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WIC: A SUCCESS STORY

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN

FRAC
FOOD RESEARCH AND ACTION CENTER

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ABOUT FRAC...

The Food Research and Action Center (FRAC) was organized in 1970 as a nonprofit law firm and advocacy center working with the poor and near poor to alleviate hunger and malnutrition in the United States. FRAC works primarily with the Federal food programs—the food stamp, school lunch and breakfast, elderly nutrition, child care food, summer food, and women, infants and children (WIC) programs—as vehicles for addressing this nation's hunger problems. However, FRAC's premise in its work is that the Federal food programs cannot solve the problems of this nation's poor; hunger and malnutrition are caused primarily by a lack of income, and are tragic symptoms of the maldistribution of economic resources in this country.

Therefore, in the 1980's FRAC will be engaged in efforts to help groups around the country work with the food programs, not only to meet the immediate needs of America's hungry, but also as an organizing tool for poor people and their allies in the larger effort at creating meaningful social change. This work will focus on four areas:

- to represent the interests of the poor and near poor in the development and implementation of the federal food programs, and to protect their rights with litigation and legal support to local Legal Services offices and other legal advocacy groups;
- to help community groups and coalitions work to improve the food programs through local organizing and advocacy efforts, and to promote the development of organization among recipients and their friends to tackle food and other poverty-related issues;
- to develop written materials to help people understand the food programs, to undertake training of community advocates working with the programs; and
- to help people understand national and state legislative issues raised by the food programs and related issues so they can express their views and have some impact on the legislation.

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For more information on the WIC program, contact:

Food Research and Action Center
1319 F Street, N.W., 5th Floor
Washington, D.C. 20004
(202) 393-5060

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A BRIEF HISTORY

In 1968, following evidence that low-income American children suffered from seriously inadequate diets, the Departments of Agriculture, Health Education and Welfare, and the Office of Economic Opportunity undertook a joint effort to provide supplemental foods to pregnant and nursing women and their young children. The value of nutritional supplements to this highly vulnerable population was readily apparent, and in 1972, the Congress authorized the Special Supplemental Food Program for Women, Infants, and Children (WIC) on an experimental basis.

WIC is unlike any other food assistance program. Limited to pregnant and nursing women and children under 5 years of age, its participants must be not only poor, but medically certified to be at nutritional risk. Administered by State Departments of Health, the program was designed to provide access to foods rich in protein, iron, calcium, and vitamins A and C (e.g., cereals, juices, eggs, infant formula, milk, and cheese). Three delivery systems are available: vouchers which can be used in local stores, direct delivery to recipients' homes, and warehouses where the nutrient-rich foods can be claimed.

Citing the ample medical and scientific evidence then available in support of the need for WIC, the late Senator Hubert Humphrey moved in 1974 to make the program available nationwide. "We can no longer afford," he declared, "to neglect our responsibilities to mothers and children who are at nutritional risk." Public Law 94-105, authorizing the program through 1978, passed virtually without dissent. At the time there were 204,000 women and children served by WIC.

Despite the recognized value of the program, the Nixon Administration refused to release the funds appropriated by the Congress for WIC. It was only after FRAC successfully sued the Department of Agriculture on behalf of potential WIC recipients *(Dotson* v. *Butz)* that the funds were released and the program, belatedly, got underway.

Today the program serves 2.3 million women, infants and children in every State, in the District of Columbia, Puerto Rico, and the Virgin Islands. Even at these levels, the program serves only about one-fourth of the estimated 8.8 million low-income women and children eligible for and in need of its benefits. Because of its unique structure, WIC has also had equally important health benefits: high risk mothers and babies now get critical pre- and post-natal care because regular clinic participation is a prerequisite for receiving WIC's nutritious foods.

