAINE

The obesity rate among WIC toddlers in Maine decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN MAINE

Maternal mortality per 100,000 births, 2010–2015	**15.7**
Infant mortality per 1,000 live births, 2017	**5.8**
Preterm birth rates, 2017	**9%**

MAINE WIC PARTICIPANT CHARACTERISTICS

$20,045
average family income in 2018

75%
received Medicaid in 2018

$40.57
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MAINE ECONOMY IN FY 2019

$8.5M
to spend at food retailers

$4.3M
formula rebates received

$6.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MARYLAND

State WIC Director
Jennifer Wilson
201 W Preston St, 1st Floor,
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Maryland WIC received at least 12 waivers, including physical presence and extended certification periods for children.

51%
of infants born in Maryland participated in WIC in 2017

64%
of eligible individuals in Maryland participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Maryland WIC participation in 2018

144,160
WIC PARTICIPANTS

Pregnant women	11,484
Breastfeeding women	15,155
Postpartum women	6,590
Infants	36,712
Children	74,219

BREASTFEEDING IN WIC

Maryland WIC breastfeeding initiation rates increased by **12 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Maryland in 2018, **32 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MARYLAND

The obesity rate among WIC toddlers in Maryland decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN MARYLAND

Maternal mortality per 100,000 births, 2010–2015	**23.5**
Infant mortality per 1,000 live births, 2017	**6.5**
Preterm birth rates, 2017	**11%**

MARYLAND WIC PARTICIPANT CHARACTERISTICS

$20,090
average family income in 2018

80%
received Medicaid in 2018

$37.27
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MARYLAND ECONOMY IN FY 2019

$54.8M
to spend at food retailers

$31.0M
formula rebates received

$36.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MASSACHUSETTS

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Massachusetts WIC received at least 11 waivers, including physical presence and larger package sizes for whole grains.

43%
of infants born in Massachusetts participated in WIC in 2017

56%
of eligible individuals in Massachusetts participated in WIC in 2017

WHO PARTICIPATES IN WIC?

117,693
WIC PARTICIPANTS

Massachusetts WIC participation in 2018

Pregnant women	10,109
Breastfeeding women	9,460
Postpartum women	7,395
Infants	30,181
Children	60,548

BREASTFEEDING IN WIC

Massachusetts WIC breastfeeding initiation rates increased by **6 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Massachusetts in 2018, **29 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MASSACHUSETTS

The obesity rate among WIC toddlers in Massachusetts decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN MASSACHUSETTS

Maternal mortality per 100,000 births, 2010–2015	**6.1**
Infant mortality per 1,000 live births, 2017	**3.8**
Preterm birth rates, 2017	**9%**

MASSACHUSETTS WIC PARTICIPANT CHARACTERISTICS

$19,765
average family income in 2018

90%
received Medicaid in 2018

$38.90
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MASSACHUSETTS ECONOMY IN FY 2019

$48.2M
to spend at food retailers

$24.5M
formula rebates received

$24.4M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MICHIGAN

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Michigan WIC received at least 8 waivers, including physical presence and extended certification periods for children.

48%
of infants born in Michigan participated in WIC in 2017

53%
of eligible individuals in Michigan participated in WIC in 2017

WHO PARTICIPATES IN WIC?

238,396
WIC PARTICIPANTS

Michigan WIC participation in 2018

Pregnant women	17,939
Breastfeeding women	11,799
Postpartum women	19,800
Infants	53,413
Children	135,445

BREASTFEEDING IN WIC

Michigan WIC breastfeeding initiation rates increased by **13 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Michigan in 2018, **14 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MICHIGAN

The obesity rate among WIC toddlers in Michigan decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN MICHIGAN

Maternal mortality per 100,000 births, 2010–2015	**19.4**
Infant mortality per 1,000 live births, 2017	**6.6**
Preterm birth rates, 2017	**10%**

MICHIGAN WIC PARTICIPANT CHARACTERISTICS

$18,229
average family income in 2018

82%
received Medicaid in 2018

$36.99
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MICHIGAN ECONOMY IN FY 2019

$91.2M
to spend at food retailers

$52.1M
formula rebates received

$57.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MINNESOTA

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Minnesota WIC received at least 11 waivers, including physical presence and extended certification periods for children.

36%
of infants born in Minnesota participated in WIC in 2017

59%
of eligible individuals in Minnesota participated in WIC in 2017

WHO PARTICIPATES IN WIC?

117,229
WIC PARTICIPANTS

Minnesota WIC participation in 2018

Pregnant women	9,277
Breastfeeding women	10,140
Postpartum women	6,668
Infants	24,983
Children	66,161

BREASTFEEDING IN WIC

Minnesota WIC breastfeeding initiation rates increased by **6 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Minnesota in 2018, **34 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MINNESOTA

The obesity rate among WIC toddlers in Minnesota decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN MINNESOTA

Maternal mortality per 100,000 births, 2010–2015	**13.0**
Infant mortality per 1,000 live births, 2017	**5.0**
Preterm birth rates, 2017	**9%**

MINNESOTA WIC PARTICIPANT CHARACTERISTICS

$28,675
average family income in 2018

85%
received Medicaid in 2018

$38.52
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MINNESOTA ECONOMY IN FY 2019

$46.3M
to spend at food retailers

$29.0M
formula rebates received

$32.2M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE MISSISSIPPI BAND OF CHOCTAW INDIANS

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
MBCI WIC received at least 2 waivers, including physical presence and remote benefit issuance.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

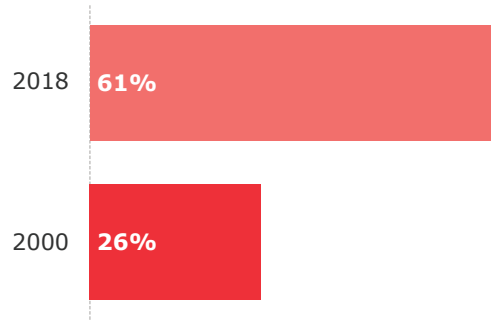
774
WIC PARTICIPANTS

Pregnant women	97
Breastfeeding women	26
Postpartum women	62
Infants	183
Children	406

Mississippi Band of Choctaw Indians WIC participation in 2018

BREASTFEEDING IN WIC

Mississippi Band of Choctaw Indians WIC breastfeeding initiation rates increased by **35 percentage points** between 2000 and 2018.



MISSISSIPPI BAND OF CHOCTAW INDIANS WIC PARTICIPANT CHARACTERISTICS

$9,838
average family income in 2018

55%
received Medicaid in 2018

$33.53
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MISSISSIPPI BAND OF CHOCTAW INDIANS ECONOMY IN FY 2019

$261,094
to spend at food retailers

$402,372
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MISSISSIPPI

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Mississippi WIC began the transition from a direct distribution system to EBT/e-WIC at retail settings during the pandemic. Mississippi received at least 5 waivers, including physical presence and relief from in-person monitoring requirements.

65%
of infants born in Mississippi participated in WIC in 2017

55%
of eligible individuals in Mississippi participated in WIC in 2017

WHO PARTICIPATES IN WIC?

94,445
WIC PARTICIPANTS

Mississippi WIC participation in 2018

Pregnant women	8,519
Breastfeeding women	3,545
Postpartum women	9,705
Infants	24,267
Children	48,409

BREASTFEEDING IN WIC

Mississippi WIC breastfeeding initiation rates increased by **9 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Mississippi in 2018, **10 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MISSISSIPPI

The obesity rate among WIC toddlers in Mississippi decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN MISSISSIPPI

Maternal mortality per 100,000 births, 2010–2015	**22.6**
Infant mortality per 1,000 live births, 2017	**8.7**
Preterm birth rates, 2017	**14%**

MISSISSIPPI WIC PARTICIPANT CHARACTERISTICS

$13,745
average family income in 2018

66%
received Medicaid in 2018

$54.70
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MISSISSIPPI ECONOMY IN FY 2019

$52.0M
to spend at food retailers

$17.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MISSOURI

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Missouri WIC completed EBT/e-WIC rollout during the pandemic. Missouri received at least 7 waivers, including physical presence and extended certification periods for children.

43%
of infants born in Missouri participated in WIC in 2017

46%
of eligible individuals in Missouri participated in WIC in 2017

WHO PARTICIPATES IN WIC?

