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TESTIMONY PRESENTED TO

U.S. SENATE COMMITTEE ON
AGRICULTURE, NUTRITION, AND FORESTRY
SUBCOMMITTEE ON NUTRITION

REAUTHORIZATION OF THE WIC PROGRAM

PRESENTED BY:

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Mr. Chairman, members of the committee, thank you for this opportunity to testify on nutrition and, in particular, on the Women, Infants, and Children Special Supplemental Food Program (WIC). To aid your deliberations on reauthorization of the WIC program we will:

1. Review the 1983 Massachusetts Nutrition Survey;

2. Discuss the programs implemented in Massachusetts in response to the findings; and

3. Discuss Massachusetts' experience and other evidence relevant to the need for WIC reauthorization at a higher funding level to allow more women, infants, and children to participate.

I. MASSACHUSETTS NUTRITION SURVEY

In 1983, Massachusetts was faced with reports from pediatricians of clinical cases of malnutrition among children. Additionally, many individuals were concerned about the impact of federal budgets cuts, increasing unemployment, and the re-emergence of hunger and homelessness in our state. The Massachusetts Legislature raised questions about these reports.

With funding from the Legislature, the Department of Public Health responded to these concerns by conducting the 1983 Massachusetts Nutrition Survey. The survey was intended to complement clinical information and anecdotes by defining the level and type of malnutrition and by identifying high risk groups.

The methods used for the Nutrition Survey can be summarized as follows:

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- We studied 1,429 low-income children between the ages of 6 months and 6 years who attended health centers in 20 cities and towns across the Commonwealth.

- We measured and weighed children and collected recent laboratory information from their medical records.

- We assessed three types of malnutrition using standard public health nutrition indicators: a) height-for-age below the 5th percentile was used as a measure of chronic undernutrition; b) weight-for-height below the 5th percentile was used as a measure of acute undernutrition; c) hematocrit below 33% for children under 2 years and below 34% for children 2 to 6 years was used as a measure of anemia.

The results of the Massachusetts Nutrition Survey make it clear that malnutrition has not been eliminated.

- We found that 9.8% of children had height-for-age below the 5th percentile, nearly double the expected number. Low height-for-age may reflect chronic, long term nutritional deprivation or reduced genetic potential for growth. The level of low height-for-age was highest among the white children in the sample (11.3%) and they were worse off than either black children or Hispanic children. Projecting our age and race specific rates to the state as a whole leads to an estimation of 10,000 to 17,000 chronically undernourished children under age 6 in Massachusetts. There is good evidence that chronic undernutrition adversely affects a child's ability to learn and to fight infection.

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- We found that 3% of children had a weight-for-height below the 5th percentile. It would have been extremely suprising to identify a high level of wasting due to acute malnutrition in this population. Nevertheless, there were children in the group diagnosed as failure-to-thrive, and this is an important population that requires clinical services.

- We discovered 12.9% of children to be anemic. Anemia is always abnormal and most often related to iron deficiency.

- Although we had only a small group of Asian children, including southeast Asian immigrants, they appeared to be a particularly high risk group. 15.7% were low height-for-age and 11.8% were acutely undernourished. Since this is a small group, it does not bias overall findings of the Massachusetts survey.

- The poorest children had the highest percentage of low height-for-age. For those below 100% of the poverty level, the proportion was 10.5% compared to the observed 5% for children above 200% of poverty.

In addition to these findings about the extent of malnutrition and the groups of children at highest risk, we also obtained information on how many of these children were receiving public assistance.

- Using family income levels as an approximation of financial eligibility, our data indicated that many of the sampled children were not receiving benefits even though they seemed to be financially eligible. 32 percent who appeared financially eligible for food stamps were not getting them.

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- 18 percent who appeared financially eligible for Aid to Families with Dependent Children (AFDC) were not obtaining the cash payments.

- 54 percent who were financially eligible for the Women, Infants, and Children supplement food program (WIC) were not enrolled.

This last finding is not suprising, and is actually a high participation rate when compared to WIC's statewide participation rate. At the time of the survey, WIC reached only 19 percent of financially eligible children aged 1 to 5 in Massachusetts. The higher participation rate in this sample may reflect WIC's success in outreach to poverty-level families served by community health centers.

Unlike the AFDC and food stamps programs, which are entitlements, WIC has never had enough money to serve the entire eligible population. To qualify, women, infants, and children must be at nutritional risk as well as financially eligible. In the survey sample we found that 15% of the children who were both financially eligible and who had documented nutritional deficiencies were not enrolled in the WIC program. Extrapolating these findings to the entire state, we estimate that an additional 10,000 children who already show signs of malnutrition should be enrolled in the program.

We are absolutely convinced that the findings of the Massachusetts Nutrition Survey indicate a significant nutrition problem among low income children in Massachusetts.

- The findings are consistent with CDC surveillance data from other parts of the country showing that poor children have higher levels of low height-for-age and anemia.

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- The data are consistent with an enormous body of literature that shows that poor children grow less rapidly than wealthier children of the same genetic stock and that as populations grow more affluent, their children get taller.

