U.S. DEPARTMENT OF AGRICULTURE

WIC Breastfeeding Policy Inventory II

Local Agency Report

November 2024

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This study was conducted by Insight Policy Research, Inc. (now Westat Insight) under contract 12319821A0008 with the Food and Nutrition Service, U.S. Department of Agriculture (USDA). The findings and conclusions in this report are those of the authors and should not be construed to represent any official USDA or U.S. Government determination or policy.

Suggested Citation

Wroblewska, K., Zvavitch, P., Perez-Zetune, V., Amaro-Rivera, K., Gleason, S., Cassar-Uhl, D., & Geller, M. (2024). *WIC Breastfeeding Policy Inventory II: Local Agency Report*. U.S. Department of Agriculture, Food and Nutrition Service. Project Officer: Karen Castellanos-Brown.

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Acknowledgments

This report was prepared by Insight Policy Research, Inc. (now Westat Insight) under contract 12319821A0008 from the U.S. Department of Agriculture, Food and Nutrition Service (FNS). It represents a team effort in which many individuals made contributions in addition to the authors. The authors gratefully acknowledge their assistance. In particular, we recognize Dr. Karen Castellanos-Brown, Project Officer, and Cheryl Funanich, Terra (Olivia) Deavers, Valery Soto, and Ruth Morgan for their leadership and guidance. We thank the numerous FNS headquarters staff who provided support and expert advice to the Westat Insight team. Their insightful comments on the interim deliverables and throughout the study greatly influenced this research. We also thank the FNS Regional Office staff for supporting data collection and encouraging Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) State and local agencies' responses to the surveys.

The authors also express appreciation to the dedicated WIC State agency and local agency staff who responded to the study surveys. Their time and effort to provide complete and accurate data made this research possible.

The authors also gratefully acknowledge our technical working group members who contributed valuable insights during the study planning and dissemination phases based on their research and lived experiences:

- Carole E. Peterson, M.S., IBCLC, Lactation Education Consultants
- Claresa Bedonie, Inter Tribal Council of Arizona WIC
- Darlena Birch, M.B.A., R.D.N., National WIC Association
- Jamie Vigil, CLC, Pueblo of Isleta WIC
- Jean O'Leary, M.P.H., R.D., Washington State WIC
- Karen Kurtz, IBCLC, Gateway WIC (New Jersey)
- Mary Story, Ph.D., R.D., Duke University
- Norma Ortiz Escobar, IBCLC, New Hanover County WIC (North Carolina); La Leche League Leader
- Ronietra Stewart, R.D.N., IBCLC, Public Health Foundation Enterprises WIC Program (California)
- Shannon E. Whaley, Ph.D., Public Health Foundation Enterprises WIC Program (California)
- Zeida Eslava-Cortez, WIC Unity Health Center (Washington, DC)

The authors thank external consultants Linnea Sallack and Dr. Angela Odoms-Young for their expertise and thoughtful reviews. We also thank the numerous individuals from Westat Insight who provided valuable assistance throughout this study. We thank Dr. Debra Wright, Lyndsay Huey, Chrissy Steigelman, Karmen Perry, and Dani Hansen for their support with data collection; Josh Rozen for his SAS coding expertise and assistance; Breanna Wakar for providing statistical guidance; Dr. Jonathan Blitstein for his thought leadership and contributions; Dr. Claire Wilson for providing thoughtful suggestions on the report content; and our professional editors and graphic designers for their production assistance.

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Chapter 1. Introduction

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides benefits such as nutritious supplemental foods; nutrition education and counseling; breastfeeding promotion and support; and referrals to healthcare and social services to income-eligible pregnant, breastfeeding, and postpartum[1] women and infants and children up to age 5 who are at nutrition risk. The U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) administers WIC at the Federal level.[2] In fiscal year (FY) 2022, FNS provided grants to 89 WIC State agencies to operate WIC in all 50 States, 33 Tribal Organizations, the District of Columbia, and 5 territories (American Samoa, Puerto Rico, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands). Established to counteract the negative effects of poverty on prenatal and pediatric health, WIC served 7 million women, infants, and children in April 2022. For FY 2022, Congress appropriated $6 billion for WIC.

Breastfeeding is a priority for WIC. Aligned with recommendations from the American Academy of Pediatrics (2022), WIC supports and promotes breastfeeding as the optimal source of infant nutrition for most babies. WIC State and local agencies educate expectant and new mothers about the benefits of breastfeeding and provide support and encouragement to breastfeed throughout the infant's first year and beyond.

In 2021, FNS contracted with Insight Policy Research (now Westat Insight) to conduct the *WIC Breastfeeding Policy Inventory II* (WIC BPI II). WIC BPI II provides a comprehensive description of breastfeeding statistics, policies, procedures, and practices at the WIC State and local agency levels, with a special focus on equity (see text box for the study objectives). This *WIC BPI II: Local Agency Report* is one in a series of three reports produced for the study; companion reports focus on WIC State agency policies and practices and State and local agency use of FNS breastfeeding resources.[3,4]

Study Objectives

1. Provide a comprehensive description of breastfeeding statistics, policies, procedures, and practices at the WIC State and local agency levels, including implementation of peer counseling programs, staff training on breastfeeding, use of the national breastfeeding campaign, and best practices to improve breastfeeding initiation and duration rates.
2. Examine equity in the availability of breastfeeding support that results from local and State policies and practices.
3. Explore methods for routine collection of information on the number of WIC designated breastfeeding experts (DBEs).

A. Background

In the United States, breastfeeding rates have increased overall in recent years. Several factors have created a more supportive environment for breastfeeding and likely contributed to these increases,

[1] Current WIC regulations allow food packages to be prescribed to women up to 6 months postpartum who are not breastfeeding or minimally breastfeeding; these women are included in the definition of postpartum women in this report. See 7 C.F.R. 246 (Special Supplemental Nutrition Program for Women, Infants, and Children, 1985).
[2] See 7 C.F.R. 246 (Special Supplemental Nutrition Program for Women, Infants, and Children, 1985).
[3] For further details on WIC State agency findings, see: Gleason, S., Cassar-Uhl, D., Perez-Zetune, V., Zvavitch, P., Amaro-Rivera, K., Esposito, J., & Geller, M. (2024). *WIC Breastfeeding Policy Inventory II: State Agency Report*. Prepared by Insight Policy Research, Inc. U.S. Department of Agriculture, Food and Nutrition Service. Project Officer: Karen Castellanos-Brown.
[4] For further details on WIC State and local agency use of FNS resources, see: Esposito, J., Wroblewska, K., Zvavitch, P., Gleason, S., & Cassar-Uhl, D. (2024). *WIC Breastfeeding Policy Inventory II: State and Local Agency Use of FNS Breastfeeding Resources*. Prepared by Insight Policy Research, Inc. U.S. Department of Agriculture, Food and Nutrition Service. Project Officer: Karen Castellanos-Brown.

including campaigns designed to build awareness about the benefits of breastfeeding, a cultural shift toward normalizing breastfeeding, policy changes that protect a mother's right to breastfeed in public, and improved workplace accommodations for breastfeeding mothers. The benefits of breastfeeding for both mothers and their infants are well-documented. Breastfed infants have a lower risk of obesity, type 1 diabetes, infections, and sudden infant death syndrome (Victora et al., 2016; Li et al., 2022; Thompson et al., 2017). Breastfeeding mothers have a lower risk of hypertension, type 2 diabetes, and breast and ovarian cancer (Victora et al., 2016; Feltner et al., 2018). As more evidence accumulates, it reinforces the importance of breastfeeding.

Despite an overall increase in breastfeeding, disparities by race and ethnicity, income, educational attainment, and maternal age persist (CDC, 2023; Haas et al., 2022). For example, national data consistently show that non-Hispanic Black women and infants experience lower breastfeeding initiation and duration rates than other racial and ethnic groups (Beauregard et al., 2019; Chiang et al., 2021). Many women experience barriers to breastfeeding. However, some barriers are more common among women from historically underrepresented groups. These barriers include less family and social support for breastfeeding, the need for prompt return to work after childbirth, and more limited access to information that promotes and supports breastfeeding (Jones et al., 2015). Understanding the root causes and structural factors contributing to disparities in breastfeeding outcomes may help address these disparities and promote health equity (see text box).

Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health—such as poverty and discrimination and their consequences, which include powerlessness and lack of access to good jobs with fair pay; quality education, housing, and healthcare; and safe environments.

(Braverman et al., 2018)

Breastfeeding promotion and support are core components of the nutrition services WIC provides. To address some of the common barriers breastfeeding mothers face, WIC provides breastfeeding education and support groups, breastfeeding aids such as breast pumps, and social support through its Breastfeeding Peer Counseling Program (peer counseling program). The peer counseling program is an evidence-based model that helps pregnant and postpartum WIC participants connect with peers from their community. Breastfeeding peer counselors are paraprofessionals who have experience breastfeeding one or more of their own children and support WIC participants in meeting their breastfeeding goals by providing realistic and practical guidance (e.g., counseling) in a variety of settings. Peer counselors can also refer breastfeeding participants to professionals such as designated breastfeeding experts (DBEs) who are trained to assess and provide counseling on complex breastfeeding issues.[5] Research has shown that participation in the peer counseling program is associated with higher rates of breastfeeding initiation and duration (Feltner et al., 2018).

State and local WIC agencies have considerable flexibility in how they establish policies and practices related to breastfeeding promotion and support. As a result, the breastfeeding resources available to WIC participants vary across State and local agencies. Recently published research found the odds of breastfeeding were higher among participants at WIC sites that had access to a peer counseling program, had access to an International Board Certified Lactation Consultant[6] (IBCLC), made postnatal

[5] FNS defines a DBE as an individual who is an expert with special experience or training in helping breastfeeding mothers and who provides breastfeeding expertise and care for more complex breastfeeding problems when WIC staff face situations outside their scope of practice (USDA, 2016). DBEs must meet several criteria, including the successful completion of the FNS or a State-approved competency-based training, and have at least 1 year of experience in counseling breastfeeding mothers.

[6] These IBCLCs may be designated breastfeeding experts but were not described as such in the cited research article.

home visits,[7] allowed any staff member to provide breast pump education, or had a policy not to provide formula during the first 30 days postpartum (Gleason et al., 2020). The odds of breastfeeding increased with each additional support present at the site. These findings suggest structural factors, such as staffing decisions and the distribution of peer counseling funds, may help or hinder WIC participants' breastfeeding outcomes.

B. Prior Study and Recent Programmatic Changes

The first WIC BPI study (WIC BPI I) provided a broad snapshot of breastfeeding practices, policies, and breastfeeding measures across State and local agencies (Forrestal et al., 2015). Since the publication of the WIC BPI I report, WIC breastfeeding initiation rates have increased from 67.7 percent in 2012 to 70.0 percent in 2022, peaking at 71.8 percent in 2018, and WIC has undergone important changes that may affect how WIC State and local agencies promote and support breastfeeding (Zvavitch et al., 2024).

WIC BPI I Key Findings

- 78 percent of local agencies had at least one staff member with a certification in lactation counseling, consulting, education, or management
- 69 percent of local agencies operated a peer counseling program
- Most local agencies collected information on breastfeeding initiation, duration, and exclusivity; 51 percent of local agencies collected information on breastfeeding intensity (Forrestal et al., 2015)

- **FNS WIC breastfeeding resources:** In 2018, FNS launched a national breastfeeding campaign called *WIC Breastfeeding Support: Learn Together. Grow Together*. The campaign aims to provide information, support, and resources, including through the WIC Breastfeeding Support site, to those seeking to breastfeed. FNS also developed a breastfeeding training curriculum, which offers competency-based training for WIC staff who provide breastfeeding promotion and support.