122,864
WIC PARTICIPANTS

Missouri WIC participation in 2018

Pregnant women	11,895
Breastfeeding women	7,914
Postpartum women	11,280
Infants	31,629
Children	60,146

BREASTFEEDING IN WIC

Missouri WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Missouri in 2018, **21 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MISSOURI

The obesity rate among WIC toddlers in Missouri decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN MISSOURI

Maternal mortality per 100,000 births, 2010–2015	**32.6**
Infant mortality per 1,000 live births, 2017	**6.4**
Preterm birth rates, 2017	**11%**

MISSOURI WIC PARTICIPANT CHARACTERISTICS

$19,133
average family income in 2018

71%
received Medicaid in 2018

$34.07
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MISSOURI ECONOMY IN FY 2019

$43.6M
to spend at food retailers

$33.3M
formula rebates received

$28.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
MONTANA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Montana WIC received at least 14 waivers, including physical presence and additional varieties of fruits and vegetables.

34%
of infants born in Montana participated in WIC in 2017

36%
of eligible individuals in Montana participated in WIC in 2017

WHO PARTICIPATES IN WIC?

18,288
WIC PARTICIPANTS

Montana WIC participation in 2018

Pregnant women	1,528
Breastfeeding women	1,395
Postpartum women	1,008
Infants	4,013
Children	10,344

BREASTFEEDING IN WIC

Montana WIC breastfeeding initiation rates increased by **6 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Montana in 2018, **29 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN MONTANA

The obesity rate among WIC toddlers in Montana decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN MONTANA

Maternal mortality per 100,000 births, 2010–2015	**24.4**
Infant mortality per 1,000 live births, 2017	**5.7**
Preterm birth rates, 2017	**10%**

MONTANA WIC PARTICIPANT CHARACTERISTICS

$17,328
average family income in 2018

53%
received Medicaid in 2018

$34.64
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MONTANA ECONOMY IN FY 2019

$6.5M
to spend at food retailers

$3.6M
formula rebates received

$6.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
THE MUSCOGEE CREEK NATION

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Muscogee Creek WIC received at least 5 waivers, including physical presence and vendor-related flexibilities.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

2,662
WIC PARTICIPANTS

Muscogee Creek WIC participation in 2018

Pregnant women	209
Breastfeeding women	85
Postpartum women	202
Infants	532
Children	1,634

BREASTFEEDING IN WIC

Muscogee Creek WIC breastfeeding initiation rates increased by **14 percentage points** between 2000 and 2018.

Among WIC infants who initiated breastfeeding in Muscogee Creek in 2018, **20 percent** continued breastfeeding at 6 months.

MUSCOGEE CREEK WIC PARTICIPANT CHARACTERISTICS

$17,178
average family income in 2018

84%
received Medicaid in 2018

$35.57
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE MUSCOGEE CREEK ECONOMY IN FY 2019

$972,960
to spend at food retailers

$563,448
formula rebates received

$865,450
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE NAVAJO NATION

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Navajo Nation WIC received at least 13 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

8,840
WIC PARTICIPANTS

Navajo Nation WIC participation in 2018

Pregnant women	823
Breastfeeding women	648
Postpartum women	332
Infants	1,428
Children	5,609

BREASTFEEDING IN WIC

78% of WIC infants in Navajo Nation initiated breastfeeding in April 2018

Among WIC infants who initiated breastfeeding in Navajo Nation in 2018, **34 percent** continued breastfeeding at 6 months.

NAVAJO NATION WIC PARTICIPANT CHARACTERISTICS

$19,161
average family income in 2018

77%
received Medicaid in 2018

$40.85
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NAVAJO NATION ECONOMY IN FY 2019

$3.4M
to spend at food retailers

$1.3M
formula rebates received

$3.2M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NEBRASKA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Nebraska WIC received at least 15 waivers, including physical presence and larger package sizes for whole grains.

39%
of infants born in Nebraska participated in WIC in 2017

49%
of eligible individuals in Nebraska participated in WIC in 2017

WHO PARTICIPATES IN WIC?

40,080
WIC PARTICIPANTS

Nebraska WIC participation in 2018

Pregnant women	3,117
Breastfeeding women	3,294
Postpartum women	3,278
Infants	10,129
Children	20,262

BREASTFEEDING IN WIC

Nebraska WIC breastfeeding initiation rates increased by **11 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Nebraska in 2018, **20 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NEBRASKA

The obesity rate among WIC toddlers in Nebraska increased by **<1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN NEBRASKA

Maternal mortality per 100,000 births, 2010–2015	**16.8**
Infant mortality per 1,000 live births, 2017	**5.8**
Preterm birth rates, 2017	**10%**

NEBRASKA WIC PARTICIPANT CHARACTERISTICS

$22,284
average family income in 2018

64%
received Medicaid in 2018

$39.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEBRASKA ECONOMY IN FY 2019

$16.0M
to spend at food retailers

$8.7M
formula rebates received

$10.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NEVADA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Nevada WIC received at least 7 waivers, including physical presence and aggregate family purchasing for whole grains and cheese.

51%
of infants born in Nevada participated in WIC in 2017

48%
of eligible individuals in Nevada participated in WIC in 2017

WHO PARTICIPATES IN WIC?

73,301
WIC PARTICIPANTS

Nevada WIC participation in 2018

Pregnant women	5,182
Breastfeeding women	5,322
Postpartum women	6,423
Infants	18,396
Children	37,978

BREASTFEEDING IN WIC

Nevada WIC breastfeeding initiation rates increased by **4 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Nevada in 2018, **13 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NEVADA

The obesity rate among WIC toddlers in Nevada decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN NEVADA

Maternal mortality per 100,000 births, 2010–2015	**6.2**
Infant mortality per 1,000 live births, 2017	**5.8**
Preterm birth rates, 2017	**11%**

NEVADA WIC PARTICIPANT CHARACTERISTICS

$18,887
average family income in 2018

36%
received Medicaid in 2018

$36.46
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEVADA ECONOMY IN FY 2019

$25.7M
to spend at food retailers

$16.5M
formula rebates received

$15.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NEW HAMPSHIRE

State WIC Director
Lissa Sirois
29 Hazen Dr,
Concord, NH 03301

Phone: 603-271-4544
Email: Lissa.Sirois@dhhs.nh.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
New Hampshire WIC received at least 11 waivers, including physical presence and extended certification periods for children.

28%
of infants born in New Hampshire participated in WIC in 2017

37%
of eligible individuals in New Hampshire participated in WIC in 2017

WHO PARTICIPATES IN WIC?

New Hampshire WIC participation in 2018

14,961
WIC PARTICIPANTS

Pregnant women	1,103
Breastfeeding women	1,087
Postpartum women	993
Infants	3,384
Children	8,394

BREASTFEEDING IN WIC

New Hampshire WIC breastfeeding initiation rates increased by **8 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in New Hampshire in 2018, **24 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NEW HAMPSHIRE

The obesity rate among WIC toddlers in New Hampshire increased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**16%**

MORTALITY AND BIRTH OUTCOMES IN NEW HAMPSHIRE

Maternal mortality per 100,000 births, 2010–2015	**16.8**
Infant mortality per 1,000 live births, 2017	**3.9**
Preterm birth rates, 2017	**8%**

NEW HAMPSHIRE WIC PARTICIPANT CHARACTERISTICS

$22,911
average family income in 2018

79%
received Medicaid in 2018

$27.33
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEW HAMPSHIRE ECONOMY IN FY 2019

$4.0M
to spend at food retailers

$3.1M
formula rebates received

$4.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NEW JERSEY

State WIC Director
Nancy Scotto
PO Box 364,
Trenton, NJ 08625-0364

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Email: Nancy.Scotto-Rosato@doh.nj.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
New Jersey WIC received at least 12 waivers, including physical presence and larger package sizes for whole grains.

33%
of infants born in New Jersey participated in WIC in 2017

53%
of eligible individuals in New Jersey participated in WIC in 2017

WHO PARTICIPATES IN WIC?

