Improving Child Nutrition Programs to Reduce Childhood Obesity
Healthy Families and Communities Subcommittee
House Education and Labor Committee
(Chairwoman Carolyn McCarthy)
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Comments Pertaining to WIC Reauthorization
Lorrene Ritchie, PhD, RD, Director and Adjunct Professor
Dr. Robert C. and Veronica Atkins Center for Weight and Health,
University of California, Berkeley

My name is Lorrene Ritchie, and I am the Director of Research at UC Berkeley's Dr. Robert C. and Veronica Atkins Center for Weight and Health. The Center is an obesity prevention research center, the only one in the nation focusing on primarily environmental and policy approaches to prevent pediatric obesity. I am a co-author on the book Obesity: Dietary and Developmental Influences. I have also been an Evidence Analyst for the American Dietetic Association (ADA), co-authored the ADA's Position Paper on Pediatric Weight Management and was a member of the ADA's Pediatric Weight Management Workgroup to formulate evidence-based practice guidelines for dietetic professionals.

Thank you for the opportunity to provide input on the reauthorization of the **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** particularly regarding approaches to reducing the epidemic of childhood obesity. The WIC program offers an unparalled opportunity to prevent the development of nutrition-related health problems at the most critical stages of life—pregnancy, infancy, and young childhood. Additionally, the program reaches a population in the U.S. with the highest risk for obesity and its related health challenges, while at the same time having the least access to resources for prevention. This is an unprecedented time for WIC, because across the country WIC is beginning to implement the new Food Packages. We applaud the USDA's decision to contract with the Institute of Medicine to conduct a study of the WIC foods and to adopt the resulting recommendations into the Final Food Package Rule. The changes to the WIC Food Packages represent an extraordinary step in improving this federal nutrition program to address child obesity. In addition to the Food Package changes, WIC's impact can be strengthened by enhancing the nutrition services provided as identified in the five recommendations I will outline.

The statistics on child obesity are staggering and unprecedented. Obesity rates among children in the United States have more than tripled in the last 30 years (Ogden, 2002, 2008). Of most concern, obesity is increasingly affecting our nation's youngest children. Before beginning school, nearly one out of every 5 preschool-age child is already obese (Anderson, 2009). Obese preschoolers are more likely to grow into obese adolescents and obese adults (Nader, 2006; Gardner, 2009). Increasing numbers of children are developing type 2 diabetes, early signs of clogged arteries, and sleep and breathing difficulties – side-effects of poor nutrition and excess weight gain (Dietz, 1998; Messiah, 2009). Obesity in youth is contributing to escalating health care costs (Trasande, 2009). Poor nutrition is also related to reduced concentration and behavioral problems, which in turn, can impact a children's ability to succeed in school (Florence, 2008). A growing body of research further suggests that a child's dietary and health habits form at a young age – prior to entering elementary school (Patrick, 2005). The link between early behaviors and obesity later in life leads to the conclusion that successful obesity prevention strategies must begin at a very young age. In fact, they should begin prenatally and in the first hour of life. If we do not take bold steps now to improve nutrition and prevent obesity, the present generation of young children will likely be the first in our nation's history to live a shorter life than their parents.

What is contributing to this excess weight gain? On the surface, this problem seems deceptively simple — too many calories consumed and too few calories burned. However, the forces that lead to this energy imbalance on a population level are numerous and pervasive. Healthy food and beverage options generally require more time, money, energy and effort to consume than less healthy options. In particular, low-income families face numerous challenges including excessive weight gain in pregnancy, low initiation and duration of breastfeeding, overfeeding of formula, and inaccessibility to healthful foods. It is essential to position federal child nutrition programs so that we can begin to address these issues.

Fortunately, there are several changes to WIC to consider that could continue to make WIC an even more effective public health nutrition program. I offer the following suggestions for strengthening the nutrition services components of the WIC Program to address child obesity.

Recommendation #1: Maintain and increase time for nutrition education in WIC.
Making healthful choices for one's family requires a knowledge base. Many young parents have had minimal or no nutrition education and as they begin their family they are charged with the most important preventive health decisions for their families. Our WIC studies show that WIC education can be effective. Optimal nutrition education requires sufficient time at WIC appointments to talk with WIC families about their nutrition-related concerns and assist them with overcoming the many barriers to healthy choices. One way to address the need for additional staff time with WIC participants is to ensure that there is adequate funding for the Nutrition Services Administration portion of the WIC appropriation. Another way is to reduce time spent on time-consuming administrative activities.

