

Wellness In the Community



Volume 16

Arkansas Breastfeeding and WIC Program Update

Winter, 2003

How WIC is Promoting Wellness In the Community

Susan Winkler, MS, CFCS

The WIC Program includes a nutrition education component that is available to all WIC participants. Lesson plans and education materials are designed to enhance the WIC participant's working knowledge of good nutrition, healthy eating, and other topics of interest. WIC has always maintained that good eating habits start early and preventive measures are most effective when started at an early age.

The Arkansas WIC Program has structured its nutrition education focus to correspond to the overwhelming demand for additional health information on a serious health concern – childhood obesity. The education theme for 2003 is “*Wellness In the Community – Healthy Eating, Healthy Weight, Healthy Living.*” Health and wellness tips, physical activity suggestions,

recipes and family activities will be included in the educational materials to be made available to parents and caregivers through their participation in the WIC program.

Arkansas WIC served an average of 84,000 participants a month during the last federal fiscal year. These participants included pregnant, breastfeeding and postpartum mothers, infants under one year, and children to age five. WIC continually strives to present the newest health information to its participants, and the latest in education and research to the Arkansas educators who share these messages with the participants.

What is WIC doing about childhood obesity? It is the overall goal of Arkansas WIC to address this problem at the earliest possible stage of life before television and advertising media can influence

and alter healthy choices. WIC has the opportunity, challenge and the mandate to provide a variety of health and wellness information to educators and participants.

WIC supports efforts by families to make healthier choices. Each healthy change is one more

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“Nutrition Education: On The Road to Excellence – Fit Kids” teleconference will be presented on April 3, 2003. The purpose of the teleconference is to educate health professionals about obesity and guidelines for effective counseling. See Resources page for more information.

Nutri News

Identifying Obesity in Children

By *Susan Handford, MS, RD, LD*

Did You Know?

People trying to reduce sugar or calories in their diet often think that honey is a better replacement for sugar. However, honey contains more calories, 64 in a tablespoon while sugar has 50. There is no advantage to using honey in place of table sugar.

Honey is not recommended for any child under age one. It is not pasteurized and may contain clostridium botulinum spores that can cause serious illness in young children.

Some foods labeled as sugar-free may contain sweeteners such as sorbitol or mannitol that are another type of sugar. These products are not calorie free and will affect the person's blood glucose.

All carbohydrates affect blood glucose. Simple sugars found in candy and other sweets don't produce an exaggerated rise in blood glucose provided that they are eaten with a meal and counted as a carbohydrate. Sweets should be eaten in moderation as they have little nutritional value and contribute to weight gain.

Pediatric growth charts have been used by health professionals to track the growth of infants, children and adolescents in the United States since charts were developed in 1977. The National Center for Health Statistics (NCHS) developed the charts as a clinical tool to determine if a child's growth is adequate. When the charts were first developed, it was recommended that they be revised periodically. With more recent and comprehensive national data now available, along with improved statistical procedures, the 1977 NCHS charts were revised and updated in 2000. Growth charts are not intended to be used as a sole diagnostic instrument, but rather to contribute to forming an overall clinical impression for the child being measured.

The most significant addition to the revised charts is the addition of Body Mass Index (BMI) charts for boys and for girls, ages 2-20 years. These BMI-for-age charts replace the 1977 weight-for-stature charts. BMI (wt./ht. squared) is used to judge whether an individual's weight is appropriate for their height. BMI is the most commonly used approach to determine if adults are overweight or obese and is also the recommended measure to determine

if children are overweight. The new BMI-for-age charts can be used beginning at 2 years of age, when an accurate stature can be obtained.

In recent years, BMI has received increased attention for pediatric use. In 1994, an expert committee charged with developing guidelines for overweight in adolescence, recommended that BMI be used to screen for overweight adolescents. In addition, in 1997 an expert committee concluded that BMI should be used to screen overweight children, ages 2 years and older, using the BMI curves from the revised charts. Research shows no increased risk of adult obesity based on size during the first two years of life.