- **WIC State agencies' increased use of technology to communicate with and educate WIC participants:** The Coronavirus Disease 2019 (COVID-19) public health emergency led to significant disruptions in the delivery of nutrition education and breastfeeding support services. WIC offices received waivers to operate remotely to reduce the spread of the virus and maintain the safety of staff and the communities they serve.[8] Some States ended all in-person visitation, and many clinics saw an increase in the number and type of remote education and support services delivered via web- and smartphone application-based platforms. Although some WIC State agencies were already in the process of implementing telehealth and virtual service technologies, COVID-19 and USDA's waiver authority led to an increased use of technology to communicate with and educate WIC participants.

[7] WIC State and local agencies determine whether peer counselors can visit participants in their homes. Home visits can be reassuring to mothers with breastfeeding concerns, help family members see how they can support breastfeeding, and provide peer counselors with valuable insights about the mother's home environment that may influence her breastfeeding success.

[8] Under the Families First Coronavirus Response Act of 2020 (FFCRA, Pub. L. 116-127), the USDA had the authority to grant certain programmatic waivers to State agencies that administer WIC. FFCRA waiver authority ended September 30, 2021. Pursuant to Section 1106 of the American Rescue Plan, USDA had the authority to waive the physical presence and remote benefit issuance requirements for all State agencies that elect to use them. These waivers remain in effect until September 30, 2026, or, for projects requiring waivers, until the WIC Outreach, Innovation, and Modernization Evaluation is complete.

- **Expansion of peer counseling program funding:** Each year, Congress sets aside funding to support the peer counseling program. This set-aside has grown over time, from $20 million in 2005 to $60 million in 2011 and finally to the fully funded amount of $90 million in 2020.

Given these programmatic changes and additional investments in WIC breastfeeding promotion and support, FNS conducted WIC BPI II to understand the current state of WIC breastfeeding policies and practices.

C. Approach

WIC BPI II provides an update on WIC State agency and local agency policies and practices across six broad research topics (see text box). By systematically collecting and disaggregating data from a census of WIC State and local agencies, WIC BPI II helps illuminate the role WIC breastfeeding policies and practices can play in ensuring equitable services and support.

Broad Research Topics

- Breastfeeding Peer Counseling Programs
- *WIC Breastfeeding Support: Learn Together. Grow Together.* social marketing campaign (not covered in this report)
- Virtual breastfeeding services
- WIC State Plan and WIC State Policy and Procedure Manuals
- Equity
- Breastfeeding measures

The *Local Agency Report* provides a comprehensive description of peer counseling programs, DBEs, and other community partnerships among local agencies; the use of virtual breastfeeding services; the use of practices to promote equity and inclusion among local agencies; and the availability of equity-forward practices by participant race and ethnicity and local agency urbanicity. See appendix A for the full listing of WIC BPI II research questions. Throughout the study, the team applied culturally responsive and equitable evaluation approaches (see text box).

Culturally Responsive and Equitable Evaluation Approaches Applied to This Study

- Used asset-based language and avoided "othering"
- Focused on structural factors (e.g., the availability of breastfeeding resources) that may limit participants' ability to achieve desired outcomes
- Promoted inclusion by engaging a technical working group with representatives from groups that may be affected by this work (e.g., WIC State agencies, local agencies, participants)
- Discussed findings in the context of structural factors
- Disseminated findings in plain language through formats accessible to members of the communities of interest

1. Data Sources

The study team used four local-level data sources to prepare this report: the WIC BPI II Local Agency Survey, the Families First Coronavirus Response Act (FFCRA) Local Agency Waiver Use Survey, WIC Participant and Program Characteristics 2022 (WIC PC 2022), and FY 2022 WIC Breastfeeding Data Local Agency Report (FNS-798; see table 1.1). All data sources were collected in or are current as of FY 2022, except for the FFCRA WIC Local Agency Waiver Use Survey. See appendix B for further details.

Table 1.1. Overview of Data Sources Used to Prepare Report

Source	Nature of Information	Universe
FY 2022 WIC BPI II Local Agency Survey	Fielded between August and November 2022 and captured current or future-oriented information about local agency breastfeeding policies and practices not available from other sources	1,527 of 1,777 WIC local agencies responded to the survey
FFCRA Local Agency Waiver Use Survey	Fielded between March and April 2021 (under separate contract) to understand local agency operations before and as a result of the COVID-19 public health emergency	1,710 local agencies that responded to the WIC Local Agency Waiver Use Survey were also in the WIC BPI II Local Agency Survey frame
WIC PC 2022	WIC PC 2022 data were used in two ways: 1. Aggregated to the local agency level to describe the population of WIC participants in each local agency 2. Participant-level data to calculate equity gap scores	The universe of data varied: 1. 1,771 local agencies in the WIC PC 2022 file were also in the WIC BPI II Local Agency Survey frame 2. 5,765,144 WIC participants
FY 2022 WIC Breastfeeding Data Local Agency Report (FNS-798)	Used data on the number of breastfeeding women at each local agency to calculate the ratio of breastfeeding support staff to participants	Excludes data for two WIC State agencies; values were set to missing in the final dataset

BPI = Breastfeeding Policy Inventory; FFCRA = Families First Coronavirus Response Act; WIC PC = WIC Participant and Program Characteristics; FY = fiscal year

2. Analysis

The study team produced descriptive statistics using SAS® software and weighted all local agency survey results to adjust for survey nonresponse.[9] The team qualitatively analyzed responses to open-ended survey questions to identify key themes and describe similarities and differences in practices among local agencies. The team also reviewed "other, specify" responses to identify common and potentially innovative approaches. Descriptions of the data preparation steps follow:

- **Cleaned the survey data** by applying consistency edits, set outliers to missing, checked that responses followed the survey skip logic, and created new analytic variables
- **Created analytic files,** which includes a local agency analytic data file with one record per local agency (n = 1,777). The study team created a separate participant-level file using WIC PC data (n = 5,765,144).
- **Conducted nonresponse bias analysis** for the local agency survey to assess any differences between respondents and nonrespondents by agency characteristics and FNS Region
- **Created survey weights** to account for nonresponse in the local agency survey; created a weight adjustment based on the total number of local agencies in each FNS Region divided by the number of local agency respondents

To address study objective 2, the team examined participant access to equity-forward breastfeeding policies and practices, such as breastfeeding peer counselors and virtual breastfeeding services. Through multivariate analysis, the team examined the extent to which the racial or ethnic makeup of the WIC population at a local agency and local agency urbanicity predict whether the local agency has a

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particular equity-forward policy or practice. Equity in WIC State agency policies and practices is further examined in the *WIC BPI II: State Agency Report.*

D. Local Agency Survey Respondent Characteristics

Most local agencies (1,527 of 1,777) completed the survey, yielding an 85.9 percent response rate. Nearly all local agency survey respondents (97.0 percent) were contracted by their WIC State agency to serve WIC participants through one or more local clinics; about 3 percent of respondents were WIC State agencies with one or more local offices where WIC State agency staff provide services directly to WIC participants. Most local agencies were small, with a caseload of fewer than 1,000 participants (43.3 percent), and self-identified as a city, county, or State health department (67.1 percent). About two-thirds of local agencies had at least 50 percent of program participants living at 100 percent or less of the Federal Poverty Guidelines (64.4 percent). Nearly one-quarter of local agencies were located in the Midwest FNS Region (24.2 percent) and in a rural area (25.1 percent). See appendix table E.1 for comprehensive local agency characteristics.

Chapter 2. Breastfeeding Peer Counseling Programs, Designated Breastfeeding Experts, and Community Partnerships

To support breastfeeding participants, WIC local agencies can implement peer counseling programs, employ or work with DBEs, and form community partnerships. Local needs, available resources, and program implementation decisions can play a role in whether a local agency has the capacity to implement these services and partnerships. Using data from the local agency survey, this chapter examines the presence of peer counseling programs, DBEs, and community partnerships; peer counselor and DBE staffing; peer counselor service delivery sites; and available trainings. Findings related to staffing were further examined by local agency size: small (fewer than 1,000 participants), medium (1,000–4,999 participants), and large (5,000 or more participants).

A. Breastfeeding Peer Counseling Program

The Breastfeeding Peer Counseling Program,[10] an FNS-developed initiative, is intentionally designed and funded to assist and encourage breastfeeding among WIC participants (USDA, 2016). The program aims to foster mother-to-mother support within the WIC community. Peer counselors are mothers who have personal experience breastfeeding their own children. They are trained to provide basic breastfeeding information and support to WIC participants to help them achieve their breastfeeding goals. Research has demonstrated that program participation is associated with higher rates of breastfeeding initiation and duration (Feltner et al., 2018). The peer counseling program serves as an important addition to regular WIC program services. Peer counselors enhance the breastfeeding support provided by WIC, complementing but not replacing the work of other WIC staff members (USDA, 2016).

How does FNS define a WIC breastfeeding peer counselor?

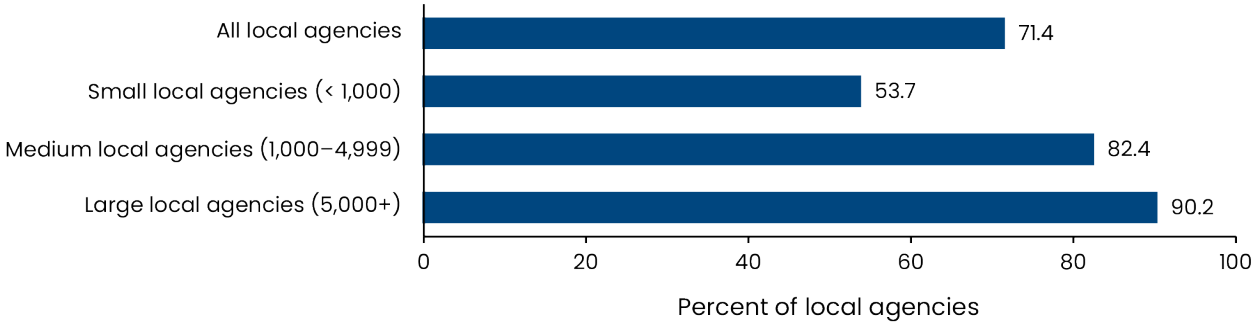
- Paraprofessional
- Member of the same community as WIC participants they serve
- Available to WIC participants outside usual clinic hours and outside the WIC clinic
- Has previous experience with breastfeeding

1. Presence of Breastfeeding Peer Counseling Program

Almost three-quarters of local agencies (71.4 percent; see figure 2.1) operated a peer counseling program. Fewer small local agencies operated this program (53.7 percent) compared with medium and large local agencies (82.4 and 90.2 percent, respectively).