Unfortunately, the future of the program is once more in jeopardy. Legislation for fiscal years 1983-84 sets limits on WIC program spending that will make growth impossible. In fact, in 1983 many state WIC programs have been forced to scale back participation in the face of a swelling number of eligible recipients. Programs with long waiting lists are also faced with rising food and basic costs. This means that many women and young children who are nutritionally at risk will not receive the benefits so critical to their future well-being. It is especially difficult to justify depriving women and children of these benefits when one considers the positive results of WIC, as described on the following pages, and America's poor standing in the world community on infant mortality.

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WHAT DOES WIC PROVIDE?

WIC provides monthly, nutritious foods that are tailored to the dietary needs of pregnant and breastfeeding women, infants and children.

Pregnant Women, New Mothers and Children 1-5:	Milk, Cheese, Eggs, Full-strength Juice, and Cereal
Breastfed Infants:	Iron-fortified Cereal and Fruit Juice
Non-breastfed Infants:	Iron-fortified Formula, Iron-fortified Cereal and Fruit Juice

The *total cost* of the WIC food package averages about *$30 per person per month.*

WIC foods are most commonly obtained through the use of vouchers in grocery stores; some WIC participants get direct delivery to their homes, or pick up food packages at the WIC clinic site.

Nutrition Education

WIC participants also receive nutrition and health counseling during their visits to the WIC clinic. Nutritionists and other health professionals discuss any dietary and health problems that relate to pregnancy, breastfeeding, infant and child care.

WHO RUNS WIC?

At the Federal Level—Food and Nutrition Service of USDA.

At the State Level—State Department of Health; and for Indian programs, the Indian Tribe, Band, or Council.

At the Local Level—Hospitals, Community Health Centers, and other health agencies. (This is where WIC participants are served.)

WIC: A SUCCESS STORY

Pregnancy and early childhood are stages of the life cycle when the impact of nutrition on growth and development is critical. These are times of increased nutritional needs—in pregnancy, for the development of the fetus and maintenance of the mother's nutritional health; during early childhood for all aspects of growth, and brain development in particular.

Nutritional deficiencies during these periods can lead to:

- *Poor Outcome of Pregnancy*—miscarriage; still birth; low birth weight babies (low birth weight, less than 5½ pounds, is associated with increased infant mortality, retarded physical growth, and increased susceptibility to disease).
- *Anemia* in the mother and/or the child (anemia is a reduction in the oxygen-carrying capacity of the blood, resulting in tiredness or weakness; usually due to lack of iron in the blood).
- *Stunted Growth* in the child.
- *Mental Retardation* in the child, in extreme cases.

The WIC program, by providing nutrient-rich supplemental foods low-income pregnant women and children known to be "at risk," attempts to prevent these nutrition-related problems and to promote general good health.

Studies that have been done to evaluate the health benefits of the WIC program have shown that WIC is associated with improved pregnancy outcome (pregnant women on WIC have fewer low birth weight babies and less infant mortality than women not on WIC), a decrease in anemia in infants and children, and improvements in growth (head circumference, weight, and height).

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HARVARD SCHOOL OF PUBLIC HEALTH STUDY—COST BENEFITS OF WIC, 1979

Harvard University's School of Public Health studied the effect of the WIC Program on birthweight in four geographical areas of Massachusetts between 1973 and 1978. Medical records of 1,328 women were examined. This study sample included WIC participants and non-participants of similar medical and income background, and who were at high risk.

The Effects of WIC

- WIC mothers had significantly fewer low birth weight babies than non-WIC participants.
- Infants born to WIC mothers had significantly higher birth weights than those born to non-WIC mothers.
- The more WIC vouchers a woman received, the greater the positive effect WIC had on the birth weight of her child.
- Each WIC voucher received increased the duration of pregnancy. (As duration of pregnancy increases, the chance of having a low birth weight baby decreases.)

Cost-Benefit Analysis of WIC

The Harvard study also examined the costs and benefits of the WIC program. Costs of the WIC program were compared to the hospitalization costs incurred for treating the higher percentage of low birth weight babies that would result from no WIC program. For every dollar spent on WIC, $1.10-3.10 would be saved in hospitalization costs.