In keeping with recommended practice, the WIC program is screening children, beginning at age 2, for overweight using BMI for age. Also, since the risk of overweight in children is greatly increased based on the mother's weight, if the biological mother has a BMI of 30 or greater, the infant or child may be identified as "at risk" for overweight. As a preventive nutrition program, WIC provides families with education and counseling on healthy eating, improved physical activity, and overall healthy lifestyle for healthy weight.

Abreast of the News

By Sandra Jones, RD, MEd, IBCLC

A baby's first food may be one of the keys to preventing obesity in childhood and later life. More than 13% of children and teenagers in the U.S. are currently overweight. Several studies have suggested that exposure to excessive calories in infancy can result in excessive body fat cell development and that babies who gain weight too fast in the first year of life can become obese in later years.

Breastfeeding is one initial strategy to help reduce the risk of overweight in children. Though breastfeeding is not a guarantee that obesity will be prevented, it appears to be one factor that may improve the odds. It is not clear why breastfeeding lowers the risk of

obesity though several explanations have been suggested. First, breastfed infants have more of an opportunity to control the amount of milk they consume. Formula fed babies may be more controlled by the person feeding them who coaxes the baby to empty a bottle based on what the person believes the baby should consume. Second, breastmilk components may impact a baby's metabolism with a more positive effect on fat storage.

A recent study by Dr. Matthew Gillman, Harvard University School of Medicine, published in May 2001 (JAMA) examined 15,000 children and found that those who received more breastmilk than formula or whose

mothers breastfed them for six months or longer had the lowest risk of being overweight by the time they were 9 to 14 years of age, even after controlling for key factors such as dietary intake, physical activity levels and mother's body weight.

A study reported in the June 2002 issue of *The Lancet*, looked at more than 30,000 Scottish children that were between three and four years of age and found a link between breastfeeding and the incidence of obesity. After adjustment for socio-economic status, birth weight and sex, the results suggest that breastfeeding is associated with a reduction in the incidence of obesity.

Program Focus

By Marilou Brodie RD, LD

In 2002, the major infant formula companies began adding long-chain polyunsaturated fatty acids (LC-PUFAs) to a growing number of infant formula products on the market. Similac NeoSure Advance, Enfamil Lipil with iron, Enfamil Prosobee Lipil, Enfamil LactoFree Lipil and Enfamil Premature Lipil are all currently available from the Arkansas WIC Program for infants who

meet specific WIC guidelines. All of these infant milks contain long-chain polyunsaturated fatty acids (LC-PUFAs), specifically arachidonic acid (ARA) and docosahexaenoic (DHA).

It is suggested that the addition of DHA to infant formulas will improve infant visual function and that the addition of both DHA and ARA will improve cognitive development. However, the American Academy of Pediatrics Committee on Nutrition recommended in May 2002 that the Academy not take an official stand on the addition of LC-PUFAs to term infant formulas.

Resources

By Marilou Brodie RD, LD

February 2003

February 23-27

Intensive Course in Nutrition for Infants, Children
and Adolescents

University of Alabama at Birmingham
Birmingham, AL
www.peds.uab.edu
Charlene Rhoades 205-939-9254

February 20-24

The Lactation Counselor Certificate Training Program
The Center for Breastfeeding
8 Jan Sebastian Way, #13
Sandwich, MA 02563
508-888-8044
www.healthychildren.cc or info@healthychildren.cc

February 27-28

Arkansas Lactation Affiliate
5th Annual Arkansas Lactation Conference
Featuring Amy Spangler and Jan Barger
Hot Springs Convention Center
Hot Springs, AR
1-800-445-6175

April 2003

April 3

On the Road to Excellence – Fit Kids!
USDA Southwest Region Satellite Teleconference
Down Link Sites: Arkadelphia, Batesville, Camden,
Fayetteville, Forrest City, Hot Springs, Jonesboro,
Little Rock, Monticello, Russellville, Texarkana
swinkler@healthyarkansas.com