[10] The core components of FNS's Breastfeeding Peer Counseling Program consist of appropriate definition of a peer counselor; designated Breastfeeding Peer Counseling Program managers and/or coordinators at the State and/or local level; defined scope of practice for peer counselors limited to supporting normal breastfeeding; written job descriptions for peer counselors; compensation and reimbursement of peer counselors; training of WIC State/local peer counseling management, supervisory, and clinic staff using FNS-developed training curricula; establishment of standardized Breastfeeding Peer Counseling Program policies and procedures at the State and local levels as part of an agency nutrition education plan; adequate supervision and monitoring of peer counselors; and establishment of community partnerships to enhance the effectiveness of a WIC peer counseling program. The core components also specify that support of peer counselors includes training and continuing education of peer counselors using FNS-developed curricula; timely access to a WIC DBE for assistance with problems outside peer counselor scope of practices; regular, systemic contact with a supervisor; participation in clinic staff meetings as part of the WIC team; and opportunities for continuing education and regular meetings with other peer counselors. For more information, see https://wicworks.fns.usda.gov/resources/wic-breastfeeding-model-components-peer-counseling.

Figure 2.1. Presence of Breastfeeding Peer Counseling Program, by Agency Size



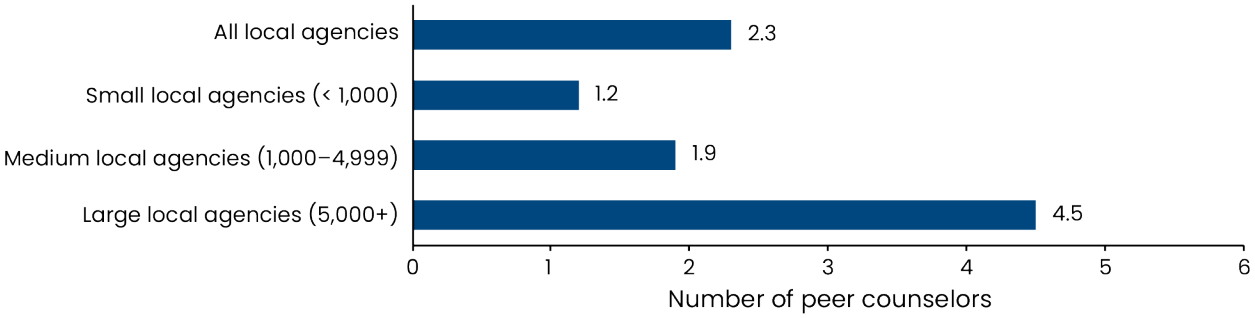
Note: "All local agencies" result excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (BPI II) Local Agency Survey. Results by size exclude an additional three local agencies not present in the WIC Participant and Program Characteristics (WIC PC) 2022 data. See appendix tables E.2 and E.3 for more information.
N = 1,527 total local agencies; 661 small local agencies; 571 medium local agencies; 292 large local agencies
Source: WIC BPI II Local Agency Survey question 7, WIC PC 2022

2. Peer Counselor Staffing

Nearly all local agencies with a peer counseling program employed a peer counselor (96.5 percent; see appendix table E.4). At the time of data collection, local agencies had, on average, 2.1 peer counselor full-time equivalents (FTEs) serving 202 breastfeeding women per peer counselor FTE (see appendix table E.5). While the presence of a peer counseling program did not vary based on local agency size, the ratio of breastfeeding peer counselor FTEs to breastfeeding women was lower in small local agencies (1:69) compared with medium (1:187) and large (1:393) local agencies.[11] However, large local agencies, on average, employed more breastfeeding peer counselor FTEs (4.5) than small and medium local agencies (1.9 and 1.2, respectively; see figure 2.2).

[11] The number of breastfeeding women is based off the average monthly number of breastfeeding women in the FY 2022 WIC Breastfeeding Local Agency Report and the number of FTEs was recorded in the WIC BPI II Local Agency Survey administered in summer 2022.

Figure 2.2. Average Number of Breastfeeding Peer Counselors Among Agencies Reporting Any Peer Counselors, by Agency Size

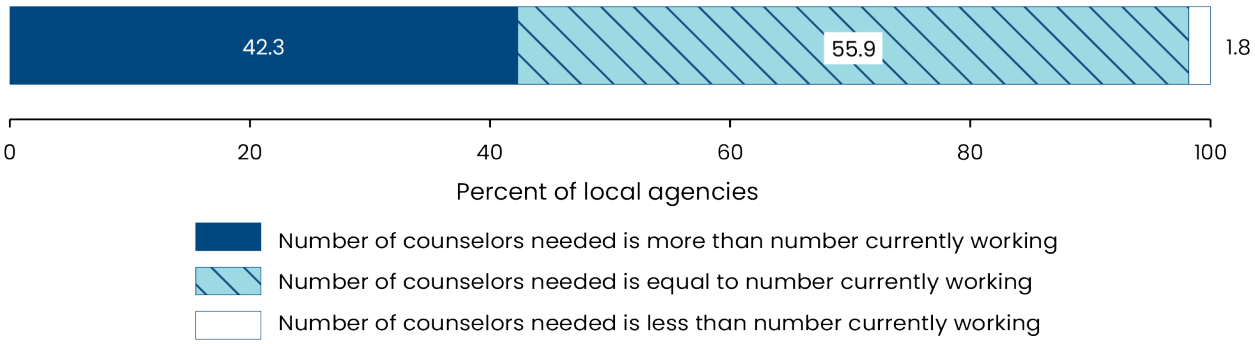


Note: Excludes 690 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, 437 local agencies did not have a Breastfeeding Peer Counseling Program, and 3 local agencies were not present in the WIC Participant and Program Characteristics (WIC PC) 2022 data. Percentages are weighted to account for agency nonresponse. See appendix table E.5 for more information.
N = 1,087 local agencies
Sources: WIC BPI II Local Agency Survey questions 8 and 9, WIC PC 2022

3. Peer Counselor Staffing Needs

Local agencies are responsible for hiring peer counselors to serve their designated caseload for peer counseling services. The survey gathered information on how many peer counselors currently work with each local agency and the respondents' opinions about the number of counselors needed to serve all clients who want to receive peer counseling services. The study team compared these two values to determine whether local agencies believed they had enough peer counselors to meet participant need. Based on this assessment, 55.9 percent of local agencies had enough peer counselors to meet their needs, and 42.3 percent needed additional peer counselors (see figure 2.3). Less than 2 percent of local agencies had more peer counselors than needed.

Figure 2.3. Peer Counselor Staffing Needs

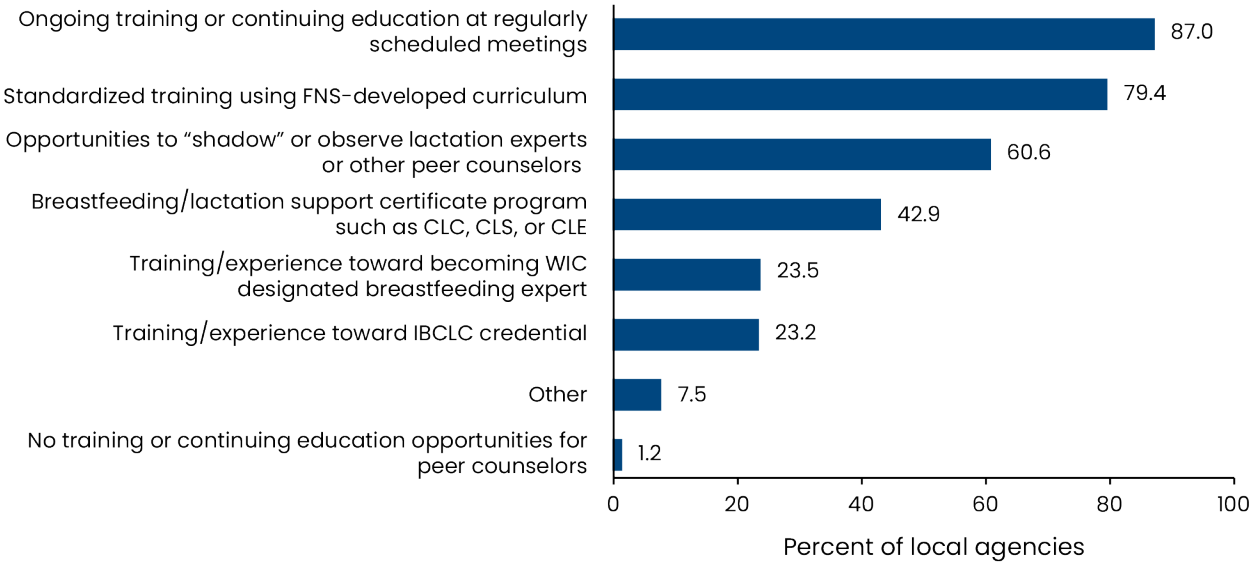


Note: Excludes 687 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, and 437 local agencies did not have a Breastfeeding Peer Counseling Program. Percentages may not sum to 100 percent because of rounding. Percentages are weighted to account for agency nonresponse. See appendix table E.6 for more information.
N = 1,090 local agencies
Source: WIC BPI II Local Agency Survey questions 8 and 9

B. Breastfeeding Peer Counselor Training and Continuing Education

Local agencies must provide training and continuing education to peer counselors (USDA, n.d.). Most local agencies (87.0 percent) provided training at regularly scheduled meetings (see figure 2.4). Nearly 80 percent of local agencies (79.4 percent) provided standardized training using FNS-developed curricula, and 60.6 percent offered opportunities to "shadow" or observe lactation experts or other peer counselors. About 40 percent of local agencies also provided training or continuing education toward a breastfeeding/lactation support certificate program, such as Certified Lactation Consultant, Certified Lactation Specialist, or Certified Lactation Educator (42.9 percent).

Figure 2.4. Types of Training or Continuing Education Local Agencies Provide to Peer Counselors



Note: Excludes 687 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, and 437 local agencies did not have a Breastfeeding Peer Counseling Program. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Other" included WIC State agency-administered trainings, conferences, webinars, trainings provided by other nongovernmental agencies (e.g., breastfeeding coalitions, private companies), meetings/calls, and in-house trainings. See appendix table E.7 for more information.
CLC = Certified Lactation Consultant; CLE = Certified Lactation Educator; CLS = Certified Lactation Specialist; IBCLC = International Board Certified Lactation Consultant
N = 1,090 local agencies
Source: WIC BPI II Local Agency Survey question 10

