Texas

June 1993

WIC News

Special Supplemental Food Program for Women, Infants and Children

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From Debra Stabeno, WIC Bureau Chief

Expansion contest across state is a growing experience

The *WIC: Grow For It!* contest this May has been a tremendous help in focusing our efforts on expansion.

Sixty-seven WIC projects participated; more than half of these conducted triple issuance at all of their clinics in May and June. At least 120 *new* Saturday clinics were held throughout the state. From reports in the field, we know participation has dramatically increased (we don't know yet *how much*, but we'll share that information as soon as phone participation is collected).

Project directors: Please be certain to send us the names of employees who worked in your Saturday clinics, and the number of hours each person worked, so we can begin our contest drawings!

This is the first time the State Office has sent so many of our staff into the field. Forty-five clerks, nutritionists, supervisors and automation staff were dispatched to assist with *WIC Grow For It* Saturday clinics. The stories from these expeditions could fill a volume, but I'd like to share a few of them with you:

Receptionist **Diane Salem** and card supervisor **Jackie Williams** helped to staff a Saturday clinic in Richmond (Project 29) on May 22.

Diane says: "We were busy all day baby-sitting children and weighing and measuring children. The people were sweet, and we were impressed by the clinic; it was very clean!"

Office manager **Betty Leudecke** and nutritionist **Jeanie Cochrane** worked Saturday, May 1, in the Antone clinic in Houston (Project 48). Jeanie says: "People were waiting to be seen when we opened the clinic at 8 a.m. We worked until after 6 p.m. and the staff took no breaks, no lunch and--believe it or not--there were no complaints!"

Jeanie also worked May 15 in Midland, where the clinic had arranged for free baby clothes to be given away to participants. Betty also worked in Baytown. "I was impressed by the participants," she says. "They came with their children and their sack lunches and waited all day with few complaints. I have the greatest respect for the WIC staff. They are a hard-working group."

Lisa Schultz (administration) and **Lee Marris** (video production) worked in Muleshoe (Project 20) on May 21 and 22.

Lisa says: "They put us right to work. On Friday we passed out fliers in Littlefield, Sudan and Muleshoe, and on Saturday, we did hematocrits, including the actual sticks, and then we issued cards."

Everywhere, State Office staff found hospitable, positive WIC workers. It was a great experience to see firsthand that WIC works--but not without a lot of effort!

My thanks to all of you who participated in *WIC Grow For It*. I hope that it was a growing experience for your clinic and for you, too! ♦

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Texas WIC News

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Texas WIC News

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• Dedicated to the memory of Red Gibson, journalism professor •

Breastfeeding Update

Keeping up with the latest

Changes in breastfeeding

By Chan McDermott, M.P.A
Breastfeeding Promotion Specialist

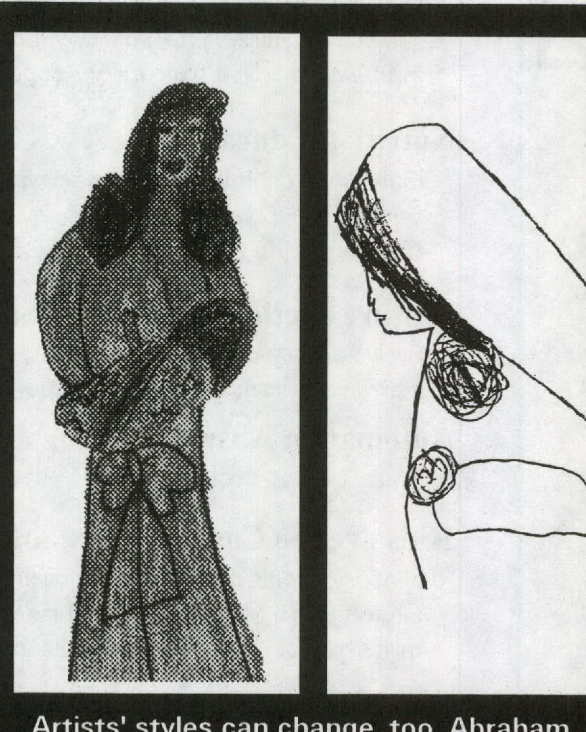
The world of breastfeeding information seems to change all too quickly. First, we learn things one way, and then we're told to do the opposite! If you need proof, check out a breastfeeding pamphlet that's five years old. Would you still stand behind what it says?

What suggestions do some of the experts currently working in the field have for keeping up with the changes? Check it out:

Phyllis Speranza, M.S.N., I.B.C.L.C., lactation consultant (Austin):

"You just have to say, 'Here's the old info and the new info; why don't you try and see what works for you?'

That is something you might have to do. Ask, 'Which one seems like it would work best for you?'"



Artists' styles can change, too. Abraham Padilla of Del Rio, an 8-year-old, drew the breastfeeding mother and baby at left; 4-year-old Danny Salazar, also of Del Rio, drew the Madonna-like pair at right.

Cathy Liles, area professional liaison for La Leche League (College Station):

"I don't think that it changes so fast. Ultimately, they're going to be successful in helping mothers to breastfeed with the volume of knowledge they had 10 years ago. The things that come up now are just useful bits and pieces of information. Read and learn what you can; focus on the mother's self-esteem. That will always be the best way you can help a mother with breast-feeding!" Liles also recommends reading newsletters and publications that update, as well as attending workshops and conferences.

Judy Hopkinson, lactation physiologist and research assistant professor at the Children's

Trained and ready to help

Kiddos drape themselves around their proud mothers as the January 1993 class of breastfeeding peer counselors finishes its training at Project 1 in Austin. The graduates are (bottom row from left) Olga Colon Simons, Julie Anderson and Kristine Kovack and (top row from left) Lisa Scheie, Mary Kraemer, Gabriela Briseno, Sandra Jaimes and Carol Dolman. These women constitute the fourth graduating class. The first was in May 1991, and the next class graduates in September.

Teachers of the 20-hour course were Sherry Scudder, Carolyn Williams and Jeanne Fisher.

Nutrition Research Center in Houston:

Hopkinson says that, when the answers are not clear-cut in medicine, you should always consider the natural setting: Initially, breastfeeding women probably wore no clothes and their nipples got a lot of sun.

"Nothing is absolute," says Hopkinson. "You've got to use your own head. And you can always call an expert. Never believe something--or change your clinical practices regarding something--the first time you hear it. It's got to be substantiated, and there will always be some time before there will be a clear definition of when the new procedure applies. Also, always remember, at some level, the mother knows the answer. Listen to what she's telling you, listen to her hunches. The first rule is, do no harm."

Barbara Wilson-Clay, I.B.C.L.C., La Leche League leader in private practice in Austin:

This expert recommends La Leche League's *Breastfeeding Abstracts* as a quick and easy means of staying up to date. Wilson-Clay says it is an inexpensive quarterly that summarizes the most important, current breastfeeding research.

In an effort to help you keep up with the issues and controversies of breastfeeding, we are starting a new column, "The Jury's Still Out" (see pages 6 and 7). It will survey leaders in the realm of breastfeeding regarding various issues. Keep reading these pages to find out more about moist-wound healing, lanolin, the uses of cabbage and more! ♦

The Jury's Still Out

The case:

Treatment of sore nipples

Dry healing vs. moist-wound healing

By Chan McDermott, M.P.A.
Breastfeeding Promotion Specialist

For the past few years at WIC, we have counseled against the use of lanolin or other nipple creams and ointments.

Our solution for sore nipples is to express some breastmilk, rub it into the skin of the nipples and let them air-dry.

We also advise correct positioning as a preventative measure. We have recently seen reports of a new nipple cream, Lansinoh, which has been endorsed by some pretty knowledgeable individuals and groups.

What makes Lansinoh different--or better--than the rest? The manufacturers claim that the product is 100 percent pure, modified lanolin with all impurities and allergens removed. But why should nursing moms be using any products on their nipples when, for so long, we have told them not to?

Moist-wound healing is not a new concept. It calls for keeping the traumatized skin moist and allowing it to heal slowly.

California pediatrician William Sears, revered for his down-to-earth parenting, breastfeeding and medical advice, writes the following in a letter to Lansinoh Laboratories that is now included in the company's promotional materials: "There have been many proven breakthroughs in the discipline of healing skin wounds and fissures and a complete change of thinking. Instead of *drying* an already damaged, cracked nipple, the treatment would be to increase the moisture content of the skin (i.e., by applying a product such as Lansinoh). By allowing the skin to regain a proper moisture balance, a rapid healing is facilitated, without crust or scab formation."

What do other experts feel about moist-wound healing as it applies to sore nipples? We polled a few:

Judy Hopkinson, lactation physiologist, research assistant professor, the Children's Nutrition Research Center, Houston:

"It's important to make a distinction between prevention and treatment. One of the things we want to prevent is fungal growth, like yeast infections. In this case, it's like diaper rash: A clean dry bottom, and a clean dry breast, mean prevention." Sunlight is also good, she says. Some nipple soreness is inevitable because of the increased skin sensitivity at this time, she adds. "Once you get into nipple damage, you might consider moist healing as a treatment if it seems appropriate."

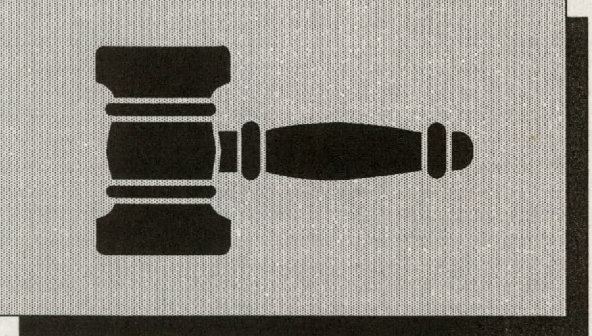
Barbara Wilson-Clay, I.B.C.L.C., La Leche League leader, lactation consultant, Austin:

"My complaint with lanolin was bad allergic reactions, allergic dermatitis.

(But) the published data (on Lansinoh) looks good. The theory of moist-wound healing has actually been nicely clinically demonstrated." Wilson-Clay compares it to lubricating chapped lips: "A very thin coat which holds necessary moisture in and lets the wound knit. Not a wet compress, but an emollient barrier. We're trying to preserve the fluid balance internally." Wilson-Clay says she would counsel use of Lansinoh or lanolin very carefully--and certainly not for anything that looked like it might be fungal, since yeast thrives in a moist environment. She has used an emollient in cases where there is severe cracking and she says the client seemed to like it.

Debi Bocar, R.N., M.S., I.B.C.L.C., lactation consultant, Oklahoma City:

Bocar says her opinion is an evolving one. Two ongoing studies are now looking into moist-wound healing for sore nipples, one being conducted by Kathleen Huggins. "We used to say, `No ointments whatsoever.' It's looking real encouraging in terms of rethinking, particularly with severely traumatized nipples." Bocar doesn't recommend using lanolin routinely to prevent sore nipples. Instead, she thinks the underlying cause of the trauma should be considered. She expresses concern that women may think there's a "magic ointment" that will cure all their soreness. However, she says, in quite severe cases, a very thin application of highly purified, medical-grade lanolin (such as Lansinoh) can be useful. "A certain percentage of moms really benefit from the placebo effect," Bocar says. "They really want to do something." One concern is that babies sometimes don't like the taste of the lanolin so it must be removed, a problem for traumatized nipples. Another concern is that lanolin can clog the nipple pores, which is why Bocar cautions against using too much. Every situation must be considered independently, Bocar says. The humidity of the climate the woman lives in makes a difference, as does the woman's body type. "As with any treatment plan," she says, "you constantly re-evaluate and determine if you want to continue that treatment."