New Jersey WIC participation in 2018

140,842
WIC PARTICIPANTS

Pregnant women	12,558
Breastfeeding women	13,730
Postpartum women	7,016
Infants	33,787
Children	73,751

BREASTFEEDING IN WIC

New Jersey WIC breastfeeding initiation rates increased by **14 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in New Jersey in 2018, **39 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NEW JERSEY

The obesity rate among WIC toddlers in New Jersey decreased by **4 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN NEW JERSEY

Maternal mortality per 100,000 births, 2010–2015	**38.1**
Infant mortality per 1,000 live births, 2017	**4.2**
Preterm birth rates, 2017	**10%**

NEW JERSEY WIC PARTICIPANT CHARACTERISTICS

$21,433
average family income in 2018

34%
received Medicaid in 2018

$56.78
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEW JERSEY ECONOMY IN FY 2019

$91.9M
to spend at food retailers

$33.8M
formula rebates received

$35.9M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
NEW MEXICO

State WIC Director
Sarah Flores-Sievers
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Santa Fe, NM 87505

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Email: Sarah.flores-siever@state.nm.us

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
New Mexico WIC received at least 9 waivers, including physical presence and extended benefit issuance periods.

50%
of infants born in New Mexico participated in WIC in 2017

42%
of eligible individuals in New Mexico participated in WIC in 2017

WHO PARTICIPATES IN WIC?

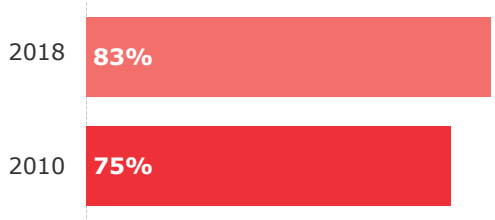
52,006
WIC PARTICIPANTS

New Mexico WIC participation in 2018

Pregnant women	4,655
Breastfeeding women	5,408
Postpartum women	2,260
Infants	11,978
Children	27,705

BREASTFEEDING IN WIC

New Mexico WIC breastfeeding initiation rates increased by **8 percentage points** between 2010 and 2018.



CHILDHOOD OBESITY IN WIC IN NEW MEXICO

The obesity rate among WIC toddlers in New Mexico decreased by **4 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN NEW MEXICO

Maternal mortality per 100,000 births, 2010–2015	**25.6**
Infant mortality per 1,000 live births, 2017	**6.0**
Preterm birth rates, 2017	**10%**

NEW MEXICO WIC PARTICIPANT CHARACTERISTICS

$19,815
average family income in 2018

75%
received Medicaid in 2018

$35.91
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEW MEXICO ECONOMY IN FY 2019

$17.4M
to spend at food retailers

$10.5M
formula rebates received

$17.6M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NEW YORK

State WIC Director
Corie Nadzan
150 Broadway, Ste 650,
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Email: Corie.nadzan@health.ny.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
New York WIC received at least 5 waivers, including physical presence and relief from in-person monitoring requirements.

49%
of infants born in New York participated in WIC in 2017

54%
of eligible individuals in New York participated in WIC in 2017

WHO PARTICIPATES IN WIC?

487,913
WIC PARTICIPANTS

New York WIC participation in 2018

Pregnant women	38,972
Breastfeeding women	52,010
Postpartum women	23,804
Infants	111,724
Children	261,403

BREASTFEEDING IN WIC

New York WIC breastfeeding initiation rates increased by **10 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in New York in 2018, **37 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NEW YORK

The obesity rate among WIC toddlers in New York decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN NEW YORK

Maternal mortality per 100,000 births, 2010–2015	**20.6**
Infant mortality per 1,000 live births, 2017	**4.6**
Preterm birth rates, 2017	**9%**

NEW YORK WIC PARTICIPANT CHARACTERISTICS

$19,539
average family income in 2018

89%
received Medicaid in 2018

$52.32
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NEW YORK ECONOMY IN FY 2019

$237.9M
to spend at food retailers

$100.8M
formula rebates received

$147.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NORTH CAROLINA

State WIC Director
Mary Anne Burghardt
5601 Six Forks Rd 1st Floor,
Raleigh, NC 27699

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Email: maryanne.burghardt@dhhs.nc.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
North Carolina WIC received at least 11 waivers, including physical presence and larger package sizes for whole grains.

53%
of infants born in North Carolina participated in WIC in 2017

51%
of eligible individuals in North Carolina participated in WIC in 2017

WHO PARTICIPATES IN WIC?

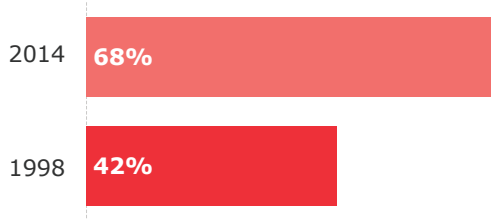
267,289
WIC PARTICIPANTS

North Carolina WIC participation in 2018

Pregnant women	23,545
Breastfeeding women	20,179
Postpartum women	18,833
Infants	63,818
Children	140,914

BREASTFEEDING IN WIC

North Carolina WIC breastfeeding initiation rates increased by **26 percentage points** between 1998 and 2014.



CHILDHOOD OBESITY IN WIC IN NORTH CAROLINA

The obesity rate among WIC toddlers in North Carolina increased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN NORTH CAROLINA

Maternal mortality per 100,000 births, 2010–2015	**15.8**
Infant mortality per 1,000 live births, 2017	**7.1**
Preterm birth rates, 2017	**11%**

NORTH CAROLINA WIC PARTICIPANT CHARACTERISTICS

$13,783
average family income in 2018

84%
received Medicaid in 2018

$37.23
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NORTH CAROLINA ECONOMY IN FY 2019

$92.6M
to spend at food retailers

$57.2M
formula rebates received

$58.6M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NORTH DAKOTA

State WIC Director
Colleen Pearce
600 E Boulevard Ave Dept 301,
Bismarck, ND 58505-0200

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Email: cpearce@nd.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
North Dakota WIC completed EBT/e-WIC rollout during the pandemic. North Dakota received at least 5 waivers, including physical presence and larger package sizes for whole grains.

30%
of infants born in North Dakota participated in WIC in 2017

51%
of eligible individuals in North Dakota participated in WIC in 2017

WHO PARTICIPATES IN WIC?

13,326
WIC PARTICIPANTS

North Dakota WIC participation in 2018

Pregnant women	1,038
Breastfeeding women	937
Postpartum women	1,045
Infants	3,190
Children	7,116

BREASTFEEDING IN WIC

North Dakota WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in North Dakota in 2018, **23 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN NORTH DAKOTA

The obesity rate among WIC toddlers in North Dakota decreased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN NORTH DAKOTA

Maternal mortality per 100,000 births, 2010–2015	**18.9**
Infant mortality per 1,000 live births, 2017	**5.4**
Preterm birth rates, 2017	**9%**

NORTH DAKOTA WIC PARTICIPANT CHARACTERISTICS

$23,108
average family income in 2018

47%
received Medicaid in 2018

$48.37
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NORTH DAKOTA ECONOMY IN FY 2019

$6.6M
to spend at food retailers

$2.4M
formula rebates received

$5.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
NORTHERN ARAPAHO

State WIC Director
Shila Kazee
7 Great Plains Rd,
Arapahoe, WY 82510

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Email: shila.kazee@northernarapaho.com

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Northern Arapaho WIC received at least 2 waivers, including physical presence and remote benefit issuance.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

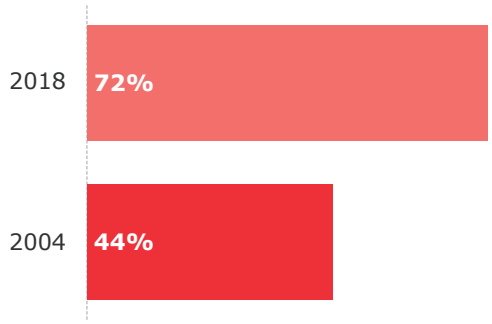
272
WIC PARTICIPANTS

Northern Arapaho WIC participation in 2018

Pregnant women	26
Breastfeeding women	17
Postpartum women	21
Infants	75
Children	133

BREASTFEEDING IN WIC

Northern Arapaho WIC breastfeeding initiation rates increased by **28 percentage points** between 2004 and 2018.