C. Peer Counseling Service Delivery Settings

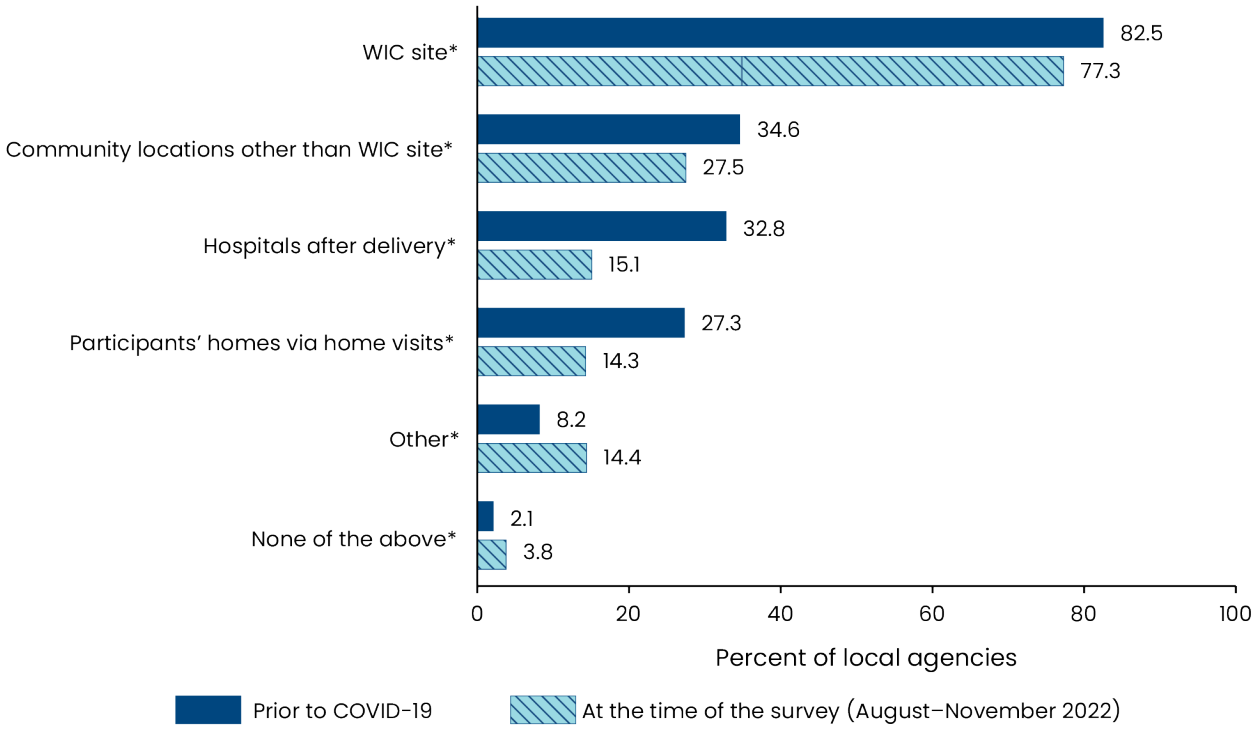
WIC breastfeeding peer counselors typically work in various community settings to support breastfeeding participants. The local agency survey asked about the physical settings where peer counselors interacted with participants before the onset of the COVID-19 public health emergency (PHE; prior to March 2020) and at the time of the survey (August to November 2022).

Local agencies most frequently reported that peer counselors provided services at WIC sites (82.5 percent before the COVID-19 PHE and 77.3 percent at the time of the survey; see figure 2.5). Less frequently reported settings included community locations other than WIC sites (e.g., libraries, parks,

community centers), hospitals, and participants' homes; local agencies used these settings more frequently before the COVID-19 PHE than at the time of the survey.

Local agencies more frequently reported the use of "other" settings (not included in the prespecified survey responses) at the time of the survey than prior to the COVID-19 PHE. These settings included curbside,[12] provider offices, and breastfeeding "cafes" or other breastfeeding support groups.

Figure 2.5. Physical Settings in Which Breastfeeding Peer Counselors Interact With Participants



Note: Excludes 687 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, and 437 local agencies did not have a Breastfeeding Peer Counseling Program. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. Common "other" responses included curbside, at provider offices, and at breastfeeding "cafes" or other breastfeeding support groups. See appendix table E.8 for more information.
* Indicates the difference between the two time periods was statistically significant using paired *t*-tests ($p < 0.01$).
N = 1,090 local agencies
Source: WIC BPI II Local Agency Survey question 11

[12] Curbside refers to services provided by a participant's car.

D. Designated Breastfeeding Experts

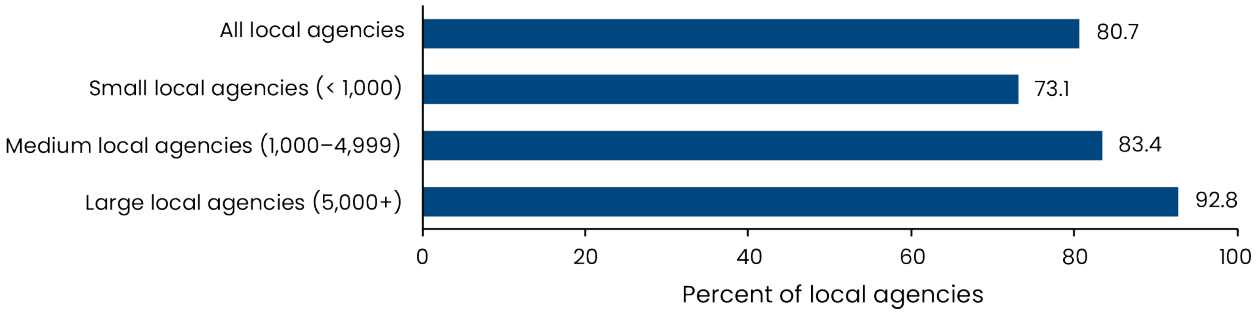
FNS defines a DBE as an individual with expertise in human lactation and qualified to provide advanced breastfeeding support (see text box; USDA, 2016). WIC staff members serving in the role of WIC DBE may be breastfeeding coordinators, Breastfeeding Peer Counseling Program coordinators, nutritionists, physicians, nurses, or other trained staff.

How does FNS define a WIC designated breastfeeding expert?

An individual who is an expert with special experience or training in helping breastfeeding mothers and who provides breastfeeding expertise and care for more complex breastfeeding problems when WIC staff face situations outside their scope of practice (USDA, 2016)

Eighty-one percent of local agencies employed or worked with a DBE (see figure 2.6). Fewer small local agencies worked with a DBE (73.1 percent) compared with medium and large local agencies (83.4 and 92.8 percent, respectively). On average, local agencies had 1.74 DBE FTEs, ranging from 0.95 DBE FTEs at medium local agencies to 1.44 DBE FTEs at small local agencies and 3.40 DBE FTEs at large local agencies (see appendix table E.5).

Figure 2.6. Presence of Designated Breastfeeding Expert, by Agency Size

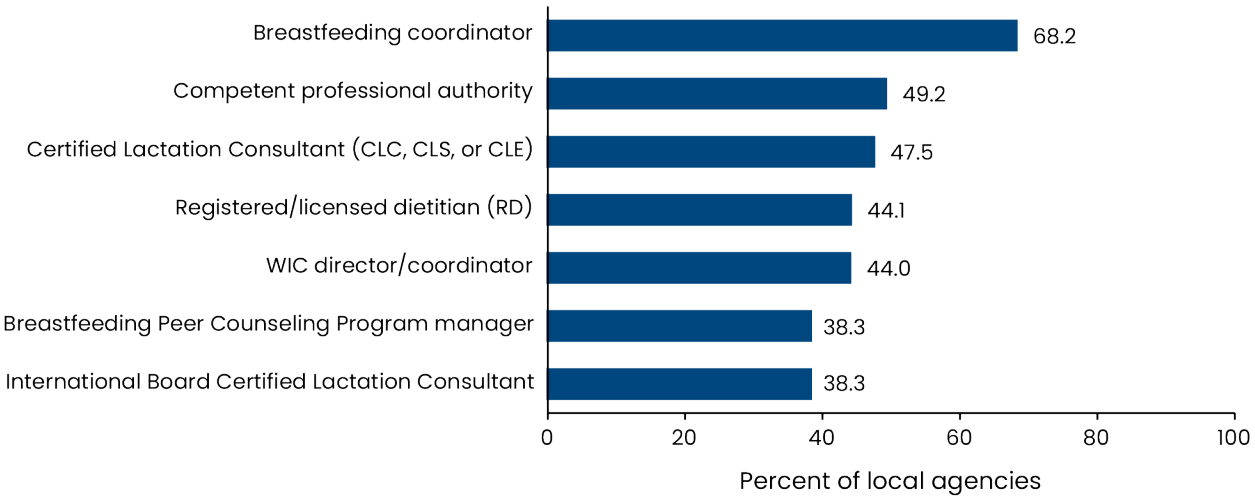


Note: Excludes 253 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (BPI II) Local Agency Survey, and 3 local agencies were not present in the WIC Participant and Program Characteristics (WIC PC) 2022 data. See appendix table E.9 for more information.
N = 1,524 local agencies: 661 small local agencies; 571 medium local agencies; 292 large local agencies
Sources: WIC BPI II Local Agency Survey question 12, WIC PC 2022

1. Other Roles DBEs Hold

DBEs may hold additional roles or job titles within WIC. Almost all local agencies (99.4 percent; data not shown) reported their DBE held at least one other role. Most frequently, DBEs also served as breastfeeding coordinators (68.2 percent), competent professional authorities (49.2 percent), and certified lactation consultants (47.5 percent; see figure 2.7).

Figure 2.7. Top Seven Other WIC Roles or Job Titles Held by Designated Breastfeeding Experts

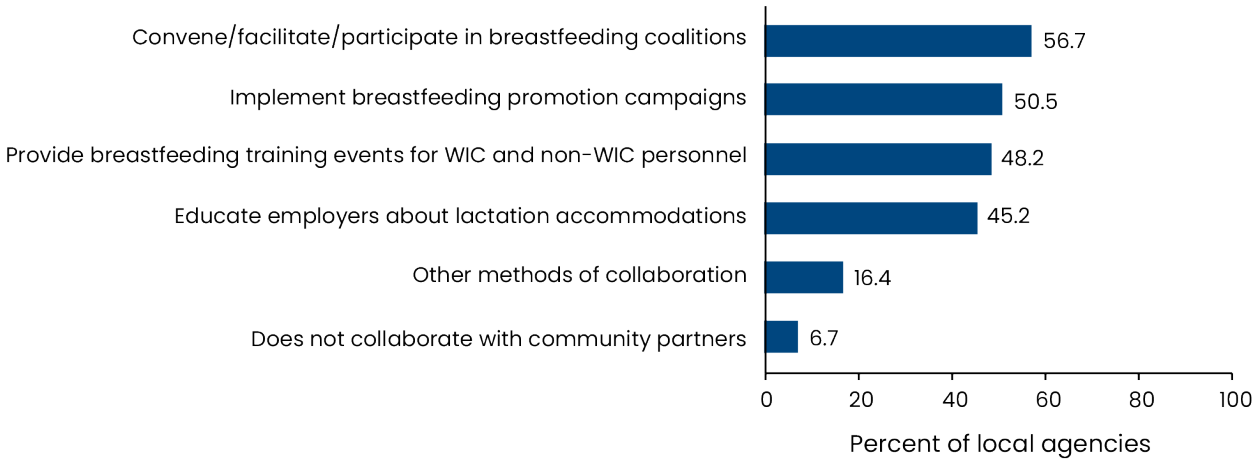


Note: Excludes 544 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, and 294 local agencies did not report any designated breastfeeding experts. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. See appendix table E.10 for more information.
CLC = Certified Lactation Counselor; CLE = Certified Lactation Educator; CLS = Certified Lactation Specialist
N = 1,233 local agencies
Source: WIC BPI II Local Agency Survey question 13

E. Community Partnerships

Almost all local agencies reported collaborating with at least one community partner. Most frequently, local agencies collaborated with community partners through a breastfeeding coalition (56.7 percent; see figure 2.8). About half of local agencies (50.5 percent) collaborated with community partners to implement breastfeeding promotion campaigns, and 48.2 percent provided breastfeeding training events for both WIC and non-WIC personnel (e.g., healthcare provider staff). Fewer local agencies (16.4 percent) reported other methods of collaboration, such as breastfeeding support groups or gaining access to and/or providing lactation support to populations that are hard to reach (e.g., incarcerated mothers).