Senator Hubert Humphrey
"Looking back on all of my years in government service, I am as proud of this program as any with which I have been involved. It represents what is best in America—a dedication to our children and our future and an attempt to nip the poverty cycle in the bud.

YALE STUDY—INFANT MORTALITY AND GROWTH, 1978

The Yale School of Medicine looked at the impact of WIC on infant mortality and infant growth in the city of Waterbury between 1975-1977.

Infant Mortality—The Effects of WIC

All infant death certificates for the 3 years chosen were examined and matched with the corresponding birth certificates. WIC rosters were used to determine if the mother was a participant in the WIC program during the pregnancy in which the infant death occurred.

- There was a statistically significant difference in infant mortality rates between WIC and non-WIC mothers: WIC, 8.4 deaths per 1,000 live births; non-WIC, 22.7 deaths per 1,000 live births.
- With each succeeding year of participation in WIC, the percentage of WIC mothers who had live births increased.
- Perinatal mortality rates (fetal deaths, plus infant deaths under 1 week of age) were also significantly different for WIC (10.5 deaths per 1,000 live births) and non-WIC (24.46 deaths per 1,000 live births) mothers.

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Infant Growth—The Effects of WIC

The Yale infant growth study compared the growth patterns of two similar groups of infants attending a clinic in Waterbury—one group of 61 infants who had been on WIC since birth for one year and a second group of 65 who were not on the WIC program. Medical records were examined for changes in weight, height, head circumference, and hematocrit levels (a measure of iron status) over a one year period. *WIC infants were at higher risk than non-WIC infants—they had lower values for weight, height, head circumference, and hematocrit levels.*

- By 6 months the differences in growth measurements decreased, and by one year, WIC infants' growth was equal to that of non-WIC infants.
- Differences in hematocrit levels between WIC infants and non-WIC infants disappeared by 12 months of age.

Senator Philip A. Hart (D-Mich.), January 1976
"The child whose brain is damaged or whose growth is stunted because of a poor diet faces a life of dependency and poverty. If the moral considerations of taking every possible step to prevent such damage are not compelling enough, then cost-cutters should at least consider the cost to future generations in terms of lost earning capacities and, perhaps, public assistance."

NORTH CAROLINA MEDICAL EVALUATION STUDY, 1979

The first major medical evaluation study of the WIC program was done by the University of North Carolina School of Public Health between 1973-1976. Data was obtained on over 41,000 infants and children and close to 10,000 pregnant and nursing women from 19 WIC projects in 14 states.

The population participating in WIC was poor and at significant nutritional risk. Infant mortality rate was greater than 50% above the national level; birth weights of infants were less than those of infants of higher income women; weights, heights, and head circumference were below normal in infants and children; anemia was highly prevalent in children: 30% for those under 2, 19% for those aged 4-5; and dietary intakes of pregnant women were inadequate in energy, protein, and several vitamins and minerals.

The Effects of WIC

For Infants and Children:

- WIC participation was associated with an increase in height and weight.
- Anemia was reduced.

For Pregnant Women:

- Their consumption of protein and most vitamins and minerals increased.
- Their hemoglobin (blood iron) levels increased.
- They gave birth to infants with higher birth weights.

Congressman George Miller (D-Cal.), August 1982
"We now have evaluations of WIC which show clear and dramatic results in improving children's chances for healthy development, saving lives and saving money. The WIC program represents one of those rare moments in the Congress when we design something to respond to a serious problem in the country, and the program actually works in solving the problem. In fact, its successes have far exceeded even our best hopes."