NORTHERN ARAPAHO WIC PARTICIPANT CHARACTERISTICS

$4,121
average family income in 2018

64%
received Medicaid in 2018

$68.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE NORTHERN ARAPAHO ECONOMY IN FY 2019

$165,939
to spend at food retailers

$365,219
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
OHIO

State WIC Director
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246 N High St 6th Floor,
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Ohio WIC received at least 13 waivers, including physical presence and larger package sizes for whole grains.

48%
of infants born in Ohio participated in WIC in 2017

47%
of eligible individuals in Ohio participated in WIC in 2017

WHO PARTICIPATES IN WIC?

218,648
WIC PARTICIPANTS

Ohio WIC participation in 2018

Pregnant women	19,532
Breastfeeding women	13,184
Postpartum women	19,632
Infants	66,124
Children	100,176

BREASTFEEDING IN WIC

Ohio WIC breastfeeding initiation rates increased by **15 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Ohio in 2018, **18 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN OHIO

The obesity rate among WIC toddlers in Ohio decreased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN OHIO

Maternal mortality per 100,000 births, 2010–2015	**20.3**
Infant mortality per 1,000 live births, 2017	**7.3**
Preterm birth rates, 2017	**10%**

OHIO WIC PARTICIPANT CHARACTERISTICS

$20,089
average family income in 2018

88%
received Medicaid in 2018

$31.16
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OHIO ECONOMY IN FY 2019

$72.0M
to spend at food retailers

$55.7M
formula rebates received

$55.0M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
OKLAHOMA

State WIC Director
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Oklahoma City, OK 73107-2419

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Email: TerryB@health.ok.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Oklahoma WIC received at least 8 waivers, including physical presence and extended certification periods for children.

43%
of infants born in Oklahoma participated in WIC in 2017

49%
of eligible individuals in Oklahoma participated in WIC in 2017

WHO PARTICIPATES IN WIC?

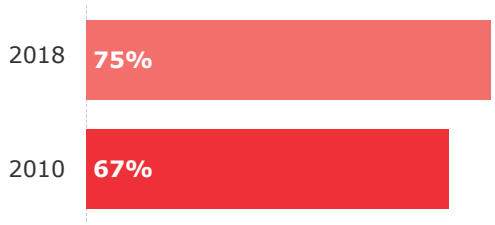
94,876
WIC PARTICIPANTS

Oklahoma WIC participation in 2018

Pregnant women	9,642
Breastfeeding women	5,587
Postpartum women	7,183
Infants	21,606
Children	50,858

BREASTFEEDING IN WIC

Oklahoma WIC breastfeeding initiation rates increased by **8 percentage points** between 2010 and 2018.



CHILDHOOD OBESITY IN WIC IN OKLAHOMA

The obesity rate among WIC toddlers in Oklahoma decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	13%

MORTALITY AND BIRTH OUTCOMES IN OKLAHOMA

Maternal mortality per 100,000 births, 2010–2015	23.4
Infant mortality per 1,000 live births, 2017	7.6
Preterm birth rates, 2017	11%

OKLAHOMA WIC PARTICIPANT CHARACTERISTICS

$19,705
average family income in 2018

79%
received Medicaid in 2018

$32.74
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OKLAHOMA ECONOMY IN FY 2019

$36.0M
to spend at food retailers

$19.0M
formula rebates received

$35.9M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
OMAHA NATION

State WIC Director
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104 Main St PO Box 337,
Macy, NE 68039

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Email: jfree@omahatribe.com

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Omaha Nation WIC received at least 4 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

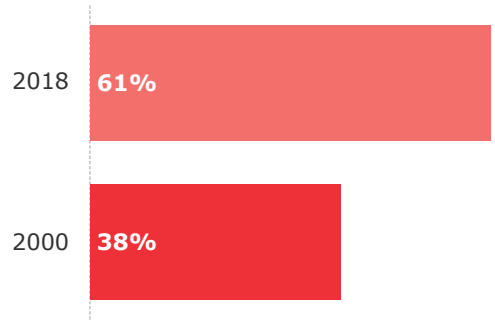
265
WIC PARTICIPANTS

Omaha Nation WIC participation in 2018

Women	36
Infants	68
Children	161

BREASTFEEDING IN WIC

Omaha Nation WIC breastfeeding initiation rates increased by **23 percentage points** between 2000 and 2018.



OMAHA NATION WIC PARTICIPANT CHARACTERISTICS

$11,271
average family income in 2018

37%
received Medicaid in 2018

$72.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OMAHA NATION ECONOMY IN FY 2019

$171,814
to spend at food retailers

$251,406
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
OREGON

State WIC Director
Tiare Sanna
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Portland, OR 97223

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Email: tiare.t.sanna@state.or.us

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Oregon WIC received at least 10 waivers, including physical presence and additional varieties of cheese, fruits, and vegetables.

42%
of infants born in Oregon participated in WIC in 2017

52%
of eligible individuals in Oregon participated in WIC in 2017

WHO PARTICIPATES IN WIC?

88,970
WIC PARTICIPANTS

Oregon WIC participation in 2018

Pregnant women	7,271
Breastfeeding women	7,501
Postpartum women	4,615
Infants	18,302
Children	51,281

BREASTFEEDING IN WIC

Oregon WIC breastfeeding initiation rates increased by **36 percentage points** between 2000 and 2018.

Among WIC infants who initiated breastfeeding in Oregon in 2018, **39 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN OREGON

The obesity rate among WIC toddlers in Oregon decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN OREGON

Maternal mortality per 100,000 births, 2010–2015	**13.7**
Infant mortality per 1,000 live births, 2017	**5.0**
Preterm birth rates, 2017	**8%**

OREGON WIC PARTICIPANT CHARACTERISTICS

$21,680
average family income in 2018

89%
received Medicaid in 2018

$35.98
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OREGON ECONOMY IN FY 2019

$35.1M
to spend at food retailers

$13.5M
formula rebates received

$23.9M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
OSAGE NATION

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Osage Nation WIC received at least 6 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

3,207
WIC PARTICIPANTS

Osage Nation WIC participation in 2018

Pregnant women	185
Breastfeeding women	167
Postpartum women	289
Infants	901
Children	1,665

BREASTFEEDING IN WIC

Osage Nation WIC breastfeeding initiation rates increased by **23 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Osage Nation in 2018, **17 percent** continued breastfeeding at 6 months.

OSAGE NATION WIC PARTICIPANT CHARACTERISTICS

$30,507
average family income in 2018

87%
received Medicaid in 2018

$28.83
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OSAGE NATION ECONOMY IN FY 2019

$1.1M
to spend at food retailers

$786,125
formula rebates received

$1.5M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
OTOE-MISSOURIA TRIBE

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Otoe-Missouria WIC received at least 4 waivers, including physical presence and larger package sizes for whole grains and eggs.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

440
WIC PARTICIPANTS

Otoe-Missouria WIC participation in 2018

Pregnant women	35
Breastfeeding women	26
Postpartum women	33
Infants	101
Children	245

BREASTFEEDING IN WIC

Otoe-Missouria WIC breastfeeding initiation rates increased by **24 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Otoe-Missouria in 2018, **15 percent** continued breastfeeding at 6 months.

OTOE-MISSOURIA WIC PARTICIPANT CHARACTERISTICS

$20,794
average family income in 2018

68%
received Medicaid in 2018

$33.45
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE OTOE-MISSOURIA ECONOMY IN FY 2019

$142,343
to spend at food retailers

$105,869
formula rebates received

$336,027
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
PENNSYLVANIA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Pennsylvania WIC completed EBT/e-WIC rollout during the pandemic. Pennsylvania received at least 8 waivers, including physical presence and extended certification periods for children.

40%
of infants born in Pennsylvania participated in WIC in 2017

48%
of eligible individuals in Pennsylvania participated in WIC in 2017

WHO PARTICIPATES IN WIC?