Cathy Liles, La Leche League area liaison, College Station:

"The healing of sore nipples is primarily responsive to proper positioning. It has very little to do with wet or dry healing. I think nipples will heal very quickly regardless of how they're treated once positioning is corrected."

Phyllis Speranza, M.S.N., I.B.C.L.C., lactation consultant, Austin:

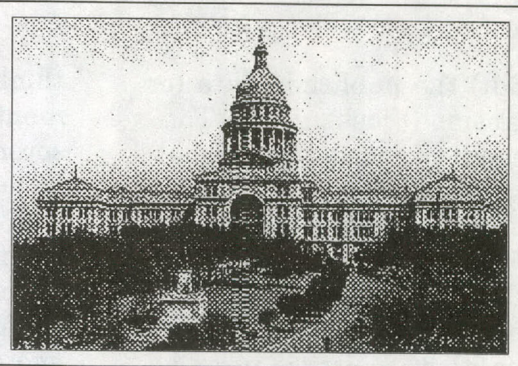
"When you're talking about a breast, you're talking about a naturally moist environment. You've got bacteria in the baby's saliva. But you've got bacteria-fighting properties in the breastmilk. There's the lysozymes that are secreted by the Montgomery glands, and that's supposed to prevent infection. Natural oils, also secreted by the Montgomery glands, help to keep a moisture balance in the areola tissue," she says.

"What did they do before we had this sheepskin product? But, instead of emphasizing soreness, I'd rather look at prevention, as in latch-on. What is causing the soreness?"

Ruth Lawrence, M.D., obstetrician and pediatrician, Rochester, N.Y.:

Dr. Lawrence's two primary concerns with lanolin are wool allergies and insecticides. She feels that, moist healing might be useful in a dry climate, but that air drying would be preferred in a humid climate. ♦

- **Walk around the Capitol:** *Display banners.*
- **Speakers:** *Notable breastfeeding advocates.*
- **Certificates for outstanding breastfeeding promoters:** *Nominate a worthy person.*
- **Exhibits:** *Bring an exhibit to share your ideas.*
- **Baby blanket contest:** *Blankets and quilts must have a breastfeeding theme.*
- **Coloring contest:** *Children are asked to draw a picture for World Breastfeeding Day.*
- **Picnic:** *Bring your lunch.*



Join the celebration at the Capitol

World Breastfeeding Day

By Jewell Stremler, C.L.E.
Peer Counselor Coordinator

TDH-WIC is joining with La Leche League of Texas and the Texas Healthy Mothers, Healthy Babies Coalition to sponsor a walk around the state Capitol and a rally and picnic on its grounds Aug. 1 to celebrate World Breastfeeding Day.

Texas Gov. Ann Richards has declared August "Breastfeeding Awareness Month." Events at the Capitol will give moms, babies, WIC staff, La Leche League groups, health professionals, lactation consultants, peer counselors and everybody who wants to support breastfeeding promotion an opportunity to kick off Breastfeeding Awareness Month activities.

Many local agencies and La Leche League groups around the state are planning World Breastfeeding Day events in their cities and towns. Some communities are planning local events on July 31 so they can travel to Austin to join the statewide celebration the next day.

Last year, many Texas projects celebrated World Breastfeeding Day in their WIC clinics. Vera Petteway-Nyormoi, breastfeeding coordinator at Project 26 in Houston, held a World Breastfeeding Day celebration in place of her nutrition education contact that day. More than 100 breastfeeding mothers joined in the celebration and picked up their food cards. A festive atmosphere was created by speakers (including her breastfeeding peer counselors), musicians (some staff members sang Spanish lullabies) and balloons. Petteway-Nyormoi handed out certificates that read, "I, (baby's name), am a breastfed baby because my mother, (mother's name), loves me so much." The media people at her health department videotaped the celebration, and a segment of it ran on Houston's public-access TV.

The governor's proclamation can be used as a model for a city or county one that can get the attention of your local media. World Breastfeeding Day and Breastfeeding Awareness Month activities can be combined with outreach efforts. Promote breastfeeding and advertise your local agency at the same time.

If you need any help in planning for Breastfeeding Awareness Month, call Janet Rourke, Jewell Stremler or Chan McDermott, WIC State Office breastfeeding promotion staff, at (512) 458-7437. ♦

Local Agency News

Routine WIC certification is a lifesaver for infant

By Carmen Keltner
Staff Writer

Little Ramon Lopez Jr., a South Texas baby, celebrated his first birthday in February--healthy and happy--thanks to the alertness of the staff at Project 88 in Halletsville.

When Ramon's parents brought in the 3-week-old infant for his WIC certification, public health nurse Theresa Kostelnik, R.N., noticed that the baby's head was enlarged. "The mother didn't realize that anything was wrong," said Kostelnik. No one in the infant's family had noticed the problem.

Kostelnik measured the baby's head circumference to confirm her suspicion of hydrocephalus, commonly known as "water on the brain."

"We don't normally do head circumferences," said

Rosa Carrillo, director of Project 88, noting that the Halletsville WIC clinic is part of an integrated city clinic. She praised the staff for being alert to a serious problem that needed further referral. Kostelnik referred the family to a medical doctor. Ramon was rushed to Santa Rosa Hospital and then to San Antonio. Without treatment, he could have suffered permanent damage.

Kostelnik noted that it's unusual for the clinic staff to see an acute-care case like this one. "Normally, they have already been diagnosed before we see them," she said. This story had a happy ending because the staff was concerned about the infant's overall well-being--not just about his WIC certification. ♦

Project 88 mourns co-worker

'If love alone could have saved you, you never would have died.'

On April 29, Project 88 community service aide Julia Ann Mondine died suddenly, the victim of a shooting. She had worked with WIC in Kingsville for almost 12 years. "Julia wasn't only our friend," says nutritionist Linda Buck. "She was also an excellent worker: very responsible, dedicated and hard-working. All of us are really going to miss her."

Mondine is survived by her mother and father, three sisters, two brothers and a host of nieces, nephews, cousins and friends--among them her grieving co-workers at WIC. ♦

Volunteer teaches parenting classes at Project 35

When WIC mothers at Project 35 in Denton recently started asking staffers if parenting classes could be offered to them, a home economist named Barbara Fowler happened to offer her services to the clinic. A teacher in various topics--including wok cooking and weight loss--Fowler works as an extension agent with the Texas Agricultural Extension Service. Since April, she has been volunteering her time to WIC to teach parenting classes.

"In July, we'll change the classes to Mondays and Tuesdays right after the clients get out of their nutrition education classes," says Trisha Battle, breastfeeding coordinator at Project 35. "The parenting classes are not in place of the regular classes; they're in coordination with them."

Topics in the classes, which last about 30 or 45 minutes, involve helping babies to grow in many ways, helping children to learn self-control, helping children to learn to feel good and helping children to learn to listen and to talk well. Fowler has brought college students to the classes to help with her presentations and has shown videos and demonstrated how to make homemade toys.

"The clients seem to really enjoy her classes," says Battle. "We've even had some daddies come in to them--and to some of the breastfeeding classes, too." ♦

Classy group:

Project 59's first breastfeeding peer counselors

(Left to right:)

- **Claudia Isaacs**, *at 18 the youngest in class, breastfed her little girl for 4½ months. She's a full-time mom and part-time student.*
- **Dalia Escamilla** *briefly breastfed all three of her kids. She's excited about helping new moms.*
- **Veronica Molina** *breastfed all three of her children for 2 to 6 months. She's a real 'go-getter.'*
- **Grace Gomez**, *who briefly breastfed her 2 older children, is still breastfeeding her 6-month-old daughter, Gracie.*
- **Aurora Flores**, *Project 59 breastfeeding coordinator, is the mother of 2 teens, each breastfed for more than a year.*
- **Lucy Perez**, *mother of four (2 teens, a 5-year-old and an 8-month-old), is still wholely breastfeeding her baby. She's the only volunteer worker.*
- **Mary Rodriguez** *(not shown) has a 14-year-old and a baby breastfed for 4 months.*

Project 33 opens new clinic

Clerical supervisors and administrative staff open up the new Marks clinic in El Paso.

At a ribbon-cutting ceremony on April 1, Project 33's newest clinic was opened in the northeast area of El Paso. "This clinic will see approximately 4,000 clients," says Donna Seward, chief of the WIC Division of the El Paso City-County Health District. "Some of these clients will be transfers from the Northeast clinic, and this will allow for growth at both locations."

Project 33 staffers were joined at the ceremony by local dignitaries such as city representative Stan Roberts and Dr. Laurance Nickey, director of the health district. TDH was represented by Cindy Banister, M.S.N., and Steve McNeely, M.Ed. Valerie Kocker of the Centers for Disease Control in Atlanta also attended the opening of the project's 13th clinic site.

A 14th site is scheduled to be opened in September. ♦

Project 17 finds ways to increase caseload

Esmeralda Waites, outreach coordinator for Project 17 in Houston, reports the following activities to increase caseload:

(1) WIC staffers started working at the clinics during lunch hours and on Saturdays and late nights.

(2) To cut back on waiting time at the local agency, income screening was done at local medicaid offices, after which clients got appointments at the local agency to finish labwork and counseling and to pick up their WIC cards.

(3) Waites spoke on radio for 30 minutes on May 18 about WIC eligibility. She encouraged listeners to the public-affairs program on KLAT to call WIC for an appointment.

(4) Karen Gibson, director of Project 17, appeared on TV station KTXH on May 22, giving background and eligibility information about WIC and its benefits. She also completed a continuously run segment for TV station KTRH called "Just a Minute." ♦

Happy Father's Day to all of our WIC dads

Projects renumbered--again

The WIC project is Lubbock is now Project 75. It used to be Project 14. (For a short while, it had been renumbered as Project 77.)

The WIC project in Amarillo is now Project 78. It used to be Project 55. (For a short while, it had been renumbered as Project 78 and then as Project 76.)

Lufkin WIC celebrates moms

Project 58 also welcomes new administrator to health district

New administrator John Bautch receives a welcoming gift.

Project 58 director Barbara Dubose presents client Molly White with a vendor's donation.

On May 8, WIC Project 58 in Lufkin held a special clinic in order to sign up new WIC participants and to reinstate former participants. All of the Lufkin area vendors donated either fruit baskets, merchandise or gift certificates to be given to the clients whose names were drawn. Molly White, a former participant who was reinstated that day as a pregnant client, was the first person for an appointment and the first winner of a gift. That just goes to show that the early bird does in fact get the worm.

All the new clients were welcomed to the WIC office with a special Mother's Day bulletin board designed with special flair by nutritionist Mary Ann Defoyd.

Also, Project 58 is happy to welcome John Bautch, the new administrator for the Angelina County and Cities Health District. He is very supportive of the WIC program. Since the staff is somewhat camera-shy, he handled most of the interviews with the local TV station. To welcome him to East Texas, the WIC staff presented Bautch with a custom-framed print of the historic Cotton Square train depot in the center of Lufkin.