- Finally, while the survey design was not perfect (there were practical constraints of funding, time, and personnel limitations), the findings cannot be explained by some chance sampling of populations that are unusually genetically growth retarded. The sample is large enough to be stratified into important racial and ethnic groups and there is no reason to believe that these groupings are systematically biased.

II. THE MASSACHUSETTS PROGRAM FOR UNDERNUTRITION

Faced with the findings of the Massachusetts Nutrition Survey, the state legislature worked closely with the Governor to develop an emergency supplemental budget package of $6.6 million for state fiscal years 1984 and 1985 to address these problems. The supplemental funding included:

- Outreach efforts by the Departments of Public Health and of Public Welfare to enroll more eligible families in WIC, Food Stamps, EPSDT, and AFDC.

- State funds to expand WIC participation by 20,000 persons, including an additional 10,000 high risk children.

- Specialized nutrition programs for Southeast Asians

- Additional funding for specialized activities like failure-to-thrive programs, clinical services for the prevention of low birth weight, and increased efforts to prevent childhood lead poisoning.

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III. WIC: AN EFFECTIVE PROGRAM FOR ADDRESSING MALNUTRITION

Massachusetts decided to channel its maternal and child nutrition efforts through the vehicle of the state WIC program for the following reasons:

- The WIC program targets food and nutrition education to the groups most vulnerable for undernutrition, i.e., pregnant low-income women, their infants who are at increased risk of low birth weight, and young low-income children.

- WIC is not merely a supplemental food program; it is a health program with goals and objectives related to the reduction of low birthweight and to the promotion of optimal growth and development in young children. Food packages are individually tailored following medical and nutritional assessments of specific needs. The program requires that health services be provided by a health agency or by an agency with strong ties to a health care provider to ensure that the at-risk woman, infant, and child population receive comprehensive integrated health services. In Massachusetts and many other states, WIC services are provided by the same local agencies that deliver Title V maternal and child health prenatal and pediatric care.

- WIC is the best available mechanism for us to reach this target population and to address their nutritional concerns. As a state agency, we now have 10 years of experience in administering WIC. Administrative and clinical systems are in place which can rapidly funnel additional funds to populations in need.

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While evaluations of WIC's effectiveness in achieving its health goals are not entirely conclusive, we believe that the evidence, particularly in regard to reduction in low birthweight, is definitely strong enough to support the need to maintain the program. In its recent review, the General Accounting Office (GAO) found that the six studies of the relationship between WIC and increased birthweight were of medium to high quality, and gave support to the program's effectiveness in increasing birthweight. The GAO further found that WIC had a greater positive effect on teenagers, blacks, and those with several health and nutrition related risks. GAO found evidence to suggest that participating in WIC for more than 6 months is associated with increased birthweights. If WIC were funded at an adequate level, women could be maintained on the program for a longer period of time.

For the same reasons that Massachusetts chose WIC as the vehicle for addressing chronic undernutrition among children, we believe that the federal government must expand its commitment to this critical program. We urge that funding for the WIC Program be, at a minimum, $1.36 billion for FY '84, $1.55 billion for FY '85, and $1.70 billion for FY '86.

There are three additional issues which are relevant to the Committee's concerns about nutrition:

First, for historical reasons, the Massachusetts WIC program always served a low proportion of eligible population. This was confirmed by the findings from the nutrition survey that 15 percent of the entire sample were both financially eli-

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gible and had nutritional indicators but were not enrolled in the WIC Program. We used these data to project a needed expansion of 20,000 participants (includes both pregnant women and children) for our state WIC Program and funded this expansion with state funds. We believe that the U.S. Department of Agriculture should develop a methodology to guide expansion on a national level to those in need of supplemental food immediately.

Second, while the USDA has indicated a commitment to equity funding, that is, equalizing participation levels across the states, this can only be achieved fairly by an adequate appropriation increase so that no state is penalized.

Third, in thinking about the better targeting of WIC benefits, we believe that this committee should carefully consider the preventive aspects of WIC as well as its therapeutic aspects. When the WIC Program is under funded, the priority system dictates that children who are already showing signs of malnutrition receive WIC benefits before those who are at risk of malnutrition but who do not yet have signs. Thus, at low levels of funding, the WIC Program acts as a treatment program rather than a program of prevention. While this is important, we feel that expansion of the WIC Program and adequate national funding will allow it to retain the preventive character which was intended in its original legislation. The close ties between WIC Programs and maternal and child health programs will help assure this goal.

IV. SUMMARY

In summary, we urge you to reauthorize the WIC Program at an increased funding level which, at a minimum, guarantees that every high risk woman, infant and

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child, regardless of state of residence, receives the nutritious food, counseling, and adjunct health care which the program provides. We urge funding at levels no less than $1.36 billion in FY '84, $1.55 billion in FY'85, and $1.70 billion in FY '86 so that the program can function as the preventive program it was intended to be. Massachusetts' experience in evaluating WIC's effiency, in studying the nutritional status of poor young children, and in administering the WIC Program, have convinced us that the program is a key and necessary tool for reducing the infant mortality rate and promoting the optimal growth and development of our children. We hope that your review of all the testimony presented here today will convince you of that as well.

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