232,320
WIC PARTICIPANTS

Pennsylvania WIC participation in 2018

Pregnant women	17,607
Breastfeeding women	13,447
Postpartum women	18,587
Infants	55,754
Children	126,925

BREASTFEEDING IN WIC

Pennsylvania WIC breastfeeding initiation rates increased by **18 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Pennsylvania in 2018, **16 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN PENNSYLVANIA

The obesity rate among WIC toddlers in Pennsylvania decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**12%**

MORTALITY AND BIRTH OUTCOMES IN PENNSYLVANIA

Maternal mortality per 100,000 births, 2010–2015	**16.3**
Infant mortality per 1,000 live births, 2017	**6.1**
Preterm birth rates, 2017	**9%**

PENNSYLVANIA WIC PARTICIPANT CHARACTERISTICS

$20,119 average family income in 2018	**79%** received Medicaid in 2018	**$42.74** average monthly food cost in FY 2019

HOW WIC SUPPORTED THE PENNSYLVANIA ECONOMY IN FY 2019

$103.7M to spend at food retailers	**$56.0M** formula rebates received	**$53.5M** nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE PLEASANT POINT PASSAMAQUODDY RESERVATION

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Pleasant Point Passamaquoddy WIC received at least 4 waivers, including physical presence and larger package sizes for whole grains.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

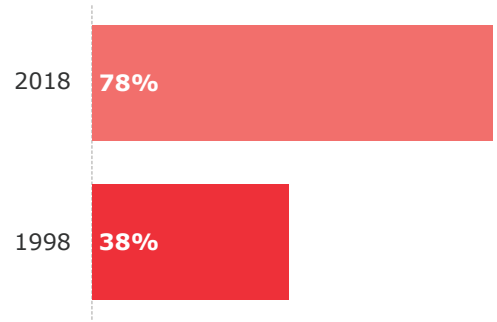
61
WIC PARTICIPANTS

Pleasant Point Passamaquoddy WIC participation in 2018

Women	9
Infants	8
Children	44

BREASTFEEDING IN WIC

Pleasant Point Passamaquoddy WIC breastfeeding initiation rates increased by **40 percentage points** between 1998 and 2018.



PLEASANT POINT PASSAMAQUODDY WIC PARTICIPANT CHARACTERISTICS

$17,191
average family income in 2018

69%
received Medicaid in 2018

$66.73
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE PLEASANT POINT PASSAMAQUODDY ECONOMY IN FY 2019

$44,443
to spend at food retailers

$33,893
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
PUERTO RICO

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Puerto Rico WIC received at least 6 waivers, including physical presence and extended certification periods for children.

78%
of infants born in Puerto Rico participated in WIC in 2017

80%
of eligible individuals in Puerto Rico participated in WIC in 2017

WHO PARTICIPATES IN WIC?

113,449
WIC PARTICIPANTS

Puerto Rico WIC participation in 2018

Pregnant women	10,325
Breastfeeding women	6,903
Postpartum women	4,815
Infants	18,921
Children	72,485

BREASTFEEDING IN WIC

Puerto Rico WIC breastfeeding initiation rates increased by **14 percentage points** between 2004 and 2016.

CHILDHOOD OBESITY IN WIC IN PUERTO RICO

The obesity rate among WIC toddlers in Puerto Rico decreased by **8 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **12%**

PUERTO RICO WIC PARTICIPANT CHARACTERISTICS

$8,274 average family income in 2018	**60%** received Medicaid in 2018	**$97.90** average monthly food cost in FY 2019

HOW WIC SUPPORTED THE PUERTO RICO ECONOMY IN FY 2019

$124.8M to spend at food retailers	**$9.5M** formula rebates received	**$34.3M** nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
RHODE ISLAND

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Rhode Island WIC completed EBT/e-WIC rollout during the pandemic. Rhode Island received at least 9 waivers, including physical presence and extended certification periods for children.

51%
of infants born in Rhode Island participated in WIC in 2017

58%
of eligible individuals in Rhode Island participated in WIC in 2017

WHO PARTICIPATES IN WIC?

21,504
WIC PARTICIPANTS

Rhode Island WIC participation in 2018

Pregnant women	1,661
Breastfeeding women	1,364
Postpartum women	1,775
Infants	5,440
Children	11,264

BREASTFEEDING IN WIC

Rhode Island WIC breastfeeding initiation rates increased by **17 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Rhode Island in 2018, **21 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN RHODE ISLAND

The obesity rate among WIC toddlers in Rhode Island decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN RHODE ISLAND

Maternal mortality per 100,000 births, 2010–2015	**18.3**
Infant mortality per 1,000 live births, 2017	**5.9**
Preterm birth rates, 2017	**8%**

RHODE ISLAND WIC PARTICIPANT CHARACTERISTICS

$19,959
average family income in 2018

83%
received Medicaid in 2018

$44.29
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE RHODE ISLAND ECONOMY IN FY 2019

$9.5M
to spend at food retailers

$5.1M
formula rebates received

$6.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE ROSEBUD SIOUX TRIBE

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Rosebud Sioux WIC received at least 5 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

1,081
WIC PARTICIPANTS

Rosebud Sioux WIC participation in 2018

Pregnant women	77
Breastfeeding women	66
Postpartum women	61
Infants	233
Children	644

BREASTFEEDING IN WIC

48% of WIC infants in Rosebud Sioux initiated breastfeeding in April 2018

Among WIC infants who initiated breastfeeding in Rosebud Sioux in 2018, **17 percent** continued breastfeeding at 6 months.

ROSEBUD SIOUX WIC PARTICIPANT CHARACTERISTICS

$7,408
average family income in 2018

71%
received Medicaid in 2018

$52.63
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ROSEBUD SIOUX ECONOMY IN FY 2019

$699,198
to spend at food retailers

$199,309
formula rebates received

$687,552
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE PUEBLO OF SAN FELIPE

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
San Felipe Pueblo WIC received at least 2 waivers, including physical presence and extended periods for direct distribution.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

249
WIC PARTICIPANTS

San Felipe WIC participation in 2018

Pregnant women	21
Breastfeeding women	26
Postpartum women	11
Infants	49
Children	142

BREASTFEEDING IN WIC

San Felipe WIC breastfeeding initiation rates increased by **35 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in San Felipe in 2018, **39 percent** continued breastfeeding at 6 months.

SAN FELIPE WIC PARTICIPANT CHARACTERISTICS

$20,452
average family income in 2018

92%
received Medicaid in 2018

$93.04
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE SAN FELIPE ECONOMY IN FY 2019

$270,374
to spend at food retailers

$171,303
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE SANTEE SIOUX

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Santee Sioux WIC received at least 5 waivers, including physical presence and larger package sizes for whole grains.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

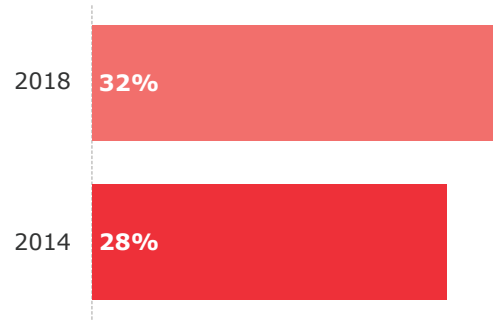
137
WIC PARTICIPANTS

Santee Sioux WIC participation in 2018

Women	21
Infants	39
Children	77

BREASTFEEDING IN WIC

Santee Sioux WIC breastfeeding initiation rates increased by **4 percentage points** between 2014 and 2018.



SANTEE SIOUX WIC PARTICIPANT CHARACTERISTICS

$6,700
average family income in 2018

53%
received Medicaid in 2018

$71.92
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE SANTEE SIOUX ECONOMY IN FY 2019

$77,167
to spend at food retailers

$91,155
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE SANTO DOMINGO WIC PROGRAM

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Santo Domingo WIC received at least 2 waivers, including physical presence and extended periods for direct distribution.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

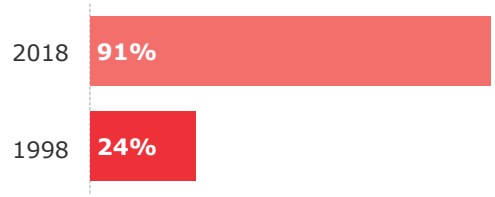
229
WIC PARTICIPANTS

Santo Domingo WIC participation in 2018

Pregnant women	19
Breastfeeding women	19
Postpartum women	11
Infants	50
Children	130

BREASTFEEDING IN WIC

Santo Domingo WIC breastfeeding initiation rates increased by **67 percentage points** between 1998 and 2018.



Among WIC infants who initiated breastfeeding in Santo Domingo in 2018, **44 percent** continued breastfeeding at 6 months.