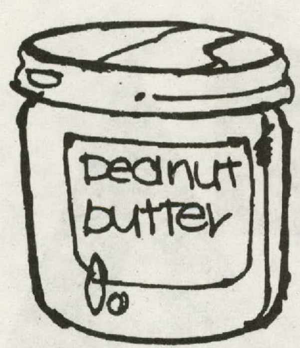
On May 15, the WIC staff participated in a health fair at the Wilson McKewen Treatment Center in Lufkin, and several appointments were made for new WIC participants. Bautch was there, too, and took time out from this schedule to assist director Barbara Dubose and clerk Teresa Blangger distribute flyers at several local shopping centers announcing our expanded hours and upcoming Saturday clinic on June 19. WIC staffers believe Bautch is sure to be an asset not only to WIC and the Angelina County and Cities Health District, but to the entire East Texas area. ♦

Energetic Project 82 nurse featured in Pampa newspaper

A Mother's Day feature article in the *Pampa News* highlighted the hectic and productive activities of Shari Davenport, Project 82's hard-working competent professional authority.

Davenport, the mother of four youngsters and the wife of a Panhandle ranch manager, keeps her days full to the brim with her responsibilities at WIC-- and then the family ones always waiting at home.

The article included a nice photo of Davenport and her family enjoying a meal at a chuck wagon during spring roundup.



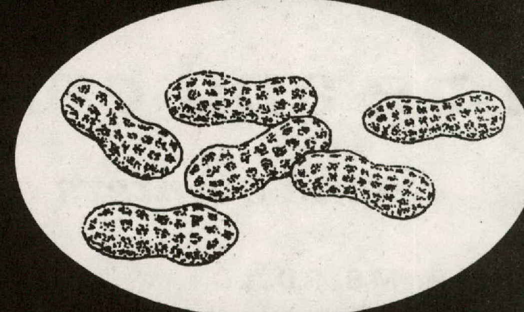
Sticking with PEANUT BUTTER

WIC participants sometimes find their cupboards filling up with more peanut butter than they know what to do with. Here are some tasty and wholesome recipes that staffers can recommend to WIC moms for serving to their families.

PEANUT BUTTER SURPRISE

3/4 cup peanut butter
1/4 tsp. cinnamon
1/2 cup raisins
3 small very ripe bananas
1 Tbsp. shredded coconut

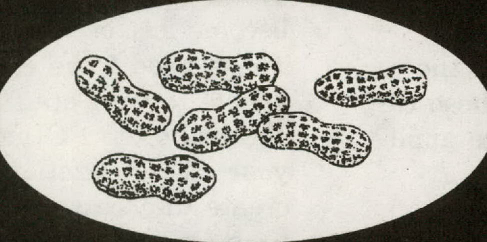
Mash together peanut butter and bananas in mixing bowl with fork. Add cinnamon, coconut and raisins. Blend well. Good on fruit, bread or crackers.



BANANA POPS

2 bananas
1/2 cup peanut butter
2 Tbsp. milk
Crushed WIC cereal

Peel bananas and cut in half lengthwise. Insert popsicle stick into end of banana. Mix peanut butter and milk together. Roll bananas in peanut butter-and-milk mix. Roll in crushed cereal. Place on wax paper and freeze for 2 hours.

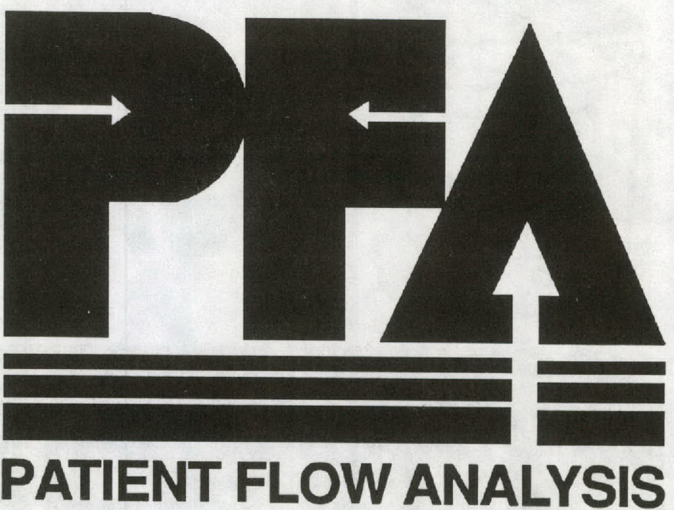


PEANUT BUTTER BREAD

2 cups flour (white or wheat)
1/4 cup sugar or honey
2/3 cup peanut butter
1 tsp. salt
4 tsp. baking powder
1-1/4 cup milk

Mix dry ingredients together in a large bowl. If using honey, cream it with the peanut butter in a separate bowl. Heat the milk until lukewarm, then add the peanut butter and blend well. Add the wet and dry ingredients together and beat thoroughly. Pour into a greased loaf pan and bake at 350°F for 45-50 minutes.

NOTE: Peanut butter and raisins should not be given to children under the age of 2.



Time and energy management

Some pointers on improving clinic flow

By Carol Filer, M.S., R.D., L.D.
Nutritionist, Clinic Management

As a trainer of patient-flow analysis, I have observed many techniques and procedures used by local agencies that have been proven to be time-saving and energy-saving. These tips could help you eliminate chaos in your clinic and enable you to deliver better customer service.

☞ Complete your preparation work

Have applicants' charts pulled before they arrive. Allowing time at the end of each day to pull records for the next day's appointments can reduce applicant waiting time during certification.

Make folders for applicants ahead of time. Instead of pulling all of the necessary forms for an initial certification at the appointment time, these can be collated before the applicant arrives.

☞ Organize your clinic

Have drop boxes for applicant charts easily accessible to each task area (such as the income-screening area, CPA's area, lab area, food-voucher-processing area). This will allow staffers to know the applicant is ready for the next step of the certification/eligibility process and will prevent having any applicants "fall through the cracks." Without drop boxes, charts can become lost or forgotten. These need to be clearly visible to your staff and checked often. Otherwise, your disorganization can create unnecessary waiting time for applicants.

Clearly mark areas in the building so that applicants know where to go. Some clinics number the rooms, or put names of the staff or task completed at each room.

☞ Organize your work areas

Store items at their point of use. Records are more convenient when stored close

A meeting of the minds

• Directors and staff from nine local agencies met for the second phase of patient-flow analysis training in late May. Utilizing this participative management tool, everyone contributed to brainstorming solutions for streamlining the flow of participants through WIC clinics. This sharing session proved to be a powerful tool as each project devised an action plan for use back home.
• Above: PFA trainees from Project 13: Elisa Perez, director; Elisa Flores, clerk; Consuelo Aguirre, health aide; and Maria Reyna, health aide.
• Opposite page: PFA trainees from Project 28: Mary Bryant, director; and George Villarreal, C.P.A.

to the reception area. If you must walk a distance to your records, you are wasting time and energy.

Store frequently used items in the normal work area where they are easy accessible, and store less frequently used items in the maximum work area.

(Definitions: The *normal work area* is the area closest to you, reachable by the hand and forearm; accessibility does not require movement of the upper arm or body. The *maximum work area* is the area around you that's reachable by the full arm from the shoulder; accessibility does not require you to use your shoulder muscles or other parts of the body.)

Storing items in these work areas will reduce the amount of reaching and will require less energy. Work done outside these areas can cause body strain and be more tiring.

Rarely used items should be stored somewhere other than the normal work area and the maximum work area. Likewise, extra-large quantities of pamphlets and forms should be stored elsewhere.

☞ Dovetail your work

When you complete two or more tasks at a time, you are dovetailing. While you are waiting for participants to remove their shoes or their children's shoes and clothing, use this time wisely: Gather the medical history, talk about the benefits of breastfeeding or score the diet recall.

Upon arrival, applicants can give staff all of their income information so that the WIC 19 can be completed while applicants jot down--using paper and pencil you've provided--their previous day's food intake.

When all the information on the WIC-19 is completed, staff can have the applicant sign and date the form.

☞ Schedule clinic tasks simultaneously

Clinic staff can prepare food vouchers while the CPA is conducting individual counseling. The CPA can pass a participant's chart to the data-entry clerk immediately after completing the assessment; this can reduce the participant's waiting time.

By using this procedure, cards are ready for issuance immediately after counseling is completed.

While cards are being processed by staff, new participants can read a set of individualized instructions or listen to a video explaining the food vouchers. ♦

Local agencies respond to training survey

Lots of excellent suggestions received--and heard

By Victoria Cummings, M.P.H.
Training Officer

We asked. You responded. Fifty-two local-agency personnel took time out of their busy schedules to complete the training survey administered in November 1992 by the State Agency.

Here's how you answered: Most respondents said they hired clinic personnel less than once a year, with the biggest turnover being among intake and data-entry clerks. Most staff training is done by local-agency personnel and is most often provided either through general staff meetings or through in-services. Most respondents agreed they need two to three months' advance notice to schedule training.

You also suggested that the State Agency provide training on a range of topics including assertive listening, income screening, gestational diabetes, child development, parenting skills, preventing staff burn-out, serving mentally ill clients, and issuance of exception formula.

Overwhelmingly, you said, "Come to us!" (to deliver training). You asked for more regional training as opposed to training in Austin.

In most cases, regional training or the use of videos were the training vehicles of choice, with articles in this newsletter running as a respectable third method.

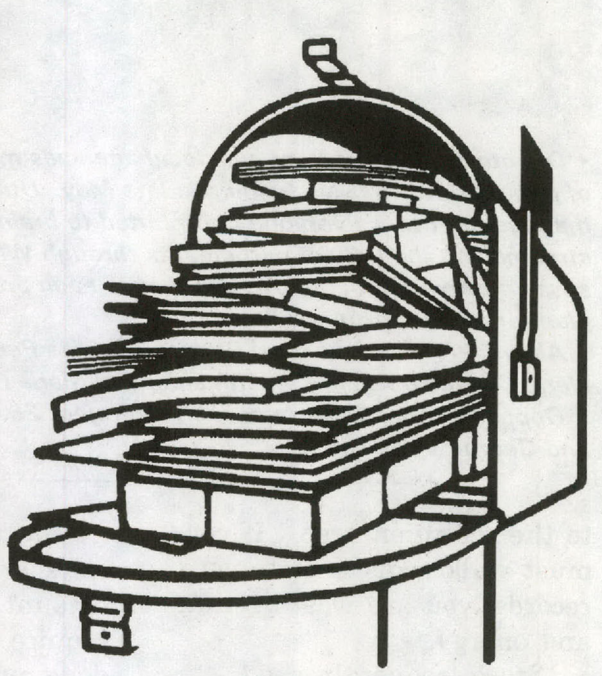
The comment section was full of great suggestions and ideas for other speakers, resources, etc., such as:

• Using WIC employees and/or former participants to cover certain topics.

• Using speakers from local hospitals.

• Using successful local businesspersons to provide tips on helping and maintaining customers.

• Having regional meetings geared toward particular job titles (clerks, CPAs, lab personnel, etc.).



What's on the table?

The State Agency training section is already on its way to addressing some of the requests made on the survey. Scheduled for completion this fiscal year are the *Hematocrit and Hemoglobin* video and manual, *Orientation to WIC* (a self-paced module), and customer-service seminars (regional).

The infant and pre-school modules are at the Texas

Department of Health print shop now. We are hoping to follow with the prenatal module in the near future. Early in the next fiscal year, we hope to provide additional regional seminars on the nutritional needs of premature infants and infants with special needs.

Two of our State Agency staff have been certified as facilitators for the "Stephen Covey Seven Habits of Highly Effective People," which we hope to be able to provide on a regional basis for local agency directors and clinic managers in FY '94.

We are also looking into providing resource lists on such topics as:

- Facility planning.
- Obtaining and recording medical histories.
- Coordinating with other programs.
- Parenting communication skills.
- Child development.
- Identifying and reporting child abuse.
- Dealing with mentally ill clients.
- Staff burnout.