Figure 2.8. Ways Local Agencies Collaborate With Community Partners



Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Other methods of collaboration" included breastfeeding support groups, gaining access to and/or providing lactation support to populations that are hard to reach (e.g., incarcerated mothers), breast pump loans, referrals, outreach efforts, breastfeeding education and resources, local breastfeeding events, and use of social media for communication efforts. See appendix table E.11 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 6

Chapter 3. Virtual Services

Local agency staff can provide breastfeeding counseling and support in person and virtually (e.g., phone, video, online). This chapter describes how the provision of virtual breastfeeding counseling and support has changed since the onset of the COVID-19 PHE, how local agencies document virtual sessions, and what training related to virtual counseling is available.

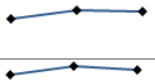
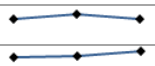
A. Provision of Virtual Breastfeeding Counseling and Support

In spring 2021, FNS fielded a survey to understand how local agencies were providing WIC services to participants during the COVID-19 PHE. Findings indicated that although virtual breastfeeding counseling and support were common before March 2020, the COVID-19 PHE and the use of the physical presence waiver among WIC State and local agencies increased the use of remote services (see table 3.1). Local agencies reported an increase in the use of live one-on-one sessions by video call (from 5.8 to 29.9 percent) and live group counseling sessions by video call (from 2.1 to 20.0 percent).

The WIC BPI II Local Agency Survey, fielded in fall 2022, captured the use of virtual breastfeeding counseling and support services in the later stages of the COVID-19 PHE. Results indicated the use of these services remained at similar levels between the early and later stages of the pandemic, with some exceptions. In particular, the use of interactive online platforms[13] decreased by about 70 percent (from 31.4 to 8.4 percent). The use of prerecorded counseling videos and live group counseling sessions by telephone decreased by about 50 percent (from 23.9 to 10.7 percent and 8.1 to 3.4 percent, respectively).

[13] The term "interactive online platform" refers to a website that can include learning modules, chat functions, bulletin boards, and calendars.

Table 3.1. Local Agency Provision of Virtual Breastfeeding Counseling and Support Before and Throughout the COVID-19 Public Health Emergency

Remote Activity	Percentage of Local Agencies			Trend
	Before COVID-19[a]	March–April 2021[a]	August–November 2022[b]	
Live one-on-one counseling sessions by telephone (*N* = 1,459)	62.4	84.9	83.2	
Mailed hardcopy reading material (*N* = 1,455)	53.3	70.1	63.6	
Text messaging (*N* = 1,455)	49.6	51.9	63.0	
Online reading materials (*N* = 1,455)	50.9	58.8	50.9	
Social media (*N* = 1,450)	35.2	35.9	42.4	
Live one-on-one counseling sessions by video call (*N* = 1,456)	5.8	30.4	31.6	
Live group counseling sessions by video call (*N* = 1,453)	2.1	20.0	20.7	
Prerecorded counseling videos (*N* = 1,454)	19.2	23.9	10.7	
Interactive online platform (*N* = 1,453)	28.4	31.4	8.4	
Live group counseling sessions by telephone (*N* = 1,452)	3.0	8.1	3.4	

Note: Excludes local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey and the WIC Waivers Local Agency Survey and local agencies that responded to the WIC Waivers Local Agency but did not respond to the specific question 24 subitems. Percentages are weighted to account for agency nonresponse. See appendix table E.12 for more information.

[a] WIC Waivers Local Agency Survey respondents were asked, "How was breastfeeding counseling conducted remotely?" They were asked to consider remote activities generally offered before and after March 2020. Local agencies responded to the survey between March and April 2021 and could select all responses that applied for each of the two time periods of interest (before COVID-19 and in response to/during COVID-19).

[b] WIC BPI II Local Agency Survey respondents were asked, "How is your local agency/program providing virtual breastfeeding counseling and support (e.g., educational materials)?" Respondents received the same response options as those presented on the WIC Waivers Local Agency Survey and could select all applicable options.

Sources: WIC Waivers Local Agency Survey question 24, WIC BPI II Local Agency Survey question 17

B. Documenting Virtual Breastfeeding Counseling Sessions

According to WIC BPI I, local agencies typically document all breastfeeding-related information in their management information system (MIS; Forrestal, 2015). The WIC BPI II survey sought to capture information on whether documentation varied between in-person and virtual counseling sessions. Eighty-five percent of local agencies indicated that staff document virtual breastfeeding counseling sessions in the same manner as in-person sessions (see appendix table E.13). Nearly all local agencies (83.7 percent; see appendix table E.13) also reported that all staff have access to information about any given participant's virtual counseling sessions for continuity of care.

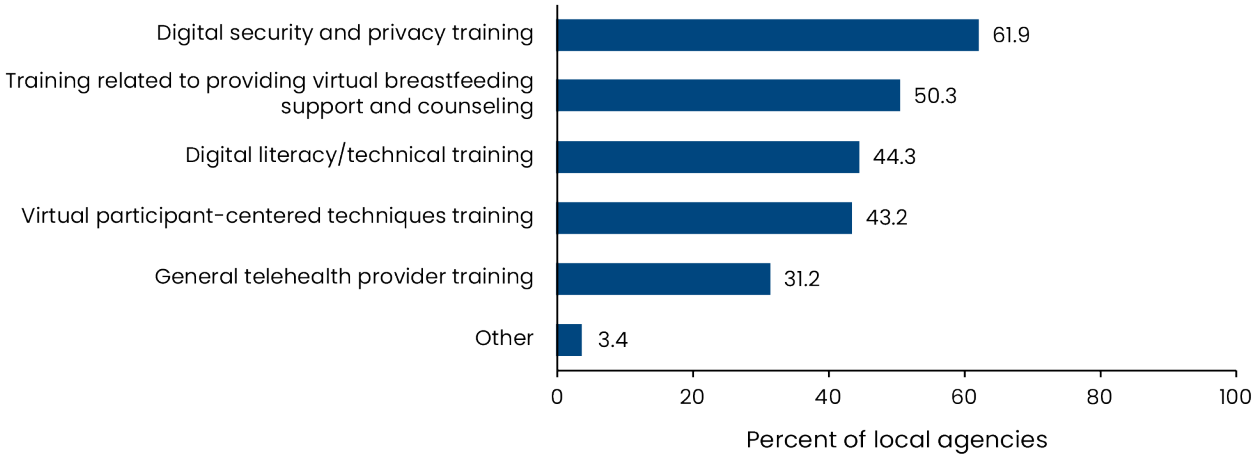
The 229 local agencies that reported documenting virtual breastfeeding counseling sessions differently than in-person sessions were asked to describe how virtual sessions are documented. Open-ended responses suggest these local agencies do not necessarily document virtual and in-person sessions differently but rather use fields in the MIS to specify how the session was conducted. For example, local agencies described using a phone icon rather than a person icon to indicate the session was conducted by phone or noting via a dropdown menu or notes field that the session was conducted by phone or

video. Some local agencies also used the open-ended response field to describe the specific location within the MIS where virtual encounters are documented, such as in the "nutrition education tab," "care plan," "breastfeeding tracking tab," or "peer counselor module."

C. Availability of Virtual Breastfeeding Counseling Training

The survey asked local agencies about the types of virtual breastfeeding counseling training available to their staff. Most commonly, local agencies indicated the availability of digital security and privacy training (61.9 percent) and training related to providing virtual breastfeeding support and counseling (50.3 percent; see figure 3.1). Over 40 percent of local agencies also indicated the availability of digital literacy/technical training (44.3 percent) and virtual participant-centered techniques training (43.2 percent). Fewer local agencies (31.2 percent) reported the availability of general telehealth provider training. Less than 5 percent of local agencies reported availability of other training (3.2 percent). As a note, the survey only asked about the availability of training, not the extent to which staff attended or otherwise engaged with the training.

Figure 3.1. Training Related to Virtual Breastfeeding Counseling Available to Staff



Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Other" included general WIC requirements training, general counseling training, documenting protocols, the referral process, and WIC State agency webinars; most responses were nonresponsive to the survey question. See appendix table E.14 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 20

Chapter 4. Practices to Promote Equity and Inclusion

Breastfeeding initiation and duration rates differ among the WIC participants by race, ethnicity, maternal education, and income (Centers for Disease Control and Prevention, 2023). By providing education and peer counseling, and assessing the need for breast pumps, WIC may help alleviate barriers preventing participants from meeting their breastfeeding goals. Local agencies have the flexibility, for example, to implement practices such as operating weekend clinic hours and hiring multilingual staff to support breastfeeding participants at convenient times and in their preferred language. These flexibilities enable local agencies to decide how to best use their staff and resources to meet the needs of their participants.

Key Concepts

- **Health equity**—fair and just opportunity to achieve health goals; requires removal of barriers linked to economic, social, and environmental conditions people face (Braverman et al., 2018)
- **Access**—opportunity to use service or program
- **Inclusion**—practice of providing access to all, particularly those who would not have access otherwise, in a manner that is welcoming and empowering
- **Availability**—presence or existence of a service or program; the availability of a service or program does not imply access for all

This chapter examines the prevalence of select local agency policies and practices that may help foster inclusion and address health disparities among WIC participants (i.e., equity-forward practices). Local agency use of one or more of these policies or practices does not necessarily mean all participants feel included and have access to the WIC resources they need to meet their breastfeeding goals because local implementation of the policy may vary; therefore, the results presented in this chapter should be interpreted with caution and not viewed as general measures of access and inclusion.

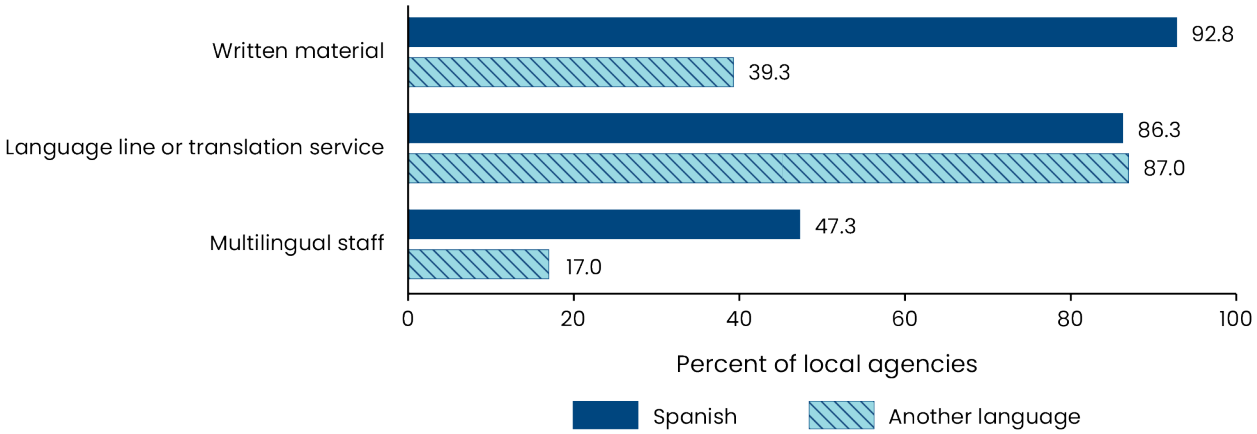
A. Meeting Needs of Participants With Limited English Proficiency

In 2022, nearly one-quarter of all households in the United States spoke a language other than English at home. About 4 percent of households spoke English less than "very well," meaning all household members above the age of 14 faced challenges communicating in English (U.S. Census Bureau, 2022). Language and cultural barriers may discourage individuals with limited English proficiency from participating in WIC.