THE SANTO DOMINGO WIC PROGRAM WIC PARTICIPANT CHARACTERISTICS

$12,290
average family income in 2018

89%
received Medicaid in 2018

$104.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE SANTO DOMINGO ECONOMY IN FY 2019

$246,353
to spend at food retailers

$280,207
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
SOUTH CAROLINA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
South Carolina WIC received at least 12 waivers, including physical presence and additional varieties of fruits and vegetables.

51%
of infants born in South Carolina participated in WIC in 2017

43%
of eligible individuals in South Carolina participated in WIC in 2017

WHO PARTICIPATES IN WIC?

South Carolina WIC participation in 2018

102,845
WIC PARTICIPANTS

Pregnant women	9,799
Breastfeeding women	6,256
Postpartum women	10,238
Infants	29,069
Children	47,483

BREASTFEEDING IN WIC

South Carolina WIC breastfeeding initiation rates increased by **13 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in South Carolina in 2018, **15 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN SOUTH CAROLINA

The obesity rate among WIC toddlers in South Carolina decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	11%

MORTALITY AND BIRTH OUTCOMES IN SOUTH CAROLINA

Maternal mortality per 100,000 births, 2010–2015	26.5
Infant mortality per 1,000 live births, 2017	6.8
Preterm birth rates, 2017	11%

SOUTH CAROLINA WIC PARTICIPANT CHARACTERISTICS

$16,942
average family income in 2018

79%
received Medicaid in 2018

$46.71
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE SOUTH CAROLINA ECONOMY IN FY 2019

$47.4M
to spend at food retailers

$25.0M
formula rebates received

$25.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
SOUTH DAKOTA

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
South Dakota WIC received at least 5 waivers, including physical presence and larger package sizes for cheese and eggs.

33%
of infants born in South Dakota participated in WIC in 2017

47%
of eligible individuals in South Dakota participated in WIC in 2017

WHO PARTICIPATES IN WIC?

17,405
WIC PARTICIPANTS

South Dakota WIC participation in 2018

Pregnant women	1,344
Breastfeeding women	1,232
Postpartum women	991
Infants	3,972
Children	9,866

BREASTFEEDING IN WIC

South Dakota WIC breastfeeding initiation rates increased by **13 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in South Dakota in 2018, **21 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN SOUTH DAKOTA

The obesity rate among WIC toddlers in South Dakota decreased by **<1 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**17%**

MORTALITY AND BIRTH OUTCOMES IN SOUTH DAKOTA

Maternal mortality per 100,000 births, 2010–2015	**28.0**
Infant mortality per 1,000 live births, 2017	**6.3**
Preterm birth rates, 2017	**9%**

SOUTH DAKOTA WIC PARTICIPANT CHARACTERISTICS

$20,607
average family income in 2018

82%
received Medicaid in 2018

$41.28
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE SOUTH DAKOTA ECONOMY IN FY 2019

$8.3M
to spend at food retailers

$3.7M
formula rebates received

$9.1M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE STANDING ROCK SIOUX TRIBE

State WIC Director
Kimberly Rhoades
139 Proposal Ave,
Fort Yates, ND 58538

Phone: 701-854-7263
Email: krhoades@standingrock.org

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Standing Rock Sioux WIC received at least 5 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

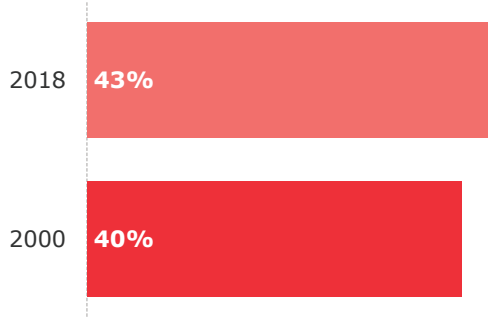
545
WIC PARTICIPANTS

Standing Rock Sioux WIC participation in 2018

Pregnant women	41
Breastfeeding women	18
Postpartum women	23
Infants	146
Children	317

BREASTFEEDING IN WIC

Standing Rock Sioux WIC breastfeeding initiation rates increased by **3 percentage points** between 2000 and 2018.



STANDING ROCK SIOUX WIC PARTICIPANT CHARACTERISTICS

$6,312
average family income in 2018

51%
received Medicaid in 2018

$56.50
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE STANDING ROCK SIOUX ECONOMY IN FY 2019

$356,020
to spend at food retailers

$64,011
formula rebates received

$1.2M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
TENNESSEE

Alesha Reeves
710 James Robertson Pkwy Andrew Johnson Towe 8th Floor,
Nashville, TN 37243

Phone: 800-342-5942
Email: alesha.reeves@tn.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Tennessee WIC received at least 9 waivers, including physical presence and larger package sizes for whole grains and canned fish.

53%
of infants born in Tennessee participated in WIC in 2017

43%
of eligible individuals in Tennessee participated in WIC in 2017

WHO PARTICIPATES IN WIC?

156,119
WIC PARTICIPANTS

Tennessee WIC participation in 2018

Pregnant women	16,126
Breastfeeding women	10,848
Postpartum women	13,790
Infants	42,884
Children	72,471

BREASTFEEDING IN WIC

Tennessee WIC breastfeeding initiation rates increased by **13 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Tennessee in 2018, **11 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN TENNESSEE

The obesity rate among WIC toddlers in Tennessee decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN TENNESSEE

Maternal mortality per 100,000 births, 2010–2015	**23.3**
Infant mortality per 1,000 live births, 2017	**7.3**
Preterm birth rates, 2017	**11%**

TENNESSEE WIC PARTICIPANT CHARACTERISTICS

$18,901
average family income in 2018

67%
received Medicaid in 2018

$36.41
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE TENNESSEE ECONOMY IN FY 2019

$49.0M
to spend at food retailers

$39.9M
formula rebates received

$42.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
TEXAS

State WIC Director
Edgar Curtis
PO Box 149347,
Austin, TX 78714-9347

Phone: 800-942-3678
Email: Edgar.Curtis@dshs.state.tx.us

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Texas WIC received at least 11 waivers, including physical presence and extended certification periods for children.

53%
of infants born in Texas participated in WIC in 2017

53%
of eligible individuals in Texas participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Texas WIC participation in 2018

839,770
WIC PARTICIPANTS

Pregnant women	68,534
Breastfeeding women	108,660
Postpartum women	38,110
Infants	203,532
Children	420,934

BREASTFEEDING IN WIC

Texas WIC breastfeeding initiation rates increased by **9 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Texas in 2018, **19 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN TEXAS

The obesity rate among WIC toddlers in Texas decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN TEXAS

Maternal mortality per 100,000 births, 2010–2015	**34.2**
Infant mortality per 1,000 live births, 2017	**5.8**
Preterm birth rates, 2017	**11%**

TEXAS WIC PARTICIPANT CHARACTERISTICS

$18,056
average family income in 2018

76%
received Medicaid in 2018

$26.45
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE TEXAS ECONOMY IN FY 2019

$216.3M
to spend at food retailers

$211.4M
formula rebates received

$196.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
THREE AFFILIATED TRIBES

State WIC Director
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New Town, ND 58763

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Three Affiliated Tribes WIC received at least 5 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

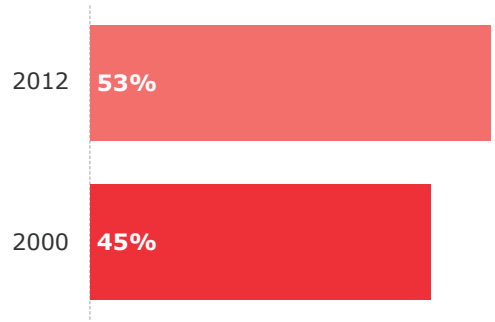
232
WIC PARTICIPANTS

Three Affiliated Tribes WIC participation in 2018

Sum of Total Women	33
Infants	67
Children	132

BREASTFEEDING IN WIC

Three Affiliated Tribes WIC breastfeeding initiation rates increased by **8 percentage points** between 2000 and 2012.



THREE AFFILIATED TRIBES WIC PARTICIPANT CHARACTERISTICS

$2,894
average family income in 2018

23%
received Medicaid in 2018

$79.19
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE THREE AFFILIATED TRIBES ECONOMY IN FY 2019

$207,082
to spend at food retailers

$236,071
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
UTAH

State WIC Director
Christopher Furner
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Salt Lake City, UT 84106

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Utah WIC completed EBT/e-WIC rollout during the pandemic. Utah received at least 3 waivers, including physical presence and larger package sizes for whole grains and eggs.