Some facility-planning information currently exists with Carol Filer and Brian Senecal, who conduct PFA training at the State Agency. They are in the process of trying to obtain more information and are eager to share what they have with many of you as they acquire it.

In addition, some information on clinic safety and infection control does exist in the current video on hematocrit and hemoglobin. State Agency staff are looking into existing videos or other materials that can easily be available for use in the local agencies.

Look for future articles in this publication on developing vendor relations. The April 1993 *Texas Wic News* features an article on child abuse; the August 1993 issue will feature a resource list that will offer local sources of speakers, films, etc.

Currently, there is plenty of help available on setting up a breastfeeding-friendly clinic. Call Janet Rourke, Chan McDermott or Jewell Stremler, 458-7437, at the State Office.

Your State Agency nutrition education contact person, also at 458-7437, can offer individual help on designing effective nutrition education materials and lessons.

If there are other areas with which you need training help, contact Tom Gosnell, training coordinator, at 458-7111, ext. 3428.

Training needs you asked for

For CPAs:

- Effective methods for nutrition education (NE)
- Developing NE locally
- Obtaining/recording medical histories
- Nutritional needs of premature infants
- Nutritional needs of infants with special needs

For office personnel:

- Facility planning
- Developing/maintaining vendor relations
- Budgeting

For all staff:

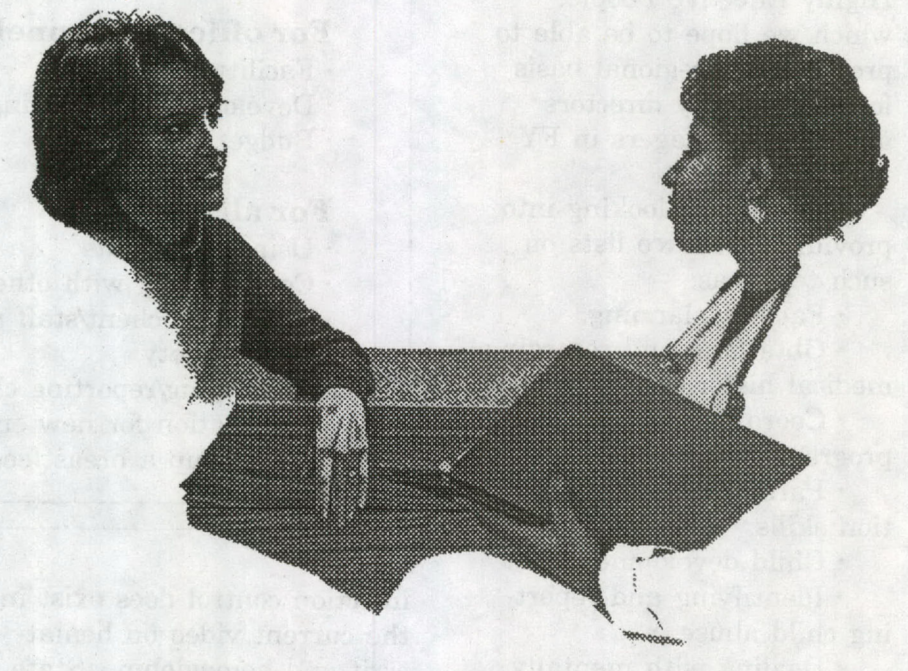
- Using self-audits
- Coordinating with other programs
- Improving client/staff relations
- Clinic safety
- Identifying/reporting child abuse
- Orientation for new employees
- Setting up a breastfeeding-friendly clinic

Nutrition Education

Individual counseling

Guidelines during rapid expansion

By Jeanie Cochrane, R.D., L.D.
Nutrition Education Specialist



If your time for individual counseling is stretched, you may want to try some of the following ideas to make individual counseling (IC) more effective with the time you have available.

(1) Do what is required by policy first. Inform participants of the risk conditions that qualified them for WIC.

(2) Ask the participant what nutrition information she would like about improving her risk conditions or her diet. Tell her what she wants to know. If she does not indicate a specific interest, counsel her on her most important risk condition.

If you have time after you have addressed her concerns, then cover other nutrition information.

(3) Spend more time with high-risk (high-priority) participants.

For example: A child who is failure-to-thrive (priority III) is at greater risk than a child with three diet deficiencies and normal growth (priority V).

(4) Don't try to cover everything in individual counseling.

- Provide information on the participant's greatest need.

For example: A pregnant woman who is not gaining enough weight may need information specific to weight gain rather than breast-feeding information.

- Don't tell participants what they already know.

For example: A mother with an anemic child may know all about foods with iron. She may need help on getting her child to eat these foods.

- If the participant will attend a group class, don't cover the same information in individual counseling.

For example: For a prior-

The family meal

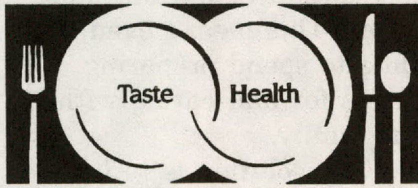
Is good eating more than just nutrients?

By Barbara Bremner, M.S.
Nutrition Education Specialist

How many of you had dinner with your family last night? Studies show that the number of people who say "yes" to this question is decreasing.

A recent national poll of parents with children under age 18 discovered that one in five families had not eaten dinner together the previous evening. Another survey found that 54 percent of children ages 9 to 15 eat with their families every day. That means that 46 percent do not!

What's interesting is that immigrants to the United States share most of their meals together as a family. This shared activity starts to decrease as they adapt to life in their new country.



Why family meals matter

Anthropologists tell us that sharing meals together is very important. For society, meals are a way to strengthen relationships and show our cultural and ethnic heritage. Food and mealtimes also provide the break we need in our working day. For families, mealtimes are even more important.

Studies have shown that parents spend far less time with their children than they used to. Children are starving from a lack of parental time, attention and affection. Sharing meals together is one way to change this. When parents share a meal with their children, they can give them attention, talk to and listen to them and give them experience in conversation.

Any meal shared with family members that is not being spent watching TV,

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ity V child, use IC to address the caregiver's concerns and to tell them why she and her child qualify for WIC. Tell them they will get diet information in their group class. In the meantime, ask them if they would like a pamphlet about feeding children. Move on to the next person.

(5) Refer when needed. For example: Use peer counselors for breastfeeding motivation, refer children with feeding problems resulting from a disability to Early Childhood Intervention, etc.

Remember:

- WIC has a commitment to provide IC to all participants at certification.
- IC should always be an interaction between you and the participant. If you find yourself doing all of the talking, stop and ask the participant for her input. ♦

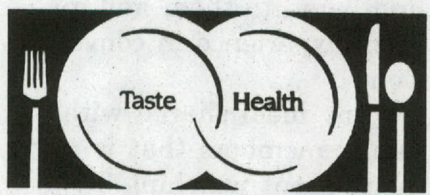
reading or being scolded is likely to be valuable. Families can share information and love that they don't have any other time to express. Meals can be especially effective in increasing the well-being of children.

Many children are receiving the food they need, but they lack the emotional and intellectual nourishment that comes with a shared family meal. To benefit from family meals, what you eat is not important, nor is the size of the family. A meal can be an elaborate dinner eaten with all of your relatives or a simple bowl of soup that a single mother eats with her child. Whatever the case, children can be nourished by the attention they receive.

Eating meals together as a family also teaches children about their cultural heritage. Rituals, such as those around holidays, give children a sense of security and a sense of how their family works together. This makes families strong. Family meals are also important because they are often more nutritious than those eaten outside of the home.

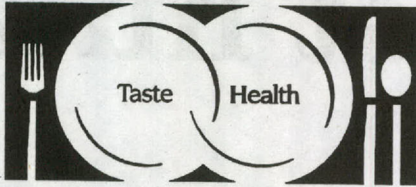
Why family meals are declining

Why are families eating



together less? It's not that people don't want to spend more time with their families, or that they don't want to eat together. The other "pulls" are just too great.

Think of the work and time constraints that most families face. Many women



today work outside of the home, yet they're still expected to do most of the child care and household work. Despite many changes in society, men are reluctant to share food preparation responsibilities. Where do women find the time?

Also, more and more parents are attending school, in addition to working full-time. This means even less time to spend preparing meals for and eating with the family.

One solution is to have children do more of the cooking. A recent survey found that 87 percent of children cooked or made some of their own meals--most often, snacks and breakfast. While this is a help with food preparation, it doesn't help the family socially if the child ends up eating alone.

What WIC can do

What is needed, I think, is a shift in emphasis and some practical solutions. As health promoters and nutritionists, we need to realize that eating enough of the right nutrients is only part of eating right. In WIC, do we need to look beyond the diet-deficiency score and start talking to our participants about family meals?

What about some practical solutions? It is necessary to find ways of bringing back family meals without making life any harder for women than it is already.

Family meals don't have to be home-prepared or even eaten at home (although this is preferable). For children, going out with the family to eat a simple meal can be a real treat--for Mom too, because she doesn't have to prepare it! This, unfortunately, is not an option for many WIC participants.

Eating together every night may not be a realistic goal for every family. How about setting aside a few evenings a week for "family meals" and making these priority occasions?

Families also need to start thinking of mealtimes as recreation. Even if a meal is simple, meals can be pleasurable. Meals should not be disciplinary occasions where children are scolded for their behavior or lack of behavior! If meals are not pleasant, children may grow

up even less likely to share meals with their families. Family members can try to think of things that will make meals pleasurable, such as listening to music or telling stories.

Finally, what have you found useful in keeping the family eating together? It may be worth sharing these tips with WIC participants. Also, don't forget to ask your participants for their solutions to the disappearing family meal!

Encouraging families to eat together is one emphasis of a project called Resetting the American Table: Creating a New Alliance of Taste and Health.

This is an effort by chefs, dieticians, food and health writers, educators and physicians, product developers and researchers to help Americans rediscover the joys of eating while moving towards a healthier diet. Both health professionals and taste professionals agree that healthful eating and the enjoyment of food are rooted in the home, around the family table. ♦

Reference:
M. Mackenzie (1993): "Is the Family Meal Disappearing?" *Journal of Gastronomy* 7(1):34-45.

Diversity in WIC

Body language

Culture-specific strategies in counseling

By Jeanie Cochrane, R.D., L.D.
Nutrition Education Specialist

I am beginning a series of articles that will focus on the diversity of the WIC population and how each local agency can respond to the specific needs of the special populations they serve. Topics will include culture specific counseling strategies, counseling the bored or highly educated WIC participant, culture-specific foods, meal suggestions for homeless participants and many more topics.