Precious minutes with WIC families can be saved by extending the "certification period" (how often a child has to be assessed for eligibility for WIC) for children. Currently states have the option to certify infants and breastfeeding women for 1 year at a time. However, the current eligibility period for children – who make up nearly two-thirds of those enrolled in WIC – remains every 6 months. This simple change would allow WIC frontline staff to redirect their focus from paperwork to the provision of timely and preventive anticipatory guidance for a vulnerable population.

Recommendation #2: Congress should ask the USDA to commission a comprehensive scientific review of WIC biochemical assessment and testing regulations.
There is no question that WIC has a role to play in screening for and educating about prevention of iron-deficiency. But it is time to ask: what is the suitable WIC role, and what level of screening is appropriate, given the current public health challenges facing our

population? Given the reduction in iron deficiency anemia concurrent with the dramatic rise in childhood obesity (Sherry, 2001; Polhamus, 2009), an evaluation of the relevance of the WIC blood test requirements is warranted in much the same way that an evaluation of the relevance of the WIC Food Packages was conducted (CWA, 2009).The substantial cost of WIC anemia screening takes precious Nutrition Services funds from focusing on obesity prevention. These funds could be better used by local programs to harness the WIC program's full capacity to address the obesity epidemic.

Recommendation #3: Increase targeted funding for breastfeeding promotion.

The values of breastfeeding are numerous and well known. WIC can be extremely successful in this arena. Breastfeeding is a low-cost way to promote health in children – it reduces infectious disease and chronic disease as well as reduces risk of obesity (Ip, 2007). Targeted funding for breastfeeding promotion and support activities, including the Breastfeeding Peer Counseling Program funding, is critical for WIC to continue its efforts to increase the rates and duration of exclusive breastfeeding. In California, breastfeeding rates have increased by as much as 11% in WIC agencies that have implemented the Breastfeeding Peer Counseling Program with special funds appropriated by Congress (Public Health Foundation Enterprises WIC, 2009). Careful evaluation of the Breastfeeding Peer Counseling Program is important so we can understand which interventions are most effective and why. However, none of the funding for the program can be used for evaluation. Moreover, current funding for the Breastfeeding Peer Counseling Program is not adequate to ensure that all WIC mothers who need it have access to peer counseling.

Recommendation #4: Coordinate nutrition messaging across federal nutrition assistance programs.

Studies show that nutrition education can be effective in influencing knowledge, attitudes and behaviors. A key way to strengthen WIC is to strengthen and align the nutrition messages in the other federal food programs. Otherwise the WIC messages get diluted and lost. It is critical to improve coordination of nutrition messaging and health education efforts between WIC and other nutrition assistance programs serving the same population,

in particular the Supplemental Nutrition Assistance Program (SNAP – the new name for federal Food Stamp Program) and the Child and Adult Care Food Program (CACFP – which is the school meal program equivalent in the child care setting).

Federal nutrition education messages need to be targeted and cohesive, strategic, providing families with young children with coordinated, culturally appropriate messages that encourage and support healthy food and activity choices and promote breastfeeding. Unfortunately, federal nutrition education efforts are the David to private industry's Goliath in terms of resources spent, thus making the need for strong, consistent federal messaging even more important until food marketing to young children is eliminated.

Recommendation #5: Increase funding to support WIC evaluation and outcomes research.

Lastly, I urge you to increase funding for additional large-scale and robust evaluations that will help us build the evidence-base for cost-effective and transferable WIC-based best practices, special interventions and service delivery innovations that can demonstrate promise in preventing obesity, its precursors, and its consequences. I am not suggesting we invest more money to prove once again that WIC achieves its overall goals to improve participant nutrition and health – numerous studies have repeatedly demonstrated that WIC improves diet, birth outcomes, infant feeding practices, cognitive development in children, immunization rate, and savings in health care costs (USDA, 2009). Instead, I emphasize the critical need for a closer examination and comparison of the costs and benefits of multiple strategies used in nutrition services delivery, nutrition education, breastfeeding promotion and direct service activities so that we build upon what works, discard what isn't working and continue to get the most return from WIC's unique investment in these nutrition services to millions of families.

For example, as a result of the FitWIC obesity prevention initiative, we learned that investing in staff wellness was important in increasing staff's effectiveness in engaging participants in obesity prevention behaviors (Crawford, 2004). Based on these findings and other studies, California WIC has supplemented implementation of the new WIC Food

Packages to include employee wellness training, enabling staff to counsel more effectively while supporting them to adopt healthy behaviors in their own lives (California Dept. of Public Health, 2009). In our WIC studies, we have noted a great deal of variation in outcomes across WIC agencies. Systemically examining the factors that contribute to these variations between agencies is another example of how evaluation could lead to program improvements.