To meet the needs of WIC participants with limited English proficiency, WIC local agencies can hire multilingual staff, provide access to a language line or translation services, and provide written materials in languages other than English. In 2022, nearly half of local agencies employed Spanish-speaking multilingual staff (47.3 percent; see figure 4.1). Some local agencies employed multilingual staff who speak languages other than Spanish (17.0 percent); these languages included Vietnamese, Arabic, French or Haitian Creole, Chinese languages, American Sign Language, Russian, or Somali (see appendix table E.15). More than 86 percent of local agencies provided access to language line or translation services to accommodate the needs and preferences of participants who speak Spanish or other languages. Almost all local agencies (92.8 percent) provided written materials in Spanish; 39.3 percent provided written materials in languages other than English or Spanish. While these findings indicate that not all local agencies provided access to language line or translation services and many did not employ staff that spoke languages other than Spanish, we know from the National Survey of WIC Participants III that less than 5 percent of participants have a primary language other than English and less than

1 percent of participants report being dissatisfied with staff's ability to speak their language (see Appendix G, Tables 1a.1 and 5a.1 of Magness et al., 2021).

Figure 4.1. Local Agencies With Multilingual Staff and Non-English Language Resources

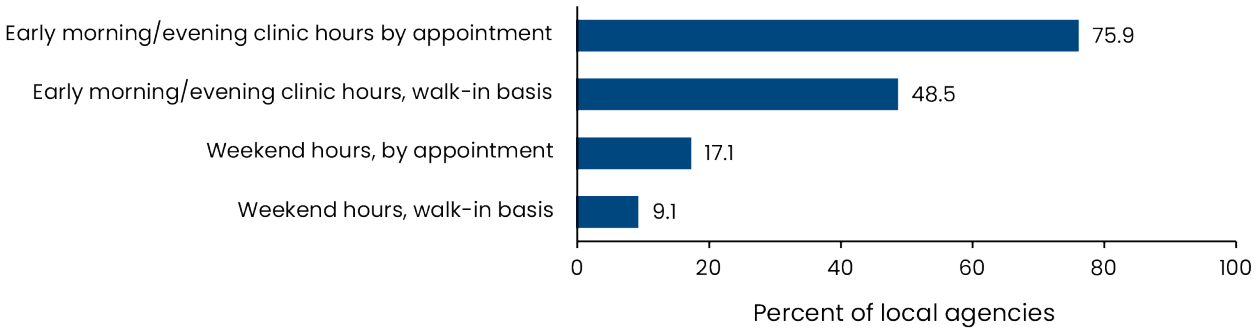


Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Another language" includes Vietnamese, Arabic, French or Haitian Creole, Chinese languages, American Sign Language, Russian, Somali, Braille, and open text responses (e.g., Karen, Pashto, Hmong, Khmer, Farsi, Urdu, Portuguese, Tagalog, Mixteco languages, and Quiché). See appendix table E.15 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 23

B. Meeting Needs of Participants Who Are Employed

WIC participants who are employed may face barriers to accessing WIC. They may have a work schedule that overlaps with WIC clinic hours and face challenges or hardships taking time off work to attend an appointment. To help alleviate this barrier, many local agencies offered alternative clinic hours. About three-quarters of local agencies provided services during early morning or evening hours by appointment (75.9 percent), and about half provided early morning or evening hours on a walk-in basis (48.5 percent; see figure 4.2). Less frequently, local agencies provided services during weekend hours by appointment (17.1 percent) and on a walk-in basis (9.1 percent).

Figure 4.2. Alternative Hours Local Agencies Offer to Accommodate Participants Who Are Employed

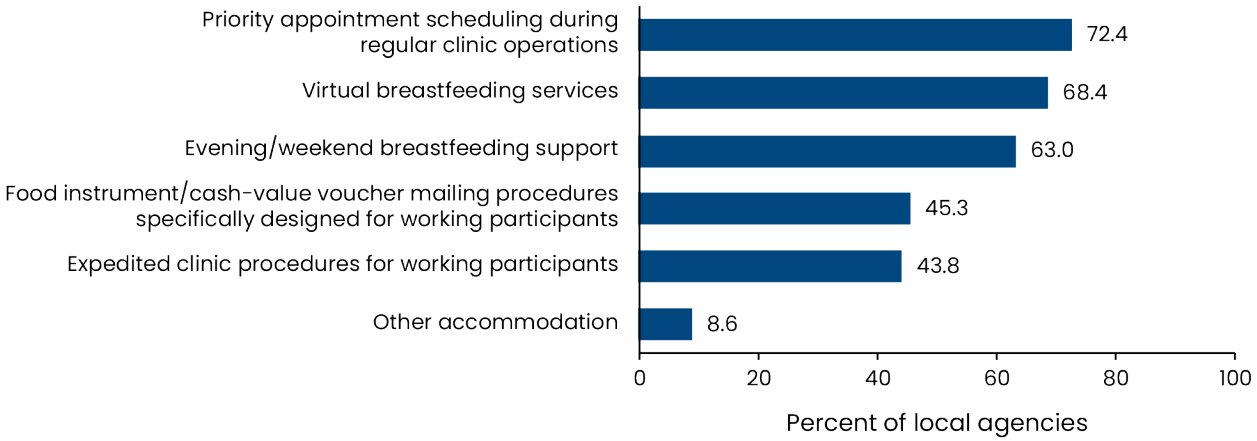


Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. See appendix table E.16 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 22

In addition to expanded clinic hours, local agencies can implement other practices to meet the needs of participants who are employed. Over 70 percent of local agencies offered priority appointment scheduling during regular clinic operations for participants who are employed (72.4 percent; see figure 4.3). Most local agencies also provided virtual breastfeeding services (68.4 percent) and evening or weekend breastfeeding support (63.0 percent). Less than half of local agencies designed food instrument/cash-value voucher mailing procedures specifically for working participants (45.3 percent) or provided expedited clinic procedures (43.8 percent). Other accommodations, as noted in an open-ended response field, include phone or smartphone app support via a warm line,[14] text, or appointment; availability of breastfeeding peer counselors outside regular clinic hours; services during lunch hours on a walk-in basis; and home or alternative site visits.

[14] A warm line is a confidential, free phone service offering support. Unlike a crisis line or hotline, it is not intended for emergencies.

Figure 4.3. Policies Local Agencies Use to Accommodate Participants Who Are Employed



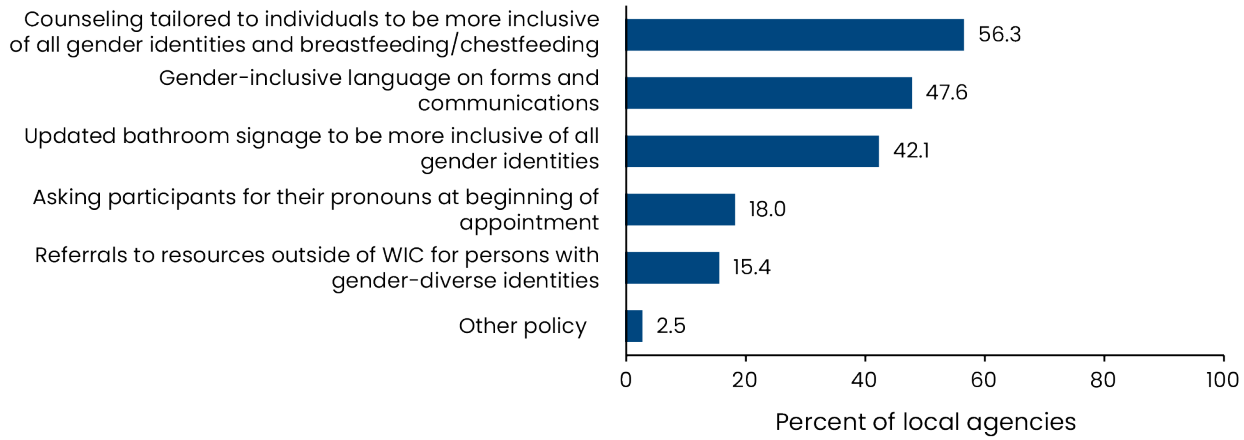
Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Other accommodation" included phone or app support available via a warm line, text, or appointment; support available during off-hours as needed; breastfeeding peer counselor availability outside regular clinic hours; walk-ins during lunch hours; and home or alternative site visits. See appendix table E.16 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 22

C. Meeting Needs of Participants With Gender-Diverse Identities

The medical community has largely viewed pregnancy and breastfeeding/chestfeeding as a woman's or mother's experience. In recent years, healthcare professionals and WIC agencies have taken steps to better serve people with gender-diverse identities (Dahl et al., 2013; Hoffkling et al., 2017; Ross et al., 2012). Local agencies commonly provided tailored counseling (56.3 percent), used inclusive language on forms and communication (47.6 percent), and updated their bathroom signage (42.1 percent; see figure 4.4). Less frequently, local agencies asked participants for their pronouns at the beginning of an appointment (18.0 percent) and provided referrals to resources outside WIC (15.4 percent). Local agencies are only able to provide referrals to services that are available in their area; the relatively low percentage of local agencies providing referrals may suggest a lack of services rather than a lack of desire on the part of staff to refer participants. Likewise, local agencies may vary in their ability to implement practices to meet the needs of participants with gender-diverse identities because of State laws or other local regulations.

The 237 local agencies that reported providing referrals to outside resources shared further details in an open-ended response field. Most commonly, local agencies shared they refer participants to resources that are not LGBTQ+ or lactation specific, such as community-based organizations providing mental health services, food, or housing assistance. Some local agencies shared they refer people to a local or online LGBTQ+ support organization or an IBCLC for lactation-specific care.

Figure 4.4. Local Agency Practices to Support Needs of Parents With Gender-Diverse Identities



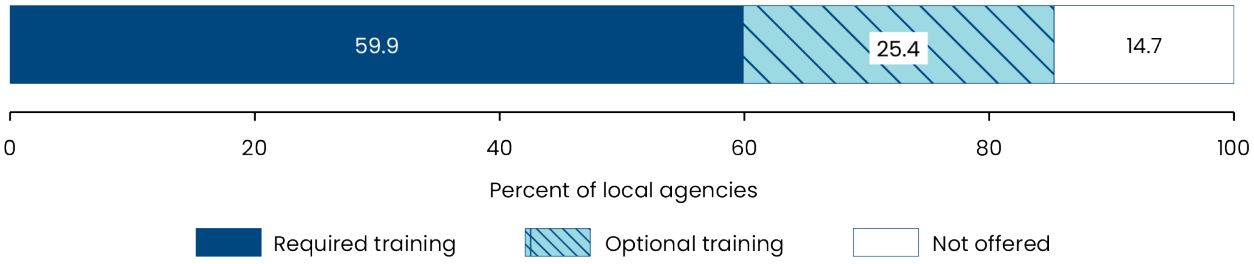
Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Percentages are weighted to account for agency nonresponse. "Other policy" included calling participants by their first name, staff training, accommodating needs as the local agency is made aware of them, using the updated Federal nondiscrimination statement, and that this issue is not relevant to the local agency. See appendix table E.17 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 24

Through an open-ended survey question, local agencies shared any current discussions and/or interest they had in addressing the needs of pregnant and breastfeeding/chestfeeding parents with gender-diverse identities. The 900 local agencies that responded to this question most often stated that they provide, receive, or desire additional training or information on the topic. Less frequently, local agencies reported using or wanting to use preferred pronouns and inclusive language. A few local agencies mentioned having LGBTQ+ or LGBTQ+ allied staff and providing trauma-informed care. A few local agencies also expressed that the materials and systems available to them do not facilitate inclusiveness. Many agencies responded that they are not currently discussing the needs of parents with gender-diverse identities or the issue was not applicable at their agency; compared to all local agency responders, these local agencies were more likely to have a smaller caseload (51.1 percent versus 43.3 percent of all local agencies) and be located in a rural area (32.4 percent versus 25.1 percent of all local agencies; see appendix table E.1).