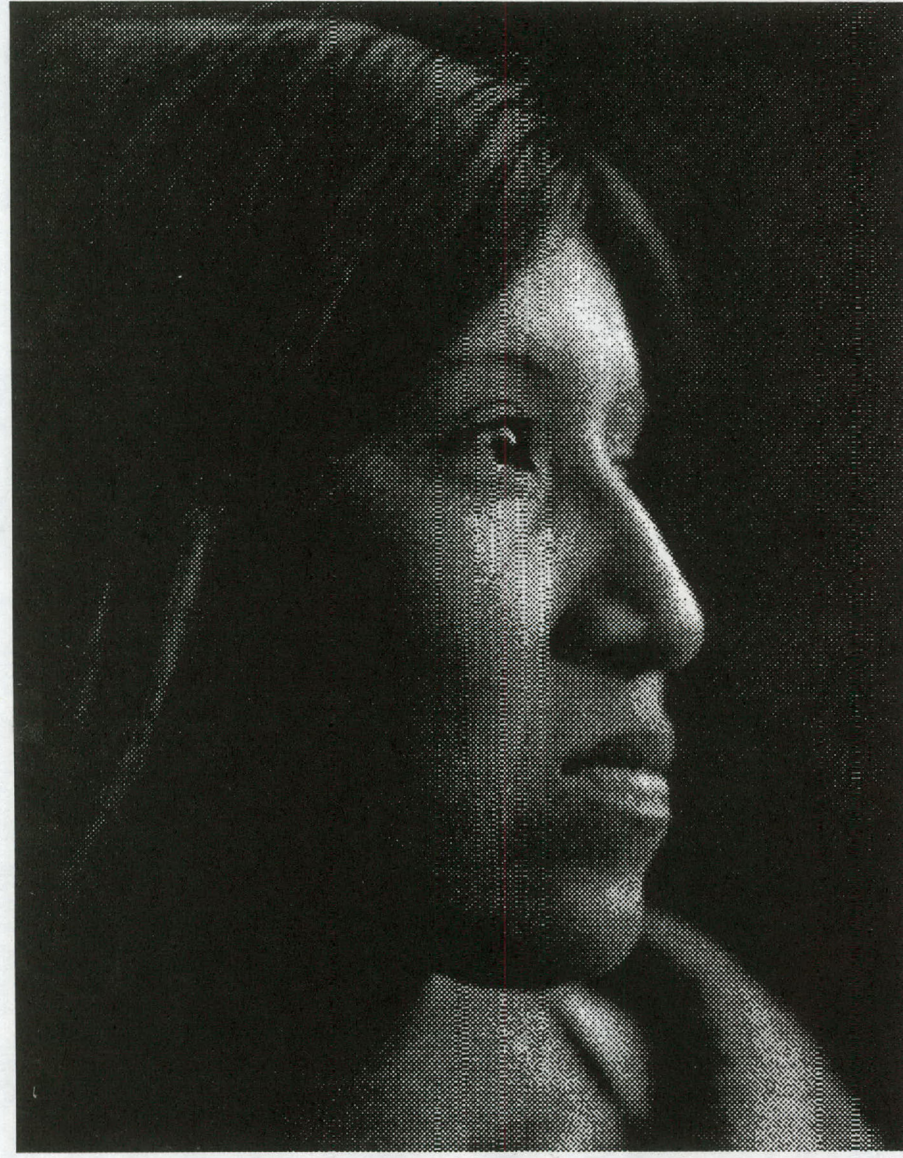
Nonverbal communication

It is estimated that 60 percent to 70 percent of what is communicated conversationally is nonverbal. Part of this nonverbal communication is body language. This includes facial expression, posture, gestures and characteristics of movement and eye contact. As with most aspects of communication, body language appears to be closely linked to culture.

Counselors tend to assume that certain behaviors are universal and have the same meaning across cultures. This can create major problems between counselors and culturally different clients.

Smiling

For example, in this society smiling usually indicates liking or positive affect. People attribute greater positive characteristics to those who smile; they are seen as intelligent, having a good personality and being pleasant. However, the Japanese smile or laugh does not necessarily mean happiness, but may convey embarrassment, discomfort and shyness. For many Asians, smiling may suggest weakness. This may lead the counselor to label the Asian client as inscrutable, sneaky or deceptive. Obviously, assigning such traits can be detrimental to the counselor/client relationship.



Courtesy of the Pierpont Morgan Library

Eye contact

Eye contact is another nonverbal behavior that varies from culture to culture.

Counselors tend to attribute negative traits to the avoidance of eye contact; shyness, unassertiveness, sneakiness or depression. While avoidance of eye contact can mean all these things, it can also be a sign of respect or deference in Mexican-American and Asian cultures.

African Americans make greater eye contact when speaking and make infrequent eye contact when listening. In contrast, white Americans make greater eye contact when listening and less frequent eye contact when speaking. In addition, many African Americans do not nod their heads or make "uh-huhs" to indicate they are listening.

Rather, the mere physical proximity of the speaker is a communication cue that one is listening. Misinterpretation of eye contact from African Americans by white counselors can lead the counselor to inaccurately view the African-American client as being sullen, resistant or uncooperative.

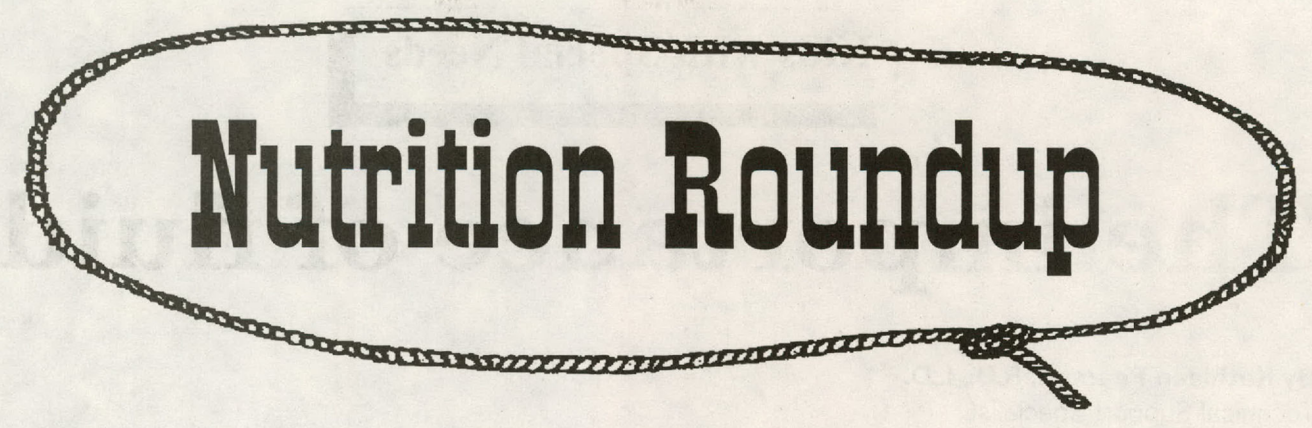
Be aware of stereotypes

When the counseling style of the counselor does not match the communication style of the culturally different client, both parties are generally uncomfortable. This can lead to short and ineffective counseling sessions, inability to establish rapport or cultural oppression of the client.

It is important for the counselor to recognize that communication style is culturally based. The counselor should be aware of how her nonverbal cues may reflect stereotypes, fears or preconceived notions about various racial groups. She should be careful about assigning personality traits based on nonverbal cues from a culturally different client. ♦

Excerpted from:

Derald W. Sue, "Culture-Specific Strategies in Counseling: A Conceptual Framework," *Professional Psychology: Research and Practice.* Vol. 21, No. 6, pp. 424-433.



Compiled by

Jeanie Cochrane, R.D., L.D.
Nutrition Education Specialist

and Barbara Bremner, M.S.
Nutrition Education Specialist

Journal article

"Pregnant Adolescents Learn About Weight Gain," *Journal of Nutrition Education* 25:50 B, 1993.

This brief article highlights a poster/jigsaw puzzle that was designed to use with pregnant teens and identifies how weight gain is distributed on the woman's body during pregnancy. It consists of an outline of a pregnant woman, with detachable plastic pieces representing the different components of weight gain. As the teens attach their part of the puzzle to the outline, that component of weight gain is discussed.

To obtain a copy of this article, contact Jeanie Cochrane in the State Office at (512) 458-7437.

For information on ordering the poster/jigsaw puzzle, contact Barbara Seed, Community Health Nutritionist, Perinatal Division, Calgary Health Services, 320-17 Avenue S.W., Calgary, Alberta, Canada T2C 3P1.

She can be reached by phone at (403) 228-8221.

Videos

New Mothers and Infant Care Series.

The five videos in this new AIMS Media release are subtitled: Everyday Care; Feeding; Common Problems; Illness, Immunization, and Safety; and Living with Baby. All use a journalistic style to interview first-time mothers and medical experts and to demonstrate child-care techniques. State WIC staff do not feel that these are suitable videos for WIC clients; they are designed for a high literacy level and make extensive use of a male pediatrician as the "expert." He is unlikely to appeal to our clients and has a very annoying manner! Only one of the videos has a nutrition component.

Pamphlets

A Food Guide for the First Five Years.

Put out by the National Live Stock and Meat Board, this 17-page pamphlet offers tips for feeding children ages 1 through 5. Unfortunately, this pamphlet is for higher-literacy readers. It contains pictures but is mostly writing, and, though there are many good tips in the pamphlet, the reading is quite labored. Some of the recommendations do not correspond with WIC's recommendations. This pamphlet is only available in English.

Though we do not recommend that you use this pamphlet with participants, it could be used as a staff

Kids with Special Needs

The importance of fluids

By Kathleen Pearson, R.D., L.D.
Technical Support Specialist

In Texas, where the climate is warm and the summer months we're in now will undoubtedly be hot, adequate fluid intake is especially important.

Why fluids are important

Along with protein, fat, carbohydrates, minerals and vitamins, fluids are a necessary nutritional requirement for living. We forget that the lack of any fluid intake will lead to the loss of life in just days. An individual can lose reserves of carbohydrate and fat and half the protein reserve, but a loss of 10 percent of one's total body water is serious. A 20 percent loss is fatal.

Fluids transport to body tissues nutrients and oxygen-carrying cells. Fluids are also the vehicle by which waste products are returned and excreted. There is generally an adequate amount of fluid included in a well-balanced diet. While this fluid may have different forms (e.g., milk, juice, beverages or soup, or contained in fruits and vegetables), it can generally be expressed in terms of water. Water is the primary ingredient of most liquids and is involved inside the human body as an almost universal solvent, as a means of transportation and as part of all the chemical reactions of digestion and utilization of food.

Nutrition Roundup (cont'd)

resource for counseling or material development. Some of the topics covered include feeding tips for young children, meal preparation tips, mealtime tips, choking-preventions tips, and how to involve children in meal preparation.

Foods with Folic Acid for Women.

TDH stock No. 1-205, available from M&CH. This is a low-literacy pamphlet listing foods with folic acid (includes pictures), providing tips for getting the most folic acid from your food and including sample menus. This pamphlet is appropriate for WIC participants.

WOMEN: Get Folic Acid From Your Foods.

TDH stock No. 1-204, also available from M&CH. This is a high-literacy pamphlet that explains why you need folic acid, when you need it, how much you need, foods containing folic acid, sample menus and the average amount of folic acid per serving for various common foods.

This pamphlet is more appropriate for WIC staff than it is for participants.

Both of these pamphlets can be ordered through the TDH Warehouse. They are not available in Spanish at this time, but are currently being translated. ♦

Dramatic shifts in body weight can signal a problem with the water balance and should be monitored. Fluid losses may be high due to chronic diarrhea, malabsorption, vomiting or certain medications. In all cases the replacement of lost fluids is necessary.

Who's at risk?

- Children with cerebral palsy, particularly as it involves the dysfunction of the oral-motor mechanism.
- Children who drool heavily or lose a large quantity of food and fluid presented to them.
- Children who may be slow eaters.
- Children with spina bifida who are at risk of contracting urinary tract infections.
- Ruminators who expel large quantities of ingested material.
- Down's syndrome children who have dry mouths and difficulty in swallowing.
- Failure-to-thrive children who have problems with food refusal and food selectivity.
- Seizure patients who are on medications with the possible side effects of loss of appetite, nausea and stomachache.
- Children with tube feedings, with particular attention to hyperosmolar (highly concentrated) formulas.
- Any child with fever and/or diarrhea.