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MASSACHUSETTS WIC EVALUATION PROJECT, 1980

The Massachusetts Department of Public Health conducted a study in 1978 to evaluate the association between a mother's participation in the WIC program and the outcome of her pregnancy. 4,125 women participating in WIC who gave birth in 1978 were individually matched to an equal number of women not on WIC who gave birth in the same year. Statistics on pregnancy outcome, obtained from birth certificates, were compared between the two groups. *WIC was found to be serving a high risk population in Massachusetts—the percentage of teenagers, unmarried mothers, Black women, and women who did not finish high school was higher among the WIC population than in the state as a whole.*

The Effects of WIC

- WIC mothers had fewer low birth weight babies than non-WIC mothers (6.9% vs. 8.7%).
- Neonatal mortality (during the period from birth to 28 days) was significantly less among infants of WIC mothers than those born to non-WIC mothers—12 deaths compared to 35.
- Birth weight was greater, and duration of pregnancy longer, in the WIC group. (Both of these measures predict a healthier infant.)
- Those who participated in WIC started receiving prenatal care earlier in their pregnancy.
- The positive effects of WIC participation on pregnancy outcome increased as duration of participation in WIC increased.
- Improvement in pregnancy outcome was even greater among higher risk sub-groups of the total population, such as teenage mothers, Hispanic and Black women, and unmarried women.

Senator Robert Dole (D-Kan.), 1982
"Nutrition assistance to mothers and children can substantially reduce the incidence of low birth weight and infant mortality. . .it is perhaps one of the most worthwhile investments that our country can make in its future."

CENTER FOR DISEASE CONTROL STUDY, 1978

The Center for Disease Control did an analysis of nutritional data for WIC participants in 6 states between 1974-1976, based on information collected through its nationwide surveillance system. 5,692 children were examined at the time of entrance into the WIC program and were followed for 1 year. Pregnancy outcome data was collected on 4,576 women in 3 states. *Children entering the WIC program were found to have a high prevalence of anemia* (10-13% for children under 2 years, 12-24% for children aged 2-5) *and had a higher incidence of low height for age than would be expected in a representative sample of U.S. children. The pregnant women were at high risk because of poor nutritional status and because a high proportion of them were teenage mothers.*

The Effects of WIC

- Children participating in WIC showed increases in hemoglobin levels, children with the lowest values improving the most.
- Anemia fell to 3% among all children.
- Low values of height for age fell from 21% to 15% for children under 2 years.
- Percentage of low birth weight infants was less among the WIC population than among the non-WIC recipients.

Senator Charles Percy (R-Ill.), 1977
"I believe the secret of our success and of WIC's growth is that these programs allow each of us, at every level, federal, state or local, to realize our own goodness, our own strengths, and our own nobility."

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HARVARD SCHOOL OF PUBLIC HEALTH—INFANT GROWTH STUDY, 1982

The Harvard School of Public Health studied an infant and child population in two Boston WIC service areas to determine the effect of the WIC program on childhood weight gain and growth. The positive weight gains of a WIC group of 914 children was compared with those of a matched control group of 1,098 non-WIC children from the same Boston neighborhoods. Using growth standards, predictions were made for infant weight at three-month intervals following birth for the WIC and non-WIC children. Results show that the weights of WIC children were consistently higher than those of the non-WIC control group. Most significant was the positive impact the WIC program had on low-birth weight infants during the critical 6-9 month post-natal period.

Effects of WIC on Infant Growth

- Weight gain, a determinant of infant growth, was greatest in a population of WIC infants and children in a controlled study with matched age, ethnic and socio-economic groups.
- For low-birth weight infants of non-WIC mothers, the gain in post-natal weight was significantly greater once they received WIC foods when compared to the low-birth weight non-WIC children.
- The greatest difference in weight gain between the WIC and non-WIC children took place during the 6-9 month period after birth.

This study showed the greatest impact of the WIC program taking place during the second half of the child's first year of life. The weight gain of the WIC children who were born both premature and at low birth weight to non-WIC mothers was most dramatic during the critical weaning period.

Report of the House Committee on Education and Labor, 1978 WIC Program Reauthorization

"During its consideration of the WIC program, the committee found a body of persuasive evidence which indicates the positive aspects of the program and its potential impact on our nation's nutritionally deprived women, infants, and children. The overwhelming support that the WIC program inspires on all levels further reinforces the committee's view that there is a critical need for its continuation."