D. Health Equity Training for WIC Staff

Health equity means everyone has a fair and just opportunity to be as healthy as possible (Braverman et al., 2018). This approach requires removing obstacles to health such as poverty and discrimination. Receipt of health equity training may increase staff awareness of the potential barriers WIC participants face. Nearly 60 percent of local agencies required staff to complete health equity training (59.9 percent), and a quarter (25.4 percent) reported offering it as an optional opportunity (see figure 4.5). Local agencies may vary in their ability to provide health equity training because of State laws or other local regulations.

Figure 4.5. Staff Training or Continuing Education on Health Equity Topics

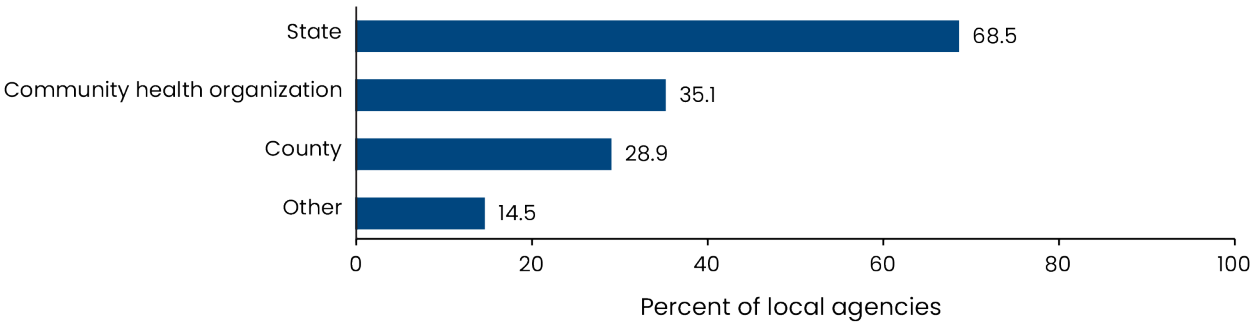


Note: Excludes 250 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey. Percentages are weighted to account for agency nonresponse. See appendix table E.18 for more information.
N = 1,527 local agencies
Source: WIC BPI II Local Agency Survey question 26

1. Health Equity Training Sources

Local agencies most often used materials they received from the State to train staff (68.5 percent; see figure 4.6). Less frequently, local agencies used health equity training materials from community health organizations (35.1 percent) and the county (28.9 percent). Other sources (14.5 percent) included nonprofit or community partners, such as breastfeeding coalitions; the sponsor or local agency; and a consultant, other private company, or contractor.

Figure 4.6. Health Equity Training Sources, Among Local Agencies Offering Training to Staff



Note: Excludes 471 local agencies: 250 local agencies did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, and 221 local agencies did not receive training on health equity topics. Percentages may sum to more than 100 percent because responses are not mutually exclusive. Common "other" responses included nonprofit or community partners (e.g., breastfeeding coalitions), sponsoring agency or local agency, consultant, other private company or contractor, Tribal, city, national, college, hospital, online, conference, and webinar. See appendix table E.19 for more information.
N = 1,306 local agencies
Source: WIC BPI II Local Agency Survey question 27

E. Efforts to Improve Access and Create an Inclusive Environment

Local agencies were asked to describe other actions they are taking to improve access and inclusion for underserved WIC participant groups (e.g., rural participants, immigrants) and WIC participant groups with longstanding health disparities;[15] 662 agencies responded to this question.

Many WIC local agencies commonly described **partnerships, collaborations, and the outreach they are conducting** to best serve their participants.

- Many local agencies shared they partner with other community nonprofits (e.g., refugee resettlement agencies) or government agencies (e.g., the Department of Corrections) to spread the word about WIC. To better meet the needs of rural participants, one local agency noted it reaches out to farms and other agricultural businesses in its area to provide information on WIC; another local agency reported it partners with nonprofits to reach migrant farmworkers.
- Some local agencies noted their efforts to better support WIC participants by improving coordination of resources among agency staff and providing multiple services (e.g., vaccinations, oral care) during one visit. A few local agencies described working with multilingual community health workers to better support participants with limited English proficiency or those who have recently immigrated.
- Some local agencies described their efforts to connect participants with other community services and programs via referrals and with medical providers or other social service programs to provide support with housing or education. For example, one local agency shared that they provide referrals to Federally qualified health centers where participants can receive assistance applying for Medicaid.
- A few local agencies described where they conduct outreach, including community baby showers, health fairs, back-to-school clothing drives, and food distribution events.

Many local agencies also described their **efforts to broaden access to services**, especially for clients with transportation barriers, by offering mobile sites, home visits, and extended hours.

- Two local agencies discussed their plans to relocate closer to WIC-eligible populations to lessen transportation barriers.
- One local agency described providing Supplemental Nutrition Assistance Program, WIC, and Medicaid services simultaneously via a mobile unit, and another noted it enrolls WIC-eligible participants at various community events, such as health fairs, Head Start enrollment, and county fairs.
- At one local agency, the breastfeeding peer counselor maintains a breastfeeding support phone line in the evenings and on weekends.

[15] Healthy People 2030 defines a health disparity as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (Healthy People 2030, n.d.).

Local agencies shared they **foster open and inclusive environments** and try to accommodate the needs of all participants.

- Some local agencies discussed their aim to hire diverse staff, such as multilingual breastfeeding peer counselors, to reflect the WIC population.
- Some local agencies commented they are participating in additional education and/or training, such as health equity task forces, to foster inclusivity and better support their clients.
- One local agency described hiring peer dads to serve as mentors to fathers in the community to address breastfeeding disparities.

Chapter 5. Availability of Select Equity-Forward Practices

One of the objectives of this study was to examine equity in the availability of breastfeeding support that results from State and local policies and practices. To further address this objective, this chapter examines the availability of four equity-forward practices by participant race and ethnicity and by local agency urbanicity; these are just a subset of the practices local agencies may use to alleviate common barriers to program participation and breastfeeding. The study team selected these four practices based on available data from the WIC BPI II Local Agency Survey and whether there was sufficient variation in the presence of a practice among local agencies to facilitate analysis. The study team defined availability as the presence of a service or program—that is, whether or not the participant was certified to receive WIC benefits at a local agency that had implemented the practice. A description of each practice, and the study team's rationale for its inclusion in this analysis, follows.

- Local agencies can **operate a Breastfeeding Peer Counseling Program**. This evidence-based program supports women in their decision to breastfeed (Feltner et al., 2018; Gleason et al., 2020). The peer counseling program helps normalize breastfeeding and provides an additional resource for women to discuss any challenges or questions that may arise.
- Another way local agencies support breastfeeding is through **live virtual breastfeeding services**, which include live one-on-one counseling or group sessions by video call or telephone. By offering virtual services, local agencies may help alleviate transportation barriers and help participants save travel time.
- Local agencies can make **accommodations to meet the needs of participants who are employed.** In the survey, local agencies indicated which of the following 10 accommodations they use: early morning or evening hours by appointment, early morning or evening walk-in hours, weekend hours by appointment, weekend walk-in hours, priority appointment scheduling during regular site operations, food instrument/cash-value voucher mailing procedures designed for participants who work, expedited site procedures for participants who work, evening or weekend breastfeeding support, virtual breastfeeding services, or other accommodations. When local agencies implement these flexibilities, participants can more easily use WIC services despite challenges caused by their work schedule. The study team considered local agencies as offering options to participants who are employed if they indicated using at least 3 of these 10 accommodations.
- Local agencies can **take actions to meet the needs of participants with gender-diverse identities.** In the survey, local agencies indicated which of the following five actions they have taken: use gender-inclusive language on forms and communications, use bathroom signage inclusive of all gender identities, ask participants their preferred pronouns at the beginning of an appointment, provide tailored counseling to be more inclusive of all gender identities to people who wish to breastfeed/chestfeed, and refer participants to outside resources for persons with gender-diverse identities. The study team considered local agencies as taking actions to meet the needs of participants with gender-diverse identities if they indicated doing at least one of the five actions.

This chapter presents the **availability of equity-forward practices** by examining the percentage of participants served by local agencies with each of these practices[16] by participant race and ethnicity and local agency urbanicity. The six ethnoracial groups include: American Indian and Alaska Native; Asian; Black or African American; Hispanic; Native Hawaiian or Pacific Islander; Multiracial; and White. To assess relative differences in the availability of each practice, the results include an equity gap score (see text box). This score can be interpreted as how much the percentage of the participant group with the lowest availability would need to increase to have equal availability as the participant group with the highest percentage.

Equity Gap Score

Equity gap score is the ratio of the participant group with the highest percentage to the participant group with the lowest percentage. An equity gap score of 1.0 symbolizes equal availability—the larger the score, the greater the inequality.

Local Agency Characteristics

The study team adjusted for the following local agency characteristics in the logistic regression models: FNS Region, local agency caseload size, local agency type, breastfeeding status of infants served, and poverty status of participants served.

The chapter also examines the **odds of local agencies implementing equity-forward practices** based on the results of logistic regressions that estimate the association between the presence of a given practice and local agency characteristics (see text box). Whereas the equity gap scores are descriptive statistics, statistically significant logistic regression results indicate the differences cannot be explained by local agency characteristics included in the model, such as local agency size.

Variation in the use of equity-forward practices may reflect local agency's decisions about how to best use their staff and resources to meet the needs of their participants. However, differences in implementation of these practices may result in variation in how participants experience WIC. Importantly, results in this chapter focus on the availability, or presence, of a practice and should not be interpreted as a measure of the extent to which participants have access to WIC services.

Taken together, the results in this chapter are one tool for FNS and WIC State agency staff to better understand the potential ethnoracial and geographic disparities that may exist in their area. The results are not causal and should not be interpreted as such. Rather, they should be considered alongside other research (e.g., qualitative data about participant experiences with the peer counseling program, breastfeeding initiation and duration rates) to paint a more comprehensive picture of equity in breastfeeding supports among WIC participants.

A. Availability of Equity-Forward Practices to Participants

Based on the results of the equity gap score analysis, the availability of equity-forward practices varied by ethnoracial group. These results suggest disparities exist for WIC participants by ethnoracial group. However, the equity gap score for each practice was never greater than 2. This means no ethnoracial group had twice the availability of any of these practices compared with any other ethnoracial group.

[16] The study team identified participants as being served by a local agency if they were certified by that local agency according to WIC PC 2022 data. Although WIC recommends participants go to the local agency where they were first certified, WIC participants can go to any local agency to receive WIC services with a verification of WIC certification.