April 23-25

Baptist Health Breastfeeding Management for Health Providers
An intense 3-day course
Little Rock, AR
Sharon Houston
501-202-1956
slhousto@baptist-health.org

April 30-May 2

Shaping A Healthy Future II: A Rocky Mountain
Conference on Weight Realities
Jackson, Wyoming
http://outreach.uwyo.edu/conferences/healthyfutures
1-877-733-3618, extension 2 or 307-766-5249

April 30-May 2

Interdisciplinary Leadership Training in Obesity Prevention and
Intervention for Children with Special Health Care needs
University of Tennessee Boling Center
Memphis, TN
901-448-6589 or 888-572-2249, Fax 901-448-7097;
http://www.utmem.edu/bcdd/obesity_wkshp.html

May 2003

May 10-14

Intensive Course in Pediatric Nutrition
University of Iowa
Iowa City, IA
www.medicine.uiowa.edu/PediatricNutrition/registration.html

WIC continued from front cover

step to wellness. By deciding to make healthier choices as a family, there will be long term benefits. Increasing physical activities, eating more fruits and vegetables, breastfeeding babies, reading to children, and spending family time together are a few ways to increase wellness in the community. Healthy eating can bring about a healthy weight which can help create a healthy lifestyle and that's preventive medicine at it's best!

Spotlight

By Martha S. Hall RN, MSN, IBCLC

Marilou Brodie, MS, RD, LD, is the newest member of the state WIC Work Unit. She will be working on special formula issues and nutrition projects. Marilou has been involved with WIC and regional pediatric nutrition training for health professionals for four years, most recently the Growth Chart “Train-the-Trainer” session. She has served on the ADH Folic Acid committee, March of Dimes Folic Acid committee, Obesity Task Force, Nutrition Summit, and the Arkansas Genetics Advisory Committee. She was appointed to the Arkansas Dietetics Licensure Board by Governor Huckabee and is currently serving as Secretary. She also represents the Health Department on the

UAMS/CAVHS Dietetic Internship Coordinating Cabinet and dietetic internship selection committee and assists in coordination of dietetic intern Public Health Nutrition rotations around the state for both the UAMS/CAVHS and UCA dietetic internships programs. Marilou’s past experiences include general and outpatient clinical dietetics and 11 years of general and specialty pediatric nutrition practice at Arkansas Children’s Hospital. She’s a promoter of breastfeeding and says, “I am so proud of my new great-nephew and his parents who are having a successful breastfeeding experience.”

Questions & Answers

By Susan Handford, MS, RD, LD

Q. Please explain the terms “DHA” and “ARA”.

A. DHA (docosahexaenoic acid) and ARA (arachidonic acid) are types of long-chain polyunsaturated fatty acids that are nutritional building blocks for brain and eye development. Human milk naturally contains these fatty acids with levels varying according to the mother’s diet. Babies also receive these fatty acids in utero from the mother’s placenta, with term babies receiving more than preterm babies do. Infants also make their own DHA and ARA after they are born from the precursors of these fatty acids (linoleic acid and alpha linolenic acid)

both found in all infant formulas marketed in the U.S. Experts vary in their view of the need for DHA and ARA to be added to infant formula. Some recent studies indicate infants are able to synthesize small quantities of these fatty acids. Compared with formula-fed infants, breastfed infants have higher plasma, red blood cell, and tissue levels of the acids. Functional outcome measures in several studies suggest that at least some term infants may need a dietary source of the preformed fatty acids. Other studies, however, have not shown any improvements.

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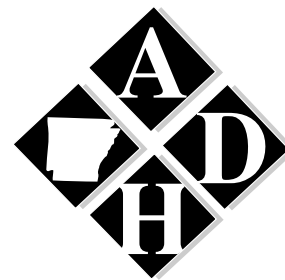
Visit our website at:

<http://www.healthyarkansas.com/breastfeeding/>

Arkansas Department of Health
WIC Nutrition and Breastfeeding
501-661-2905

Breastfeeding Helpline for
Clients and Health Professionals
1-800-445-6175

*To remove your name from the mailing list, call
501-661-2905.*



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