Fluid requirements

The amount of fluids necessary to maintain normal body functioning is dependent on age and size. The recommended amounts of daily fluids are:

Child's weight	Total fluids needed in 24 hours
7 lbs.	2 cups
12 lbs.	3-1/3 cups
21 lbs.	5 cups
26 lbs.	6 cups
36 lbs.	7 cups
44 lbs.	8 cups
63 lbs.	9-1/2 cups
99 lbs.	10-1/2 cups
119 lbs.	10-1/2 cups

A good estimate of appropriate fluid intake can be obtained in an otherwise healthy person by measuring the urine. In general, if a child urinates every three to four hours, it generally indicates a good water balance.

Tips on adding fluids to a child's diet

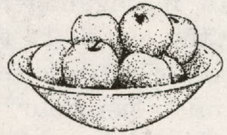
If a child refuses fluids, needs extra fluids or has trouble swallowing fluids, the following suggestions may help.

(1) Offer small, frequent sips of fluids.

(2) If your child has trouble swallowing thin liquids, thicken the liquids with dehydrated baby foods and cereals, applesauce, gelatin, yogurt, potato flakes, bread crumbs or cracker crumbs, or make milk shakes or fruit shakes.

(3) Encourage eating of foods that become liquid at room temperature, such as fruit ice, jello, ice cream, sherbet or fruit-juice popsicles.

(4) Encourage your child to eat solid foods that contain a lot of water, such as yogurt, pudding, cottage cheese, fruits and vegetables (raw or cooked, canned or frozen).



Infants and young children can become dehydrated quickly. Watch for these signs of dehydration:

- Decreased urination.
- Dry skin and mouth.
- Increased heart rate.
- Thirst with loss of appetite.
- Pale skin.
- Weight loss.

If any of these signs of dehydration appear, *contact your child's doctor.* ♦

This information has been adapted from *Eating for Good Health,* written by the John F. Kennedy Institute for Handicapped Children, and *Nutrition for Children with Special Health Care Needs,* written by the Sparks Center for Developmental and Learning Disorders.

Feature Section

♦

Our kids' safety

It's more than child's play

By Chan McDermott, M.P.H.
Breastfeeding Promotion Specialist

(1) PICKUP TRUCKS

A pickup with a bed full of children is a fairly common sight, especially in Texas, but it's very dangerous. In the Lone Star State, it's against the law for children under the age of 12 to be riding in the bed of a truck traveling more than 35 miles per hour. Children and pets should not ride in the back of trucks--sudden stops or turns can fling them out into the roadway. Another danger is that debris can be tossed up by traffic and injure someone riding in the truckbed.

CHILD SAFETY

(2) BIKES AND HELMETS

Biking is a great way to get around. It's good for the body and good for the environment. But all bike riders--even passengers--should wear helmets. Falls from bikes (and horses) are often responsible for closed-head injuries. Protect yourself and your child by purchasing--and *using*--a helmet every time you ride your bike. Remember, too, that adults set the examples. If your children see you without a helmet, they'll be tempted to not wear theirs, either. Some communities are looking at mandating helmet laws for children and other bicyclists.

(3) A HEALTHY TAN?

A tan used to be a sign of health, but now we know it's a warning of trouble down the road. Skin cancer trouble, that is. Excessive exposure to the sun--especially burns--in childhood leads directly to skin cancer as an adult. In fact, dermatologists say we get the bulk of the sun we will receive in our lifetime by the age of 25. This is worse in the summer, in part because of the clothing colors and styles we wear, but also because we spend so much time around water. Water not only reflects sun to intensify burns, it also washes off sunscreen, stripping away valuable protection.

Infants should have limited exposure to sun, and should never be exposed during the most intense hours of 10 a.m.

to 4 p.m. As children get older, they can spend more time in the sun, but should always wear a waterproof sunscreen with a sun-protective factor (SPF) of at least 20, says a representative from Sun Precautions, Inc. The longer the child is in the sun, or the fairer the child is, the higher the SPF should be, she adds.

(4) WATER FUN, WATER SAFETY

Summer is a great time for enjoying water--whether it's a swimming pool, lake, sprinkler or bucket. But, remember, a small child can drown in just an inch of water, says Lauri Montgomery, director of the Health and Safety Education Department of the Centex Chapter of the American Red Cross. And keep in mind that wet surfaces are slick! Children should never run or play around water--even at bathtime--unattended.

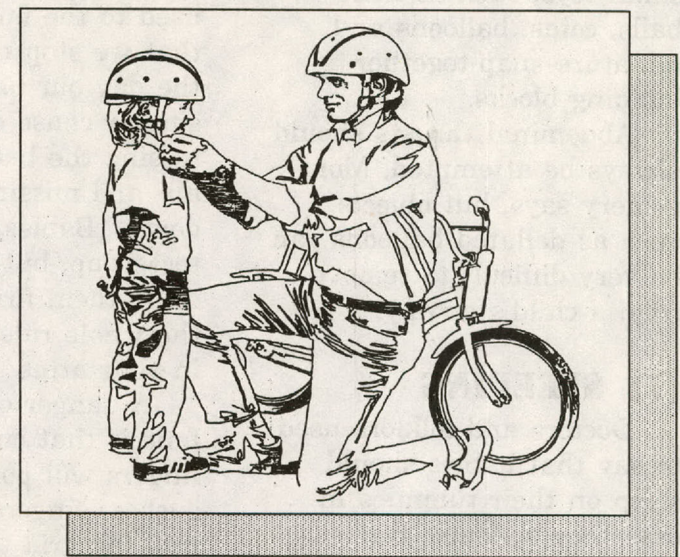
(5) FLUORIDE

Fluoride is important to the prevention of tooth decay and helps to build strong teeth and bones, says Genna La Perla, a registered dental hygienist in Austin. But, while you should begin cleaning your young child's teeth on a regular basis, don't use a fluoride toothpaste until he or she is able to spit it out. Too much fluoride can actually cause tooth damage--as well as an upset stomach.

Children get fluoride from their drinking water. Through breastmilk, breastfed babies get fluoride their mothers have consumed. In some areas, the drinking water has very little fluoride, and supplements are recommended. For a breastfeeding couplet, it's best for the mother to take the supplements and the baby to continue to derive the benefit through the milk.

(6) CHOKING

Some foods just seem to go with summer: hot dogs, grapes, popcorn and peanuts. But be careful. These foods are all "choke-prone" foods. Due to their size or texture, they should either not be given to young children to eat, or should first be prepared carefully.



CHILD SAFETY

Hotdogs should be cut in strips lengthwise, or mashed. Grapes should be cut in quarters.

And peanuts and popcorn should be avoided until the child can chew well.

Montgomery also cautions that choking can involve small toys, such as little balls, coins, balloons and minature snap-together building blocks.

Abdominal thrusts should always be attempted, Montgomery says, but objects such as deflated balloons can be very difficult to remove from a child's airway.

(7) SLEEPING

Doctors and folklore used to say that babies should sleep on their tummies in case they spit up. But studies reveal that the danger from sudden infant death syndrome (SIDS) is greater in this position.

The new recommendation is for the baby to sleep on her back or side with a towel, pillow or blanket in back, propping her up.

Studies have also shown that SIDS occurs less in breastfeeding babies and in babies who sleep with their mothers in the same bed, because being near the mother's breathing helps the baby "remember" to breathe.

(8) CEILINGS AND FANS

A great way to beat the Texas heat is with a ceiling fan. But did you know that children in Texas are injured every year when an adult unthinkingly lifts them into a ceiling fan? We become so used to the fan overhead that we stop noticing it--until the day our baby is hurt. A similar cause of injury is tossing the baby up into the air--and missing on the way down. Babies love to be tossed up, but always hold on to them firmly through the whole ride; let them "fly" in your arms.

A danger of oscillating fans is that curious little fingers will poke objects--such as fingers themselves--into the grid that covers the blades. Most new fans are designed to help prevent this problem, but if you feel that the grid on your fan is too large, you can cover it with screen wire. Keeping the fan up high on a tall table or shelf can also help.

(9) CARS IN THE SUN

Children should never be left alone in a car while Mom or Dad runs a quick errand. But in the summer, the danger intensifies. The temperature inside a parked car rises very quickly and has been responsible for the deaths of children and pets. According to a representative from the Humane Society of Austin, if people see an animal in a car in Austin, they can call 911 and a police officer will remove the animal from the car and turn it in to the Humane Society. If you plan on running errands, take the kids and dogs with you--or leave them home with a good caretaker.

(10) DOORS

People go in and out all summer long--often letting the door slam behind them. But beware! Children's fingers all too often have a way of getting caught in slamming doors. Declare door-slamming off limits in your house, and always make sure fingers and hands are accounted for before closing any doors--including the car's.

(11) CAR SEATS

Kelisa Tredway, a senior police officer with the Austin Police Department, says a safety problem that police still see is people not using child safety seats in the car. Tredway says people are confused about the issue.

Here are the rules:

• Any child under the age of 4 or under 40 pounds must be in a child safety seat in the car.

• Beyond that point, they should be seatbelted.

• All frontseat riders must be seatbelted.

Many communities have car-seat lending programs.

(12) SUMMER LATCH-KEYS

In many families, children come home to an empty house after school and are alone until a parent can get off work. In the summer, the hours can be much longer.

Red Cross worker Montgomery suggests that parents teach their children some basic safety techniques: telling callers that their parent can't come to the phone right that minute, or talking through the door to a visitor until they are certain of the person's identity and their safety. Children should never tell anyone that they are alone.

Also, children should learn to dial 911 or the number for emergency services in your community and how to call and report an emergency.

Montgomery says the American Red Cross offers a number of health and safety courses on a regular basis, including a class for latchkey kids.

Although there is a fee for the courses, it is a policy of the American Red Cross to never turn away any student because of inability to pay. Students who complete an eligibility worksheet can receive considerable scholarships for classes on first aid, CPR, water safety and much more.

Classes in both English and Spanish are available for adults and children.

The American Red Cross also offers English and Spanish workbooks and videos. And keep in mind that closed-captioned videos are also available. ♦

Photo by Kristine Wolff

Many doctors' practices don't follow AAP recommendations

Diarrhea

Two abstracts

By Abby November, Ph.D., R.D., L.D.
Nutrition Consultant

J. Snyder, "Use and Misuse of Oral Therapy for Diarrhea: Comparison of U.S. Practices with American Academy Of Pediatrics." ***Pediatrics.*** **Vol. 87, No.1., Jan 1991; 28-33.**

In this report, Snyder compares actual physician practices on the treatment of diarrhea with the recommendations of the American Academy of Pediatrics.

Although the AAP recommended rehydrating within four to six hours and reintroducing feeding within 24 hours of a diarrheal episode, the majority of community and academic physicians withhold refeeding until the second day or later.

Diarrhea is an important U.S. pediatric concern, although it is nowhere as devastating as the in the Third World. In the United States, acute diarrhea accounts for almost 20 percent of pediatrician office visits.

Dehydration is the most common complication of diarrhea, although most episodes of diarrhea in a healthy child are self-limiting. Optimal therapy includes use of oral fluids and electrolytes (sodium, chloride and glucose solutions) and early refeeding. This solution is called ORT (oral rehydration therapy). The AAP Committee on Nutrition, the World Health Organization and departments of pediatrics suggest different rations of carbohydrate-to-electrolyte in the solution.

Research recently has demonstrated the benefits of earlier refeeding, including decreased stool frequency and volume and increased speed of recovery. Well-tolerated foods consist primarily of starch (glucose) such as rice, maize, potatoes, etc.