NORTH CAROLINA STUDY OF CLINIC ACTIVITY, 1982

The University of North Carolina School of Public Health studied the effect that the WIC program had on the overall use of a local health department services by an infant and child population participating in the WIC program during 1978-1979. During this two-year period of time, it was found that clinic activity in a rural North Carolina county's health department increased substantially following introduction of the WIC program. Not only was this increase in activity due to WIC certification/recertification encounters, but, more significantly, other health services were utilized by the low-income, at-risk WIC participants.

Effects of WIC on Overall Clinic Activity

- Following the introduction of the WIC program in rural Columbus County, total clinic encounters increased by 32.5% from July 1978-July 1979.
- The number of non-WIC clinic encounters made by infants and children who were initially on the WIC program grew steadily over the two years. By 1979, 34% of all clinic visits for services *other* than WIC were made by WIC infant and children participants.
- More infants who first visited the County Health Department for WIC certification later appeared for well-child and other health services not associated with the WIC program.

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The immediate, positive health effects attributed to the WIC program are described in past studies of pregnancy outcome and infant growth with WIC participants. This study points to the long-term impact that the WIC program has had on the overall utilization of health services by a rural, low-income, medically-at-risk population of infants and children. This increased demand for health services by the WIC population will continue to play a great role in cost-effective preventive health care for those individuals most vulnerable to nutritional and health problems.

> The bi-partisan Congressional Budget Office, in a 1980 Congressional Report **(Feeding Children: Federal Child Nutrition Policies in the 1980's)**
> singled out the WIC program for its effectiveness—
> *"...WIC has been found to be medically successful."*

LOUISIANA STUDY—WIC'S EFFECT ON BEHAVIOR AND HEALTH, 1982

The Louisiana Office of Health Services studied child sibling pairs to determine the effect of early WIC supplementation on cognitive and behavior development, and certain health indices. Investigators studied twenty-one (21) sibling pairs, each containing one "early supplemental" child (on WIC from pre-natal until at least one year of age) and the other "late supplemental" child (began WIC *after* one year of age). The "late supplemental" group of children did not receive WIC's nutritional benefits during the brain-growth spurt period which takes place during the third trimester of pregnancy through the first year of life.

Effects of WIC on Cognitive and Behavior Development

- The children who were on WIC during their mother's pregnancy and until at least one year of age scored significantly higher on *all but one* of a series of cognitive and behavior tests. (Tests included visual-motor, IQ, and grade point average in elementary school.)

- Of the health measures available, the "early" supplemental group had significantly higher height-for-age scores than the "late" WIC group.

Early nutritional supplementation may impact upon later behavioral and intellectual functioning. In addition, other components of WIC clinic visits (maternal and child nutrition education, etc.) could also account for some of the cognitive differences found between the "early" and "late" supplemental groups.

> **Dr. Calvin Woodruff** Congressional Testimony, Committee on Nutrition,
> American Academy of Pediatrics, 1981
> *"...WIC not only has led to a marked improvement in the health of its participants, but it is a cost-effective program as well. ...the average cost of food supplement during a woman's pregnancy is less than $300. This is far less than the hundreds of dollars it would cost each day to keep a low birth weight newborn in a neonatal intensive care unit, or the thousands of dollars it would cost to treat the infant during the critical first year of life. ...the costs of institutionalization, ... federal social service benefits ... and lost revenues that would have to be borne by society ... for individuals crippled by mental and physical defects related to under-nutrition. The small financial outlay required to provide ... the benefits of WIC ... is nominal compared to the otherwise tragic, incalculable costs—unfulfilled hopes, unproductive lives, and unnecessary financial and emotional burdens—that would saddle handicapped individuals, their families, and friends."*

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MEMPHIS PRESCHOOL STUDY, 1977

