WIC and Breastfeeding

To provide complete disclosure, I state that I am undeniably biased toward breastfeeding (BF) and about the role of the *Special Supplemental Nutrition Program for Women, Infants, and Children* (WIC) in supporting mothers and youngs children. Therefore, when I was approached to tackle the guest editorship for the 2017 JNEB WIC BF supplement, I was delighted. Over 35 manuscripts were submitted for consideration. This supplement contains 12 of those, with others being considered for publication in later issues. All submissions reflected the hard work of WIC professionals, nutrition education researchers, and those involved with promoting, supporting, and protecting BF.

I have personally witnessed dramatic changes in WIC from its humble beginnings to its current status as 1 of the premier federal food assistance programs. These changes reflect the growing body of scientific evidence supporting the needs of infants, young children, and their mothers. Both basic and translational research directed continuous updates to the program. Since its inception, allocation of specific foods in specific amounts to specific classes of participants has been modified while its requirement for providing nutrition education and its commitment to offering social service/medical referrals has remained steadfast.

In 1977, when I began my community nutrition education career as the coordinator for the Riverside County Department of Public Health WIC program, 1 of my first efforts was to write a White Paper to the California WIC program requesting a separate package of foods for lactating mothers, who at that time were receiving the same foods as they did during pregnancy although their nutritional needs were greater. It also was a time when overall BF rates in the US were low, with less than one quarter of newborns ever breastfed before hospital discharge.[1] Furthermore, iron-deficiency anemia among infants aged 6–9 months was high.[2]

In these early years, although WIC nutritionists were charged with encouraging BF, they more often found themselves counseling mothers who were feeding over-diluted, non–iron-fortified infant formula or following their physicians' advice to give cow milk to their babies. For many of us, a primary focus became educating mothers and their health professionals about the risks associated with using these alternative forms of infant feeding and, yes, promoting the use of iron-fortified commercial formula for those non-breastfed babies. As a result, rates of infant iron-deficiency anemia throughout the US plummeted.[2] Although providing iron-fortified infant formula spurred scorn and was seen by some as a deterrent to BF, the positive results of healthier low-income infants cannot be minimized.[3]

Over the subsequent 40 years, a great number of societal changes occurred. Health professionals began to advocate for BF.[4] Campaigns to support BF women were initiated.[5] However, despite all efforts, rates of BF rose more slowly among low-income mothers than in the rest of the population.[6,7] To address these realities, the US Department of Agriculture allocated and has continued to direct additional resources within the WIC program to promote, support, and protect BF. Rates for BF mothers enrolled in WIC are still below those of mothers not enrolled in the program,[8] but great gains have been made, as exemplified by the interventions and strategies aimed directly to mothers enrolled in WIC contained within this supplement.[9-11] In addition to direct interventions, organizational and staff changes were implemented.[12-14] These coordinated strategies reflect the sociological framework upon which WIC operates, while facilitating independent efforts by local and state agencies.

My most memorable WIC experience highlighted the daily challenges and obstacles some mothers participating in WIC face. I was preparing to counsel a pregnant woman. A staff person handed me the mom's self-completed 24-hour recall, which I immediately proceeded to score. I totaled up the servings of dairy foods she was consuming. She was seated in front of my desk. As I was about to start my suggestion for increasing her milk intake, I looked up at her. Seeing her bruised and battered face stopped me in my tracks. She did not need my dietary lecture; she needed an immediate referral for social services. This single experience alerted me to consider judging women carefully and support the choices that make sense for their lives.

Low-income mothers face obstacles and barriers that discourage or even prevent them from BF[15,16] or BF exclusively.[17] For these women, interventions during the prenatal as well as postpartum periods are needed. Let us remember, however, that WIC is but 1 effort in supporting mothers and their families. Alone, WIC cannot change the situations that low-income families face. Inherent socioeconomic differences between women who enroll in WIC and those who do not may not be challenges that WIC can address, because they are uniquely personal life experiences that influence a woman's infant feeding decision.

This supplement presents results of program interventions, administrative innovations, and epidemiological research.[18,19] that it is hoped will inspire nutrition educators to consider what they can do to enhance their own efforts. During production of this supplement, several recent reports and reviews regarding WIC and/or BF were published[3,15,20] that might not have been included within the authors' citation lists. In the upcoming years, efforts to understand and support BF for all families might help the nutrition education community meet Maya Angelou's encouraging words: "Do the best you can until you know better. Then when you know better, do better."

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