The following are guidelines of the AAP Committee on Nutrition regarding oral therapy for diarrhea:

1. Glucose-electrolyte solutions for rehydration/maintenance.
2. Rehydration solutions used to provide maintenance fluid/electrolyte when given with water, breastmilk or low-carbohydrate juice.
3. ORT can be used to treat mild, moderate and severe dehydration.
4. Successful therapy can be accomplished for a vomiting child.
5. Feeding should be reintroduced in the first 24 hours of the episode. These foods should include breastmilk/diluted formula for

CHILD SAFETY

infants and, for older infants and children, rice, cereal, bananas, potatoes, other non-lactose carbohydrate-rich foods and BRAT (bananas, rice, apples, toast). Infants and children should be monitored closely for signs of dehydration.

More than 400 physicians were surveyed as to their therapy for diarrhea, and 100 percent agreed on ORT use. However, there was less agreement with refeeding schedules, other oral rehydration types and treatment of the vomiting child.

The AAP stated that "vomiting need not be a contraindication to successful ORT," but many physicians did not agree.

It is obvious from the results of this study that a uniform program for health providers on therapy for diarrhea is needed. ♦

J. Bezarra, T. Stathos, B. Duncan, J. Gaines and J. Udall Jr. "Treatment of Infants with Acute Diarrhea: What's Recommended And What's Practiced." ***Pediatrics.*** **Vol.90, No.1, July 1992; 1-4.**

Reported in this paper are the results of a survey sent nationally to over 700 pediatricians and family physicians regarding their treatment of acute diarrhea in infants.

Acute diarrhea is the leading cause of morbidity and mortality among infants and children in Third World nations. In the United States, eight of every 1,000 infant hospitalizations relate to diarrhea.

Dehydration, a potential complication, is the prime cause for the morbidity and mortality.

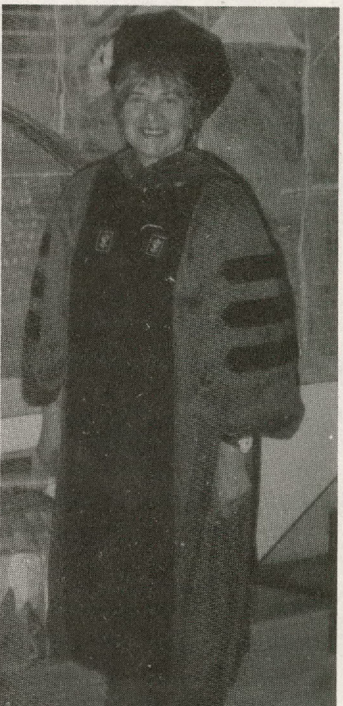
Prevention and treatment of dehydration by oral rehydration is recommended by the World Health Organization. The American Academy of Pediatrics (AAP) Committee on Nutrition recommends rapid rehydration (within four to six hours with oral glucose-electrolyte solution followed by diluted milk or formula), noting also that lactose need not be removed routinely.

In the older infant and child, a BRAT-type diet (bananas, rice, apples, toast) or non-lactose, carbohydrate-rich food should be offered shortly after rehydration.

The results of this survey indicate that the majority of respondents prolong the rehydration period and delay the reintroduction of solids.

Various hypotheses were launched to explain the difference between practice and AAP recommendations. One possibility is that the physicans were unaware of or in disagreement with the AAP guidelines.

The suvey's conclusion that educational programs on treatment of acute diarrhea are needed in the United States is a sound and responsible one. ♦

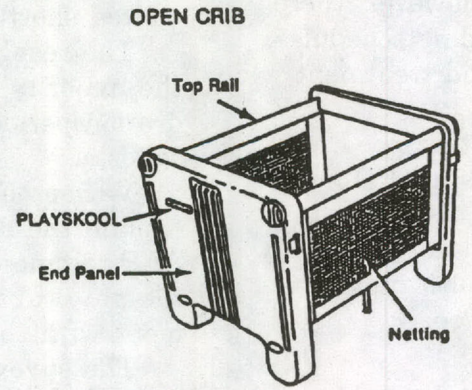


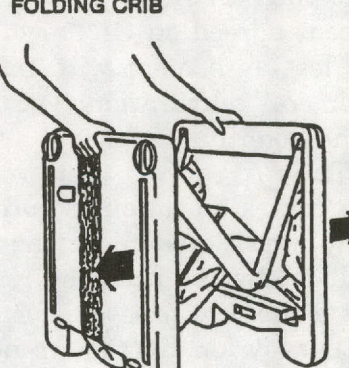
The author was awarded her doctorate on May 10.

Two portable cribs recalled

Suffocation deaths of 3 babies cited

After receiving reports of three babies who died of suffocation in cribs designed by Kolcraft Enterprises, Inc., the manufacturer is recalling two Playskool Travel-Lite portable cribs, models 77101 and 77103. The side rails of these cribs can fold during use and trap an infant in the fold's "V."





The Playskool Travel-Lite portable crib has two nylon mesh sides and two blue, solid-plastic ends. On each end, the name "Playskool" appears in white letters on a red background. The cribs fold in the center for storage and handling.

Owners of these cribs should stop using them immediately and call Kolcraft at 1-800-453-7673 for instructions on returning it. The toll-free line is open from 9 a.m. to 4 p.m. EST.

The company will arrange to have the crib picked up at the consumer's home at no charge and will also provide the customer with a refund.

In Texas, retailers carrying these products have been Wal-Mart, J.C. Penney's and the Sears catalog, in addition to local stores Storkland and Baby World in Dallas, Beard's in Lufkin and Be Be's Place in Houston. ♦

Steer clear toward safety

Let your WIC moms and staff know about a colorful, four-page pamphlet called *Kids 'n' Cars: Riding Safe.*

It includes guidelines on how to choose the right car seat for children of different ages. The decorative pamphlet also offers tips for travelling with the kiddos.

You can order it by calling either the main office of your public health region or the Safe Riders Program at 1-800-252-8255. Ask for Steve Anderson, program director. The stock number of the English pamphlet is 4-140; for the Spanish one, it's 4-140A. ♦

Automation Answers

Here's your reference guide

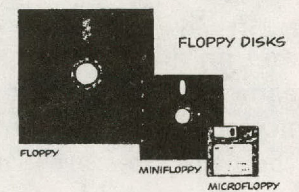
By Jacque Austin
System Support Specialist

This column is a new addition to *Texas WIC News* and is provided by the Automation Systems Support Division. Each month, we will focus on software updates and hardware news, plus topics suggested by our readers. Our goal is to stimulate discussions of these concepts at your site and to provide a computer automation reference.

In each issue, the page with our column will be perforated. We encourage you to remove the sheet and save it as a resource for computer problems.

Hardware corner

What exactly is computer hardware? It's the equipment at your site that you can touch and see, such as your workstation, monitor, server, modem, printer, tapes, diskettes and UPS. Even your cables are hardware.



June focus: Your UPS

Let's begin this month with the **U**ninterruptible **P**ower **S**ystem (UPS). Sites with a standalone or network system should have a UPS.

• ***What does the UPS do?***

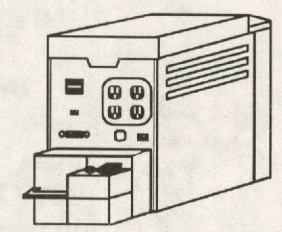
It functions as a backup power source when electricity is interrupted. The UPS will automatically support your equipment for 8 to 10 minutes, which allows time for your staff to shut down the system normally.

• ***Does the UPS need charging before use?***

Yes; connect it overnight to a power outlet before installation.

• ***What should be connected to the UPS?***

For a standalone unit, connect the computer, modem, tape drive and monitor. With a network, connect the server, workstation 1, modem and tape drive. Monitors may be added if connections are available. Printers and power strips **should not** be connected since they drain excessive electricity and prevent correct operation.



• ***Why does the UPS beep?***

Beeping indicates power has been interrupted and equipment shutdown is necessary. On a standalone, escape to the ODBS\WIC prompt, and power off the computer, modem, monitor and tape drive. On a network, escape to the ODBS\WIC prompt, then logout and then power off the workstation, modem and tape drive. Next, type "**down**" at the server keyboard, watch the monitor for a "WIC_(your 3-digit server number) has been shut down" message, and power off the server. Call for help with these steps or to reset your system.

• If you have any questions about hardware, call our help desk at **(512) 406-0700** or your local agency's director.

Help!

Software news

How do we define software?

It is the programs on our computers. ODBS is the WIC Bureau software; WordPerfect is word-processing software.

Recent changes

• ***Triple issuance***: Updates were transferred to projects during April and May for triple issuance during expansion. Call us with your questions.

• ***Poverty guidelines update***: Each April, the federal government revises the poverty guidelines that affect WIC certification. During early April, our staff contacted network sites and updated income files. Sites with standalones and laptops should have received diskettes by mail. Any questions? Phone our office or your director.

Bits and pieces

• ***Broken/unused equipment***: Please return equipment to the Texas Department of Health, 1921 Cedar Bend, Suite 145, Austin, Texas 78758.

• ***Projects change names***: Effective immediately, Project 14 is renamed 75 and Project 55 becomes 78. Site numbers remain unchanged.

New voices in our office

We have new support specialists to answer your calls. Recent additions are: Jacque Austin, Joe Brooks, Bernardette Brown, Cathy Duncan, Lee James, Dana (pronounced "Donna") Pope, Leta Prosise and Jim Wieland.

Names familiar to you are: Lori Ferguson, Mary Hightower (assistant manager), Mike Johnson, Betty Jones, Steve Kinney, Kim Stewart (manager) and Terry Taylor.

Lydia Maldonado is our receptionist.

Test yourself!

(1) A monitor:

a. looks like a television screen.

b. reveals what the computer is doing.

c. is color or monochrome (black and white).

d. all of the above.

(2) A warm boot requires pressing which 3 keys?

____

(3) A cold boot means:

________________________________.

Questions and answers

Q. ***Who do I contact for problems with WIC numbers?***

A. Betsy Smith (512-458-7775) or (512-458-7111,ext.3416)

Q. ***What is a "co-located" site?***

A. Some projects have both a clinic site and an administrative site located in the same office. If the network servers are connected with cables and can access each other, then the sites are "co-located."

Let us hear from you!

Submit your suggestions to: Texas Department of Health, WIC Automation Systems Support, Attention: Jacque Austin, 1100 W. 49th, Austin, Texas 78756. ♦

Answers for "Test yourself":

(1) (d)

(2) <ctrl><alt><del> simultaneously

(3) Turning the system power off, counting to 30, then turning power on.

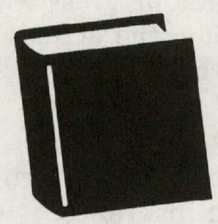
Kids are the Cornerstone

♦

For LOVE of the CHILDREN

Last in the series on a history of the 'child-saving' movement in America

By Valerie Wolfe
Supervisor
Information & Response Management



In the Shadow of the Poorhouse: A Social History of Welfare in America, by Michael B. Katz, Basic Books, Inc., New York, 1986.

War on Poverty

The last chapters in Michael B. Katz's book, *In the Shadow of the Poorhouse: A Social History of Welfare in America,* trace the expansion of social welfare through the years of John Kennedy's New Frontier and Lyndon Johnson's Great Society, as the country waged its War on Poverty.