This study, conducted in South Memphis, Tennessee in 1972 examined the nutritional benefits of participation in a federal supplementary food program similar to WIC. 250 low-income preschool children enrolled in the supplementary food program were the subjects for the study. The data obtained on them was compared to that of a similar study done in the same area in 1969 prior to the implementation of the supplementary feeding program. *50% of the preschool population was low in weight and height, and low vitamin A levels and anemia were common among them.*

The Effects of the Supplementary Food Program

- There was a significant improvement in heights and weights from 1969-1972.
- Frequency of below normal head circumference dropped from 15% in 1969 to 12% in 1972.
- There was a significant decrease in the prevalence of anemia from 1969-1972 for all children:

	1969	1972
ages 0-3	27.7%	10.9%
ages 3-6	9.6%	3.8%

- Low hemoglobin values were found in 10% of the infants born after 1970 who had received infant formula for the first 6 months of life compared to 40% for those born from 1967-1969 who did not receive infant formula through the supplementary food program.
- Low levels of vitamin A dropped from 44% of the children studied to 27% between 1969 and 1972.

WIC HELPS WOMEN, INFANTS, AND CHILDREN

As seen from these studies, WIC is reaching a high risk population of pregnant and breastfeeding women and children for whom the program is having a positive impact on health status. The most striking effect noted is that on the outcome of pregnancy. The contribution of WIC to decreasing the number of low birth weight babies born means fewer low-income children will have to begin life with the additional disadvantage of poor health.

The benefits of WIC do not end at birth, however. Children in the program who are below normal in weight and height respond to WIC by catching up growth-wise with other children. WIC also reduces anemia among children and this translates into improving their ability to learn by increasing alertness and attention span.

The WIC program is truly a model for preventive health care. By preventing possible health problems and catching existing ones early, it saves dollars that would have to be spent on expensive treatment. But more important, WIC contributes to improving the initial quality of life for thousands of women and their children.

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ADDITIONAL TESTIMONY TO THE EFFECTIVENESS OF WIC

(Excerpts from a speech by Carol Tucker Foreman
Assistant Secretary, U.S. Department of Agriculture)

Is WIC effective? I think you know the answer to that. Recent studies by the Center for Disease Control reported significant findings concerning the positive nutritional benefits of the WIC Program. Children enrolled for one year showed considerable improvement in blood values, with those who initially had the lowest hemoglobin and hematocrit values showing the most improvement. Children with low weight for their height grew significantly during the first six months of their participation.

There's also strong evidence to suggest that the incidence of low birth weight babies is substantially reduced through participation by mothers in the WIC Program. Studies by CDC and other researchers illustrate some truly dramatic nutritional gains.

A Yale University Medical School study of WIC participants in Waterbury, Connecticut, showed that, over several years, a steadily growing impact was seen in reducing the fetal death rate in a high risk population. An infant growth study showed that WIC participants caught up with nonparticipants in all measures of health.

In Michigan, 30 percent of the high risk women were anemic before they came into the WIC Program. After participation, the figure was 6 percent. And anemia among participating children in Oregon was reduced from 13 percent to 1 percent. In the Pennsylvania WIC Program, the infant death rate was 10.6 percent before participation. And it was zero after participation. Premature birth rates decreased from 12.8 to 1.6 percent. And pregnancies with complications were reduced from 30.0 percent to 17.6 percent. I think we can answer that WIC is efficient and is effective.

Is WIC compassionate? Ask the 35-year-old diabetic mother from Lincoln, Nebraska, who says that she couldn't have eaten well, couldn't have kept her family together, couldn't have taken care of her children had it not been for her participation and her children's participation in the WIC Program. Indeed, ask any mother whose child was once malnourished or anemic, stunted or listless, and has now attained good blood values, normal growth and the liveliness of a happy child.

If WIC is a demonstrably efficient, effective and compassionate program, I think it can best be demonstrated in some progress that has been made among those people and in those areas most in need of social services in this country and most diffficult to serve. You know that some of the nation's worst nutritional problems plague American Indians in the West and the Southwest. And we've made some, if nowhere near enough, progress in serving those people. The infant mortality rate on seven Indian reservations in Montana declined from 31.5 per thousand to 16.6 per thousand, following the introduction of the WIC Program.