28%
of infants born in Utah participated in WIC in 2017

38%
of eligible individuals in Utah participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Utah WIC participation in 2018

54,221
WIC PARTICIPANTS

Pregnant women	4,297
Breastfeeding women	5,131
Postpartum women	3,222
Infants	13,512
Children	28,059

BREASTFEEDING IN WIC

Utah WIC breastfeeding initiation rates increased by **22 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Utah in 2018, **32 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN UTAH

The obesity rate among WIC toddlers in Utah decreased by **5 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **8%**

MORTALITY AND BIRTH OUTCOMES IN UTAH

Maternal mortality per 100,000 births, 2010–2015	16.8
Infant mortality per 1,000 live births, 2017	5.7
Preterm birth rates, 2017	9%

UTAH WIC PARTICIPANT CHARACTERISTICS

$25,086
average family income in 2018

44%
received Medicaid in 2018

$36.76
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE UTAH ECONOMY IN FY 2019

$19.3M
to spend at food retailers

$8.8M
formula rebates received

$14.6M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
UTE MOUNTAIN UTE TRIBE

State WIC Director
Venus Mills
PO Box 168,
Towaoc, CO 81334-0168

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Email: vbancroft@utemountain.org

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Ute Mountain Tribe WIC recceived at least 5 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

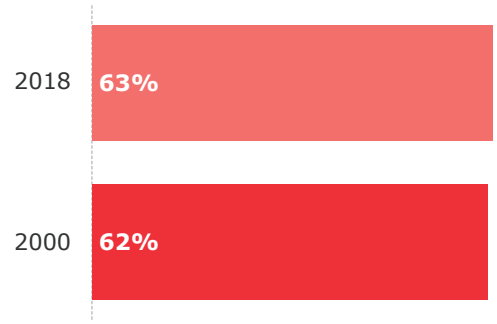
159
WIC PARTICIPANTS

Ute Mountain Ute WIC participation in 2018

Women	26
Infants	42
Children	91

BREASTFEEDING IN WIC

Ute Mountain Ute WIC breastfeeding initiation rates increased by **1 percentage point** between 2000 and 2018.



UTE MOUNTAIN UTE WIC PARTICIPANT CHARACTERISTICS

$1,650
average family income in 2018

65%
received Medicaid in 2018

$46.04
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE UTE MOUNTAIN UTE ECONOMY IN FY 2019

$93,747
to spend at food retailers

$283,402
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
VERMONT

State WIC Director
Karen Flynn
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Vermont WIC received at least 9 waivers, including physical presence and larger package sizes for cheese and whole grains.

40%
of infants born in Vermont participated in WIC in 2017

51%
of eligible individuals in Vermont participated in WIC in 2017

WHO PARTICIPATES IN WIC?

12,403
WIC PARTICIPANTS

Vermont WIC participation in 2018

Pregnant women	965
Breastfeeding women	1,178
Postpartum women	597
Infants	2,256
Children	7,407

BREASTFEEDING IN WIC

Vermont WIC breastfeeding initiation rates increased by **9 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Vermont in 2018, **36 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN VERMONT

The obesity rate among WIC toddlers in Vermont increased by **<1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **15%**

MORTALITY AND BIRTH OUTCOMES IN VERMONT

Infant mortality per 1,000 live births, 2017 **4.1**

Preterm birth rates, 2017 **8%**

VERMONT WIC PARTICIPANT CHARACTERISTICS

$23,211
average family income in 2018

81%
received Medicaid in 2018

$45.66
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE VERMONT ECONOMY IN FY 2019

$6.2M
to spend at food retailers

$0.9M
formula rebates received

$4.5M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
THE U.S. VIRGIN ISLANDS

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Virgin Islands WIC received at least 6 waivers, including physical presence and larger package sizes for whole grains.

45% of infants born in the United States participated in WIC in 2017

51% of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

USVI WIC participation in 2018

3,201 WIC PARTICIPANTS

Pregnant women	220
Breastfeeding women	498
Postpartum women	87
Infants	724
Children	1,672

BREASTFEEDING IN WIC

USVI WIC breastfeeding initiation rates increased by **12 percentage points** between 2008 and 2018.

Among WIC infants who initiated breastfeeding in USVI in 2018, **49 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN THE U.S. VIRGIN ISLANDS

The obesity rate among WIC toddlers in U.S. Virgin Islands increased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016 **13%**

THE U.S. VIRGIN ISLANDS WIC PARTICIPANT CHARACTERISTICS

$14,505 average family income in 2018

57% received Medicaid in 2018

$65.69 average monthly food cost in FY 2019

HOW WIC SUPPORTED THE USVI ECONOMY IN FY 2019

$2.3M to spend at food retailers

$0.8M formula rebates received

$1.9M nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
VIRGINIA

State WIC Director
Paula Garrett
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Richmond, VA 23219

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Email: Paula.Garrett@vdh.virginia.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Virginia WIC received at least 10 waivers, including physical presence and relief from in-person monitoring requirements.

36%
of infants born in Virginia participated in WIC in 2017

42%
of eligible individuals in Virginia participated in WIC in 2017

WHO PARTICIPATES IN WIC?

141,741
WIC PARTICIPANTS

Virginia WIC participation in 2018

Pregnant women	12,173
Breastfeeding women	8,228
Postpartum women	12,714
Infants	36,386
Children	72,240

BREASTFEEDING IN WIC

Virginia WIC breastfeeding initiation rates increased by **8 percentage points** between 2004 and 2014.

Among WIC infants who initiated breastfeeding in Virginia in 2018, **12 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN VIRGINIA

The obesity rate among WIC toddlers in Virginia decreased by **6 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**15%**

MORTALITY AND BIRTH OUTCOMES IN VIRGINIA

Maternal mortality per 100,000 births, 2010–2015	**15.6**
Infant mortality per 1,000 live births, 2017	**5.9**
Preterm birth rates, 2017	**10%**

VIRGINIA WIC PARTICIPANT CHARACTERISTICS

$14,014
average family income in 2018

71%
received Medicaid in 2018

$32.34
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE VIRGINIA ECONOMY IN FY 2019

$42.5M
to spend at food retailers

$32.1M
formula rebates received

$32.8M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
WASHINGTON

State WIC Director
Paul Throne
310 Israel Rd SE,
Tumwater, WA 98501

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Email: paul.throne@doh.wa.gov

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Washington WIC received at least 7 waivers, including physical presence and relief from in-person monitoring requirements.

40%
of infants born in Washington participated in WIC in 2017

49%
of eligible individuals in Washington participated in WIC in 2017

WHO PARTICIPATES IN WIC?

161,947
WIC PARTICIPANTS

Washington WIC participation in 2018

Pregnant women	16,875
Breastfeeding women	12,804
Postpartum women	6,049
Infants	35,153
Children	91,066

BREASTFEEDING IN WIC

Washington WIC breastfeeding initiation rates increased by **4 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Washington in 2018, **43 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN WASHINGTON

The obesity rate among WIC toddlers in Washington decreased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**13%**

MORTALITY AND BIRTH OUTCOMES IN WASHINGTON

Maternal mortality per 100,000 births, 2010–2015	**14.8**
Infant mortality per 1,000 live births, 2017	**4.1**
Preterm birth rates, 2017	**8%**

WASHINGTON WIC PARTICIPANT CHARACTERISTICS

$25,163
average family income in 2018

84%
received Medicaid in 2018

$36.24
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WASHINGTON ECONOMY IN FY 2019

$57.1M
to spend at food retailers

$27.9M
formula rebates received

$47.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
WEST VIRGINIA

State WIC Director
Heidi Staats
350 Capitol St Rm 519,
Charleston, WV 25301-1757

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
West Virginia WIC received at least 10 waivers, including physical presence and extended certification periods for children.

56%
of infants born in West Virginia participated in WIC in 2017

49%
of eligible individuals in West Virginia participated in WIC in 2017

WHO PARTICIPATES IN WIC?