Fighting racism

New forces were at play in these years. The Democratic Party allied itself more and more with the poor, especially urban blacks, and thus continued to support welfare as a way to politically mobilize the poor. This led to the direct use of social-welfare policy to fight racism in America.

The civil rights movement helped shape new theories that poverty was an issue of race as well as class. In 1963, when Martin Luther King led 200,000 people in the March on Washington, he demanded jobs as well as voting rights for blacks. Civil rights activists began to attack the "suitable home" provision in state Aid to Dependent Children (ADC) regulations. Some states denied aid to nonwhites and children born out of wedlock. In the South, critics of welfare charged that it would decrease the supply of cheap black labor.

In 1966, the National Welfare Rights Organization (NWRO) was founded. It consisted primarily of middle-class organizers, social scientists, intellectuals, lawyers and church officials. A network of blacks and whites was mobilized to demonstrate in welfare offices, to lobby Washington and state capitols and to bring test cases to court. Katz believes NWRO "played a major role in reshaping the food stamp program, in expanding other

nutritional and health programs for poor children and mothers, and in securing other policies that added to the basic resources of poor families."

Focus on opportunity

Between the 1960s and the mid-1970s, new or expanded government programs reduced poverty, hunger, malnutrition and disease. The poor's access to health services increased, and unemployment, housing and educational opportunities--especially for black Americans--also continued to grow. The focus of the time was on opportunity, not inequality. Leaders in the movement wanted to give everyone a chance to compete for success.

In some ways, this was an important turning point in social-welfare theory in America. By viewing the need for welfare as a result of artificial and unjustifiable barriers, rather than a lack of moral or intellectual character, the route to providing equal opportunity seemed to lie just ahead.

Helping children

One major problem appeared to be the inability of poor children to take advantage of education and other opportunities for social advancement, not to mention the fact that they were hungry. These children often lacked cultural skills and family support; therefore, they needed an earlier start to be able to compete--a "head start."

And that's what they got. Operation Head Start funded special pre-school programs for disadvantaged children. This led to Operation Follow Through and eventually to the authorization of scholarships and low-interest loans for college.

Katz categorizes the anti-poverty programs of the Kennedy, Johnson, and Nixon administrations as falling into the following four areas:

- Promotion of opportunities.
- Stimulation of community action.
- Introduction of new services.
- Expansion of transfer payments.

Improving the quality of life

In eight years between 1965 and 1972, annual social-welfare payments increased dramatically from $75 billion to $185 billion in federal spending. Services no longer emphasized a reduction of dependency, but were instead aimed at "enhancing human development and the general quality of life."

New social programs helped in the areas of social-work assistance, health care and legal assistance. Medicare and Medicaid worked, according to Katz, as a "modest revolution in health care." In 1963, 20 percent of Americans below the poverty line had never been seen by a doctor. By 1970, because of Medicare and Medicaid, this percentage had dropped to 8 percent, the number of prenatal visits of poor women to doctors had increased and the overall infant mortality rate had dropped 33 percent.

Between 1965 and 1972, federal spending for nutritional programs other than food stamps increased from $870 million to over $1.8 billion. Spending on Aid to Families with Dependent Children (AFDC) and social security remained the core of public assistance (in 1972, 43.3 percent of all federal welfare spending primarily went to these two programs). During this time, the Supreme Court struck down three obstacles to services: residency requirements for AFDC, the denial of aid to families with "employable mothers" and the "absent-father rule."

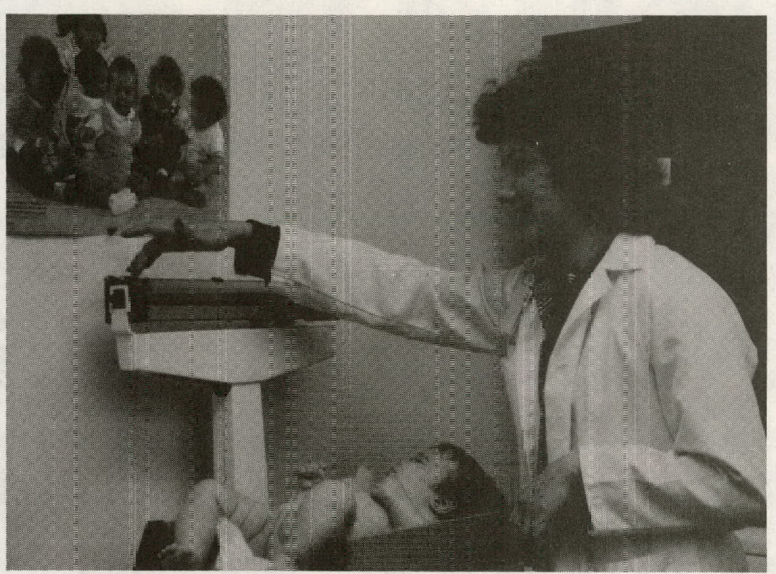
Hard reality

The "downside" to all this progress was that because of inflation, the actual value of AFDC and other benefits declined during the 1970s.

A major problem, Katz says, was that America remained the "only modern Western nation without national health insurance." He quotes a report by Alfred Kahn and Sheila Kammerman, who studied eight nations' income transfers for families with children and gave this finding: "When it comes to relieving parents of some of the costs of

rearing children, the United States does less than any of the other countries."

They reported that poor parents in America, as compared with those in other advanced democracies, have lower relative incomes and fewer incentives to work, in addition to less assistance with retraining, job placement and child care.



WIC is one of several social programs developed in the United States after a century of debate on the causes and effects of poverty–and possible cures for it.

Battles won

Katz does feel that America during this time was successful in five major areas:

(1) More people than ever before, especially among those who were most disadvantaged, received aid. They had the guarantee of a minimally adequate diet and access to health care.

(2) Discrimination, especially in the area of equal opportunity for jobs, was reduced.

(3) An emphasis on community action interested a new generation in social service.

(4) Relations between the federal government and its poor citizens changed so that greater access existed to help citizens deal with discrimination in housing, education and social-welfare benefits.

(5) It became apparent that the federal government had the resources and the administrative capacity to promote and sustain social-welfare progress.

Viewing poverty

The book is concluded with some projections into the future and a discussion of continuing issues important in any analysis of social welfare--past, present and future. For example, figures that show a reduction in poverty are dependent on the "official poverty line." Consider the numbers of people who fall just on the other side of this line, and the numbers can be significantly larger.

Katz suggests that a truly comprehensive look at poverty would rely on looking at these people too, and would recognize that many individuals and families slip in and out of poverty in any period of time. One study showed that during a 10-year period only about 8 percent of the sample population in the study were poor at any one time; however, about 25 percent fell into poverty for brief periods during the time of the study.

The "forces that push individuals and families into poverty originate in the structure of America's political economy," Katz says. "Some of us are lucky, not different."

Transcend the debate

Katz warns against the sentiment of the 1980s, when he feels government waged a "war on welfare," not a war on poverty. He asks us to transcend the debate about the relation between welfare and the work ethic.

Instead, he poses the idea that "work is integral to human life" and those on welfare would like to be productive citizens who contribute to society.

Productivity and a highly developed social welfare state *can* coexist.

By expanding the availability of child care, providing nutrition education and supplemental food necessary for healthy growth, supporting working families, creating jobs and making health care affordable and available to all, we can, in the long run, become a more successful society. ♦

Sharing with Maternal & Child Health

New partnership to provide family health services

Exercise with military in Starr County is first in the nation

By Patty Stone, M.S.H.P., C.H.E.S.
M&CH Health Education Consultant

Community support was enthusiastic as Leo Vela, M.D., M.P.H., director of Public Health Region 8, welcomed officials to the Starr County Fairgrounds to kick off the new partnership.

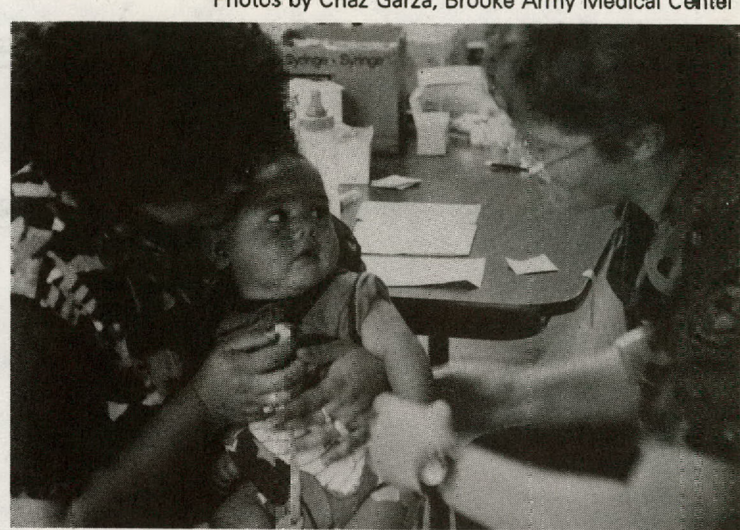
The mission of the Bureau of Maternal and Child Health is to improve the health of Texas women and children and their families through the development and support of comprehensive, quality health-care systems that are community-designed, coordinated, accessible and cost-effective.

During the first week of May, the Texas Department of Health joined in partnership with the Texas National Guard and the U.S. Army to conduct a pilot project at the Starr County Fairgrounds in Rio Grande City to provide medical services to an underserved area of Texas. This exercise was the first of its kind in the nation, using a combination of health professionals to focus on identified health-care needs for Starr County: immunizations, tuberculosis testing and, for pets, rabies vaccines.

Starr County was selected because of existing health problems:

- **Low immunization rates.** Of the approximately 7,500 pre-school children in the county, an estimated 5,000 (67 percent) are not fully immunized.
- **High tuberculosis rate.** The rate of TB is about double that of the state rate. In this county, the rate of multiple-drug-resistant TB is also increasing, which makes

Photos by Chaz Garza, Brooke Army Medical Center



early detection even more important.

• **Increasing reports of rabies.** The rabies epidemic in South Texas' wild coyotes is causing the number of rabies cases in domestic animals to increase. There is only one veterinarian in this county.

Starr County is designated both as a *medically underserved area* and a *health professional shortage area.*

This is the poorest county in the entire state, and the second poorest county in the nation. Starr County has an estimated population of 41,000. There is a clear need to compliment and supplement the existing health-care system.

This project was also an example of the kind of innovation that can help us meet the challenge given to Texans by Gov. Ann Richards and Commissioner of Health David Smith, M.D.--to immunize *all* Texas children.

Another designated priority of these two leaders is the provision of health services in schools.

Starr County has exemplified how immunizations can be provided in schools--they already have school nurses in one district administering vaccines, and they have an excellent immunization rate among school-aged children. However, the county's rate for pre-school immunization is very low--about 30 percent. That leaves almost 70 percent of children under the age of five at risk of serious diseases such as measles, mumps and rubella. This project offered the full range of childhood immunizations, as well as tetanus, diphtheria, measles, mumps, pneumococcal pneumonia and rubella immunizations for adults.

In addition to child and adult immunizations and TB tests, clinic personnel at the pilot project in May also offered blood tests for anemia and lead poisoning for children, multivitamin supplements with folic acid for

women of child-bearing age, eligibility screening for CIDC and Medicaid, enrollment in WIC and education about a variety of health topics.

This partnership worked because the community became one of the partners, the community's health needs were identified, services were accessible and cost-effective and the implementation was coordinated. ♦

Bilingual brochure distributed to all Texas WIC projects

Debra Stabeno, Chief
Bureau of WIC Nutrition
Texas Department of Health
1100 W. 49th St.
Austin, TX 78756

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