In Arizona, participating children recorded an 81 percent reduction in anemia, an 82 percent weight improvement and a 64 percent improvement in stature. Today, the Public Health Service Indian Hospital in Arizona treats far fewer children for severe nutritional diseases than it did a decade ago. Fewer children there suffer from weight deficiencies and stunted growth.

I can also report to you some progress in another target population, migrant workers. The Migrant Demonstration Project of USDA's Supplemental Food Program Division was designed to alleviate barriers that prevented migrants and seasonal workers from fully participating in WIC Program services. It had three objectives. The first was provision of funds to implement or expand WIC programs where there was a large migrant population. The second was to track participants as they moved from Texas into other states within the midcontinental migrant stream and then back to Texas. And the third was experimentation with new program services and methods.

Many of the studies that I've cited show a positive correlation between WIC and health status. More often than not, WIC participants are introduced for the first time to maternal and child health clinics and to preventative health care such an immunizations. The WIC Program is often the initial and perhaps the only, access to nutrition education.

—Carol Tucker Foreman
Speech at the Second Annual Children's
Foundation WIC Symposium, June 6, 1979

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Excerpts from: Statement of Ora Melton, *Chairperson*
Perry County (Ala.) WIC Participant Advisory Committee
Hearings before the Senate Subcommittee on Nutrition,
Senate Committee on Agriculture, Nutrition and Forestry
April 1980

I am Ora Melton from Perry County WIC Advisory Council. In Perry County we have a WIC staff which we have for a short time . . . a nurse, Mr. Rickey Calhoun. He has worked overtime trying to help those that come in. . . .

I was in there one day. I have three children on the WIC program. I had one born premature when I did not know about the WIC program. Luckily enough, he weighed enough not to be put in an incubator to stay.

Then when I was on WIC with the last baby, he was born early, but by being on the WIC program, he weighed enough so that he didn't have to stay in the hospital, because if he had stayed in there, I do not know how we would have got the bill paid.

. . . we was in there one day. He told my little girl, he said, "I want you to drink milk, not coke." And she said OK. . . . So one day I asked my daughter for half a glass of coke. She said, "What did that nurse tell you mama?" . . . One day she forgot and asked for a little coke, I said, "What did the nurse tell you?" . . .

(My children) eat their food and they're doing better. . . . The little boy who was premature, he moved up, he's underweight, but he moved up.

So I still have to give them vitamins along with the WIC program we receive. There are a lot of kids that need this who are not getting it, and those that are getting it, they are doing better.

And we plead to you and to all, please continue this program for us. There is a lot of parents that learn that dried beans and dried peas carry a lot of protein, just as much as meat, and I didn't know that myself until I started with the WIC program.

And we have a lot of people that still do not know. We have expectant mothers of several months trying to get on. We have one expectant mother. She went and signed up. She did not get on. Her baby was born. Six weeks later the baby died. Then she got on it for six months, but it was too late for her baby. And she was on the WIC Advisory council, and that disturbed her and she had a nervous problem and all because, see, she lost her child.

And since the babies are so small, when they are born, if they get the nutrition they need, it would help them to learn in school, to study more. We may have more doctors because they can learn. If I had known what I know with my first child . . . he would be in better shape than he is now, which is pretty good. And now more babies are being born anemic and that is why this has helped. . . .

So we in Perry County and Alabama, we appreciate the help we had and we really appreciate the help we get, and we hope that you will not discontinue this.

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DOCUMENTING THE EFFECTIVENESS OF THE WIC PROGRAM

(Additional Studies)

In addition to the major studies (e.g., Harvard and Yale), there are other evaluations specifically of WIC as well as many studies conducted over the past thirty years that document the positive impact of supplemental feeding programs. The following table is reproduced from March 1980 oversight hearings on Child Nutrition before the House Education and Labor Committee.