39,927
WIC PARTICIPANTS

West Virginia WIC participation in 2018

Pregnant women	3,721
Breastfeeding women	1,744
Postpartum women	4,081
Infants	10,481
Children	19,900

BREASTFEEDING IN WIC

West Virginia WIC breastfeeding initiation rates increased by **5 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in West Virginia in 2018, **7 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN WEST VIRGINIA

The obesity rate among WIC toddlers in West Virginia increased by **2 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**17%**

MORTALITY AND BIRTH OUTCOMES IN WEST VIRGINIA

Maternal mortality per 100,000 births, 2010–2015	**11.7**
Infant mortality per 1,000 live births, 2017	**7.1**
Preterm birth rates, 2017	**12%**

WEST VIRGINIA WIC PARTICIPANT CHARACTERISTICS

$9,820
average family income in 2018

90%
received Medicaid in 2018

$39.70
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WEST VIRGINIA ECONOMY IN FY 2019

$15.6M
to spend at food retailers

$9.7M
formula rebates received

$13.4M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
WICHITA, CADDO, AND DELAWARE TRIBES

State WIC Director
Carol Jared
208 Lenape Ln PO Box 247,
Anadarko, OK 73005

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Email: cjared@wcdwic.org

MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
WCD WIC received at least 5 waivers, including physical presence and vendor-related flexibilities.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

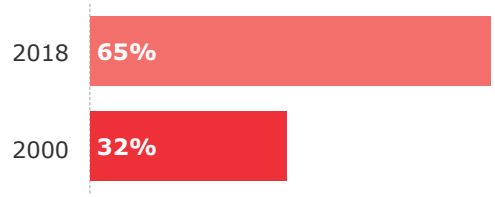
3,691
WIC PARTICIPANTS

WCD WIC participation in 2018

Pregnant women	294
Breastfeeding women	183
Postpartum women	300
Infants	798
Children	2,116

BREASTFEEDING IN WIC

WCD WIC breastfeeding initiation rates increased by **33 percentage points** between 2000 and 2018.



Among WIC infants who initiated breastfeeding in WCD in 2018, **20 percent** continued breastfeeding at 6 months.

WCD WIC PARTICIPANT CHARACTERISTICS

$20,788
average family income in 2018

80%
received Medicaid in 2018

$31.08
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WCD ECONOMY IN FY 2019

$1.3M
to spend at food retailers

$979,941
formula rebates received

$2.3M
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
THE WINNEBAGO TRIBE

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Winnebago Tribe WIC received at least 3 waivers, including physical presence and extended certification periods for children.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

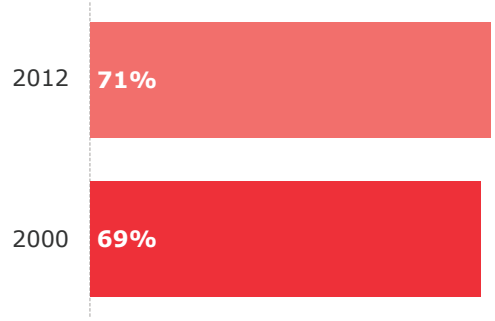
212
WIC PARTICIPANTS

Winnebago WIC participation in 2018

Women	32
Infants	68
Children	112

BREASTFEEDING IN WIC

Winnebago WIC breastfeeding initiation rates increased by **2 percentage points** between 2000 and 2012.



WINNEBAGO WIC PARTICIPANT CHARACTERISTICS

$8,765
average family income in 2018

21%
received Medicaid in 2018

$73.37
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WINNEBAGO ECONOMY IN FY 2019

$158,180
to spend at food retailers

$184,611
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
WISCONSIN

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Wisconsin WIC received at least 14 waivers, including physical presence and extended certification periods for children.

37%
of infants born in Wisconsin participated in WIC in 2017

49%
of eligible individuals in Wisconsin participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Wisconsin WIC participation in 2018

101,966
WIC PARTICIPANTS

Pregnant women	7,811
Breastfeeding women	5,573
Postpartum women	8,400
Infants	23,824
Children	56,358

BREASTFEEDING IN WIC

Wisconsin WIC breastfeeding initiation rates increased by **5 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Wisconsin in 2018, **18 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN WISCONSIN

The obesity rate among WIC toddlers in Wisconsin decreased by **1 percentage point** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	**14%**

MORTALITY AND BIRTH OUTCOMES IN WISCONSIN

Maternal mortality per 100,000 births, 2010–2015	**14.3**
Infant mortality per 1,000 live births, 2017	**6.4**
Preterm birth rates, 2017	**10%**

WISCONSIN WIC PARTICIPANT CHARACTERISTICS

$20,046
average family income in 2018

45%
received Medicaid in 2018

$36.28
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WISCONSIN ECONOMY IN FY 2019

$38.2M
to spend at food retailers

$22.6M
formula rebates received

$28.0M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

HOW WIC HELPS
WYOMING

State WIC Director
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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Wyoming WIC received at least 6 waivers, including physical presence and larger package sizes for whole grains.

32%
of infants born in Wyoming participated in WIC in 2017

43%
of eligible individuals in Wyoming participated in WIC in 2017

WHO PARTICIPATES IN WIC?

Wyoming WIC participation in 2018

9,690
WIC PARTICIPANTS

Pregnant women	788
Breastfeeding women	782
Postpartum women	697
Infants	2,190
Children	5,233

BREASTFEEDING IN WIC

Wyoming WIC breastfeeding initiation rates increased by **6 percentage points** between 2010 and 2018.

Among WIC infants who initiated breastfeeding in Wyoming in 2018, **26 percent** continued breastfeeding at 6 months.

CHILDHOOD OBESITY IN WIC IN WYOMING

The obesity rate among WIC toddlers in Wyoming decreased by **3 percentage points** between 2010 and 2016.

Obesity rate among WIC toddlers, 2016	9%

MORTALITY AND BIRTH OUTCOMES IN WYOMING

Maternal mortality per 100,000 births, 2010–2015	24.6
Infant mortality per 1,000 live births, 2017	4.8
Preterm birth rates, 2017	9%

WYOMING WIC PARTICIPANT CHARACTERISTICS

$22,451
average family income in 2018

51%
received Medicaid in 2018

$30.51
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE WYOMING ECONOMY IN FY 2019

$2.9M
to spend at food retailers

$1.7M
formula rebates received

$4.3M
nutrition, breastfeeding services & admin

Sources: CDC Morbidity and Mortality Weekly Report 2019;68:1057-1061 (cdc.gov/mmwr/) for childhood obesity in WIC. CDC WONDER (wonder.cdc.gov) for mortality and birth outcomes. National WIC Association (nwica.org) for total infants participating in state. USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

FEBRUARY 2021

Please direct all questions to NWA at 202.232.5492
visit nwica.org

National WIC Association

HOW WIC HELPS
ZUNI PUEBLO

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MISSION OF WIC

Assuring healthy pregnancies, birth outcomes, growth and development for mothers, babies, and young children to age 5 who are at nutritional risk. Providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to healthcare and critical social services.

COVID-19 Response
Zuni Pueblo WIC received at least 9 waivers, including physical presence and larger package sizes for whole grains and eggs.

45%
of infants born in the United States participated in WIC in 2017

51%
of eligible individuals in the United States participated in WIC in 2017

WHO PARTICIPATES IN WIC?

655
WIC PARTICIPANTS

Zuni WIC participation in 2018

Pregnant women	42
Breastfeeding women	65
Postpartum women	19
Infants	107
Children	422

BREASTFEEDING IN WIC

Zuni WIC breastfeeding initiation rates increased by **21 percentage points** between 1998 and 2018.

Among WIC infants who initiated breastfeeding in Zuni in 2018, **49 percent** continued breastfeeding at 6 months.

ZUNI WIC PARTICIPANT CHARACTERISTICS

$14,519
average family income in 2018

81%
received Medicaid in 2018

$53.88
average monthly food cost in FY 2019

HOW WIC SUPPORTED THE ZUNI ECONOMY IN FY 2019

$336,559
to spend at food retailers

$19,139
formula rebates received

$416,783
nutrition, breastfeeding services & admin

Sources: USDA 2017 WIC Eligibility Estimates report (fns.usda.gov/wic/national-and-state-level-estimates-wic-eligibility-and-wic-program-reach-2017) for percent of eligible individuals participating. USDA FNS WIC Program Data FY 2019 (fns.usda.gov/pd/wic-program) as of January 19, 2021. USDA WIC Participant and Program Characteristics reports for years displayed.

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