Recommendation #6: Finally, to ensure that the WIC Food Packages are responsive to changes in nutritional needs of women, infants and children and in the food supply, we urge periodic assessments of the Food Packages.

While, we are thrilled with the Final Food Package Rule and greatly appreciate the leadership demonstrated by USDA in making significant changes to the Food Packages, we want to be sure that there is opportunity for timely future revisions. To ensure that WIC continues to provide healthy food that complements the most current nutrition education and information provided to families by WIC staff, we strongly urge that the Child Nutrition Act be strengthened to require that the WIC Food Packages be re-evaluated at a minimum of every ten years to reflect current national nutrition guidelines, thus coinciding with the updates to the Dietary Guidelines.

Thank you for the opportunity to share with you these comments on strategies to continually strengthen and update the invaluable WIC program.

Bibliography

Anderson SE, Whitaker RC. Prevalence of obesity among US preschool children in different racial and ethnic groups. Arch Pediatr Adolesc Med. 2009;163:344-348.

California Department of Public Health. Healthy Habits Campaign. 2009. Available at: ww2.cdph.ca.gov/programs/wicworks/Pages/WICHealthyHabitsCampaign.aspx.

California WIC Association. Time to Re-evaluate WIC Blood Test Requirements! April 2009. Available at: www.calwic.org.

Crawford PB, Gosliner W, Strode P, Samuels SE, Burnett C, Craypo L, Yancey AK. Walking the talk: Fit WIC wellness programs improve self-efficacy in pediatric obesity prevention counseling. Am J Public Health. 2004;94:1480-5.

Dietz WH. Health consequences of obesity in youth: childhood predictors of adult disease. Pediatrics. 1998;101:518-25.

Florence MD, Asbridge M, Veugelers PJ. Diet quality and academic performance. J Sch Health. 2008;78:209-15.

Gardner DS, Hosking J, Metcalf BS, Jeffery AN, Voss LD, Wilkin TJ. Contribution of early weight gain to childhood overweight and metabolic health: a longitudinal study (EarlyBird 36). Pediatrics. 2009;123:e67-73.

Harris JL, Pomeranz JL, Lobstein T, Brownell KD. A crisis in the marketplace: how food marketing contributes to childhood obesity and what can be done. Annu Rev Public Health. 2009;30:211-25.

Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. Breastfeeding and maternal and infant health outcomes in developed countries. April 2007. Agency for Healthcare Research and Quality, Rockville, MD. Available at: www.ahrq.gov/clinic/tp/brfouttp.htm.

Messiah S. Overweight Preschoolers Raise Their Heart Disease Risk. American Heart Association's Cardiovascular Disease Epidemiology and Prevention Annual Conference. Palm Harbor, Fl. May, 2009.

Nader PR, O'Brien M, Houts R, Bradley R, Belsky J, Crosnoe R, Friedman S, Mei Z, Susman EJ; National Institute of Child Health and Human Development Early Child Care Research Network. Identifying risk for obesity in early childhood. Pediatrics 2006;118:e594-601.

Ogden CL, Carroll MD, Flegal KM. High body mass index for age among US children and adolescents, 2003-2006. JAMA. 2008;299:2401-5.

Ogden CL, Flegal KM, Carroll MD, Johnson CL. Prevalence and trends in overweight among US children and adolescents, 1999-2000. JAMA. 2002;288:1728-32.

Patrick H, Nicklas TA. A review of family and social determinants of children's eating patterns and diet quality. J Am Coll Nutr. 2005;24:83-92.

Polhamus B, Dalenius K, Borland E, Mackintosh H, Smith B, Grummer-Strawn L. Pediatric Nutrition Surveillance 2007 Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2009.

Public Health Foundation Enterprises WIC Peer Counseling Program Data, Unpublished, 2009.

Sherry B, Mei Z, Yip R. Continuation of the decline in prevalence of anemia in low-income infants and children in five states. Pediatrics 2001;107;677-82.

Trasande L, Chatterjee S. The impact of obesity on health service utilization and costs in childhood. Obesity (Silver Spring). 2009 Mar 19.

USDA. Food and Nutrition Service. How WIC Works. 2009. Available at: www.fns.usda.gov/WIC/aboutwic/howwichelps.htm.