Summary of Supplementation Studies

STUDY	NUMBER OF PEOPLE	RESULTS
	PREGNANCY	
Montreal	1,736	Birth weight increased. Low Birth Weight (LBW) 6.9% in treatment women vs. 9.5% for controls.
Hyerabad, India	25	Birth weight increased by 11.5 ounces.
Oslo, Norway	728	LBW rates 2.2% in treatment women vs. 4.6% in controls.
Scotland	730	LBW rate 6.4% in supplemented group compared to 11.1% in controls.
Guatemala	4 villages	Birth weights increased in supplemented group; LBW cut by one-half in treatment women.
Buffalo, New York	144	Prematurity decreased in treatment women 5% vs. 19%
University of North Carolina	11,000*	Birth weight and maternal weight gain increased.
Center for Disease Control	230,000*	LBW rates appear to be decreasing.
	INFANTS AND CHILDREN	
Tennessee	250	Growth improved
Colombia	11,876 families	Growth improved
University of North Carolina		Growth improved and anemia decreased.
Center for Disease Control		Growth improved and anemia decreased.

*Approximate.

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MATERIALS FROM THE FOOD RESEARCH AND ACTION CENTER

FRAC distributes periodic mailings with information on the food programs and related budget issues. In addition, we publish program *Guides* to specific food programs. There is a charge of $20.00 to receive periodic mailings and the newsletter "Foodlines," covering food program changes and budget issues. Materials are free to those individuals and groups who are eligible for the federal food programs. (Discount rates are available for bulk orders.)

- *FRAC's Guide to Quality School Lunch and Breakfast Programs* describes these child nutrition programs; outlines methods of organizing a school breakfast campaign; and discusses ways of improving meal quality. March 1983; $4.00.

- *FRAC's Profile of the Federal Food Programs*, a short pamphlet describing FRAC and outlining the seven major government food programs. January 1982; single copies free (additional copies $.50 each).

- *FRAC's Guide to the Food Stamp Program*, detailing program operation in a simple, question-and-answer format. February 1983; $4.00.

- *The Supplemental Food Program for Women, Infants and Children (WIC): A Success Story*, a synopsis of each of the major medical evaluation studies done on the WIC program showing effects of WIC on pregnancy outcome, growth, and incidence of anemia among WIC participants. February 1983; $2.00.

- *Food and Nutrition Issues in the Food Stamp Program*, a look at the nutritional and health aspects of the Program, shopping patterns of Food Stamp users, and positive economic impact of the program. June 1981; $1.00.

- *Fair Budget Action Campaign (FBAC) Organizers Manual*, provides information on the 1983 budget, content of specific proposals for FY 84, and suggestions for local action strategies. March 1983; $7.00.

- *The Impact of Child Nutrition Budget Cuts: A Look at the States and Selected School Districts*. Survey documents impact of budget cuts on reduced participation and nutritional content of meals for children. Fall 1982; $3.00.

- *Doing More With Less: Maintaining Quality Child Nutrition Programs*, a practical guide for school food service staff, school officials, parents and others interested in the child nutrition programs in their communities. Ideas on saving money in local programs, increasing student participation, and influencing decision-makers. March 1983; $5.00.

- *Documenting Hunger in Your Community*, a guide for health professionals, and community groups wishing to construct a profile of the extent of hunger locally. Suggests data sources, questions to pose, and ways to utilize findings. February 1983.

- *FRAC's Guide to State Legislation* gives suggestions on issues that can be influenced at the state level, includes chapters on state legislation re child nutrition programs, the Food Stamp Program, food sales tax, and nutrition advisory committees. February 1983; $10.00.

- *Legislative Staff Directory*, a listing of all members of Congress along with the staff persons who work on Food Stamp and Child Nutrition programs; includes telephone numbers, addresses, and members of the congressional committees overseeing these programs. February 1983; $2.00.

- Single page fact sheets on the federal food programs (e.g., WIC, elderly nutrition, food stamps, and child nutrition) are now available. Free.

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