Equity-forward practices were least available to participants who identified as American Indian or Alaska Native and those who identified as Native Hawaiian or other Pacific Islander (see table 5.1). Practices that met the needs of participants with gender-diverse identities had the highest equity gap scores and the lowest overall availability. Compared to the other equity-forward practices, a lower percentage of participants were served by a local agency that met the needs of participants with gender-diverse identities and the availability of these practices varied the most across ethnoracial groups. A detailed presentation of the results by equity-forward practice follows.

Table 5.1. Ethnoracial Groups With Most and Least Availability of Equity-Forward Practices

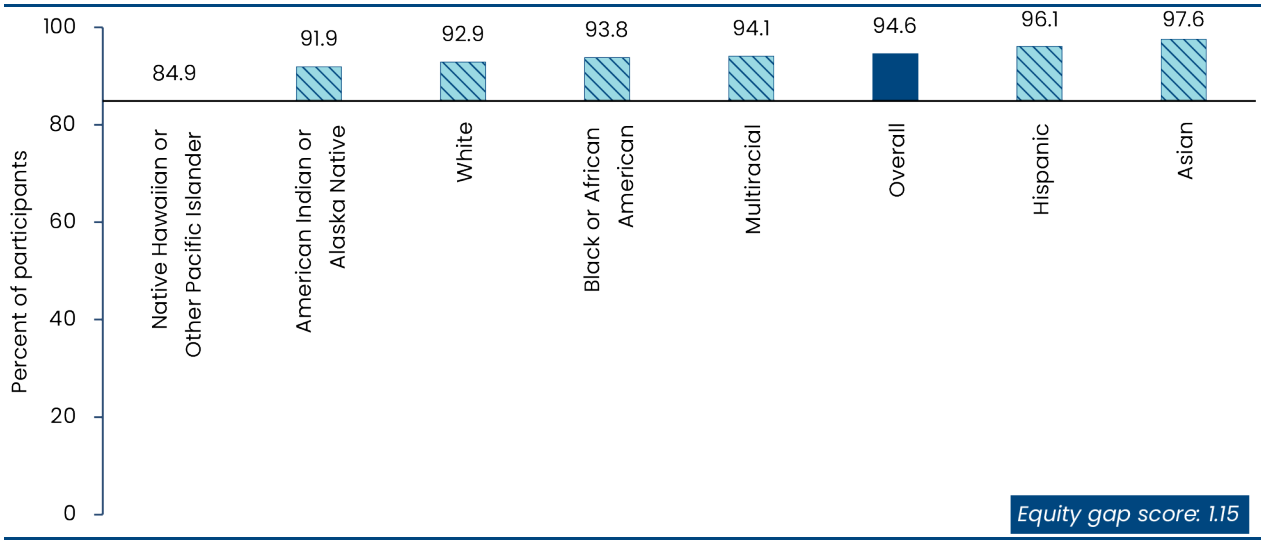
Equity-Forward Practice	Group With Least Availability	Overall Availability	Group With Most Availability	Equity Gap Score
Offered live virtual breastfeeding services	84.9 Native Hawaiian or Other Pacific Islander	94.6	97.6 Asian	1.15
Operated Breastfeeding Peer Counseling Program	77.7 American Indian or Alaska Native	88.1	90.2 Black or African American	1.16
Took one or more actions to meet needs of participants with gender-diverse identities	56.5 Native Hawaiian or Other Pacific Islander	79.4	88.2 Asian	1.56
Offered three or more options to meet needs of participants who are employed	43.1 American Indian or Alaska Native	63.8	68.6 Hispanic	1.59

Note: Excludes 265 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, were not in the WIC Participant and Program Characteristics (WIC PC) 2022 source file, or reported no participants in April 2022; these agencies served 1,044,077 participants. Ethnoracial groups are defined as mutually exclusive. A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of participants in a local agency with the practice of interest was equal between ethnoracial groups. The association between these variables was statistically significant for every policy or practice ($p < 0.001$). See appendix table E.20 for more information.
N = 5,756,612 participants overall across 1,524 local agencies
Sources: WIC BPI II Local Agency Survey questions 7, 17, 22, and 24; WIC PC 2022

1. Availability of Live Virtual Breastfeeding Services

Almost all participants were served by a local agency that offered live virtual breastfeeding services (94.6 percent; see figure 5.1). Availability was lowest among participants who identified as Native Hawaiian or other Pacific Islander (84.9 percent) and highest among participants who identified as Asian (97.6 percent). The equity gap score was 1.15, meaning the percentage of participants who identified as Asian and were served by local agencies that offered these services was 1.15 times higher than the percentage of participants who identified as Native Hawaiian or other Pacific Islander.

Figure 5.1. Percentage of Participants Served by Local Agencies With Live Virtual Breastfeeding Services, by Ethnoracial Group

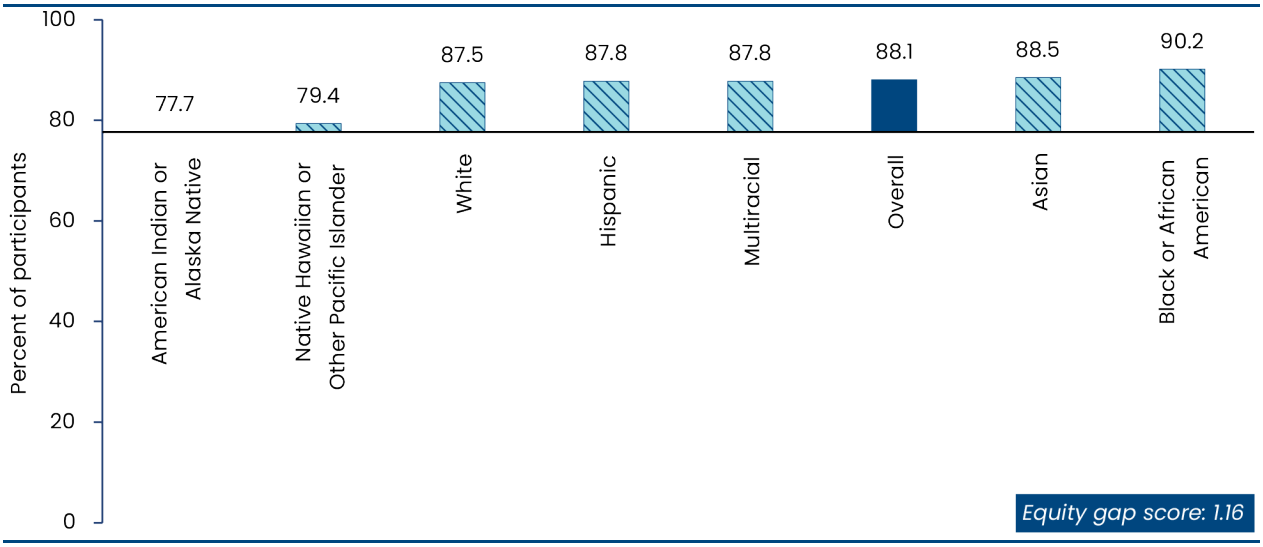


Note: Excludes 265 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, were not in the WIC Participant and Program Characteristics (WIC PC) 2022 source file, or reported no participants in April 2022; these agencies served 1,044,077 participants. Ethnoracial groups are defined as mutually exclusive. A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of participants in a local agency that provided live virtual breastfeeding services was equal between ethnoracial groups. The association between these variables was statistically significant ($p < 0.001$). See appendix table E.20 for additional information.
N = 5,756,612 participants overall across 1,524 local agencies
Sources: WIC BPI II Local Agency Survey question 17, WIC PC 2022

2. Presence of Breastfeeding Peer Counseling Program

Overall, 88.1 percent of WIC participants were served by a local agency that operated a peer counseling program[17] (see figure 5.2). By ethnoracial group, presence of a peer counseling program ranged from 77.7 percent among participants who identified as American Indian or Alaska Native to 90.2 percent among participants who identified as Black or African American, resulting in an equity gap score of 1.16.

Figure 5.2. Percentage of Participants Served by Local Agencies That Operated a Breastfeeding Peer Counseling Program, by Ethnoracial Group



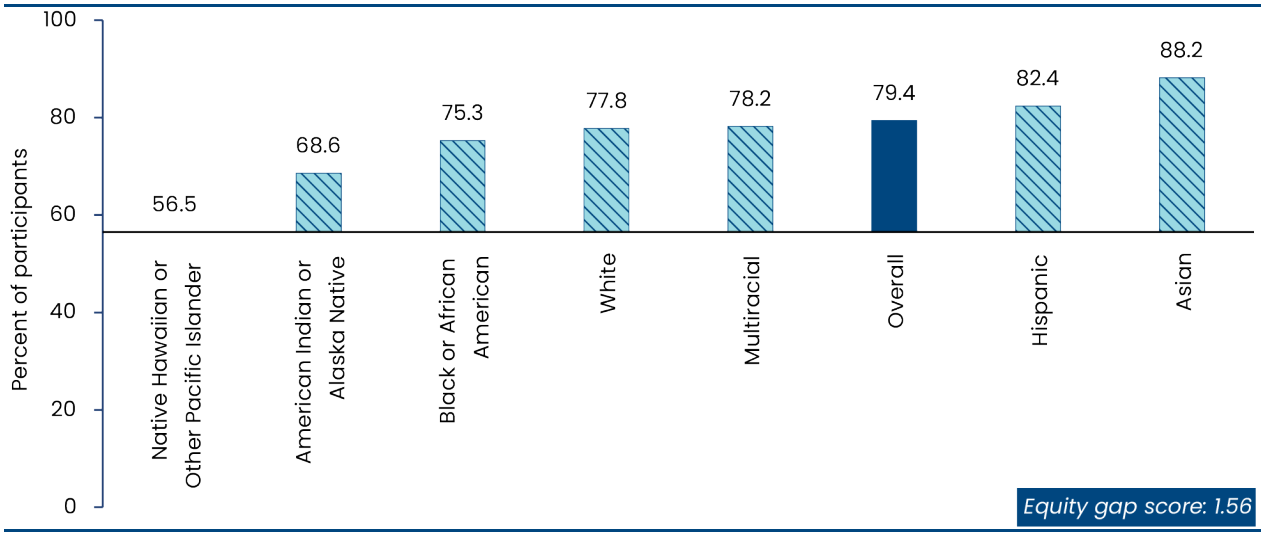
Note: Excludes 265 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, were not in the WIC Participant and Program Characteristics (WIC PC) 2022 source file, or reported no participants in April 2022; these agencies served 1,044,077 participants. Ethnoracial groups are defined as mutually exclusive. A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of participants in a local agency that operated a Breastfeeding Peer Counseling Program was equal between ethnoracial groups. The association between these variables was statistically significant ($p < 0.001$). For additional details. See appendix table E.20 for additional information.
N = 5,756,612 participants overall across 1,524 local agencies
Sources: WIC BPI II Local Agency Survey question 7, WIC PC 2022

3. Meeting Needs of Participants With Gender-Diverse Identities

Almost 80 percent of all participants were served by a local agency that took one or more actions to meet the needs of participants with gender-diverse identities (79.4 percent; see figure 5.3). These accommodations were least available to participants who identified as Native Hawaiian or other Pacific Islander (56.5 percent) and most available to participants who identified as Asian (88.2 percent). This resulted in an equity gap score of 1.56.

[17] BPI I found that 86.4 percent of participants were served by a local agency that operated a peer counselor program (Forrestal, 2015).

Figure 5.3. Percentage of Participants Served by Local Agencies Taking Actions to Meet the Needs of Participants With Gender-Diverse Identities, by Ethnoracial Group

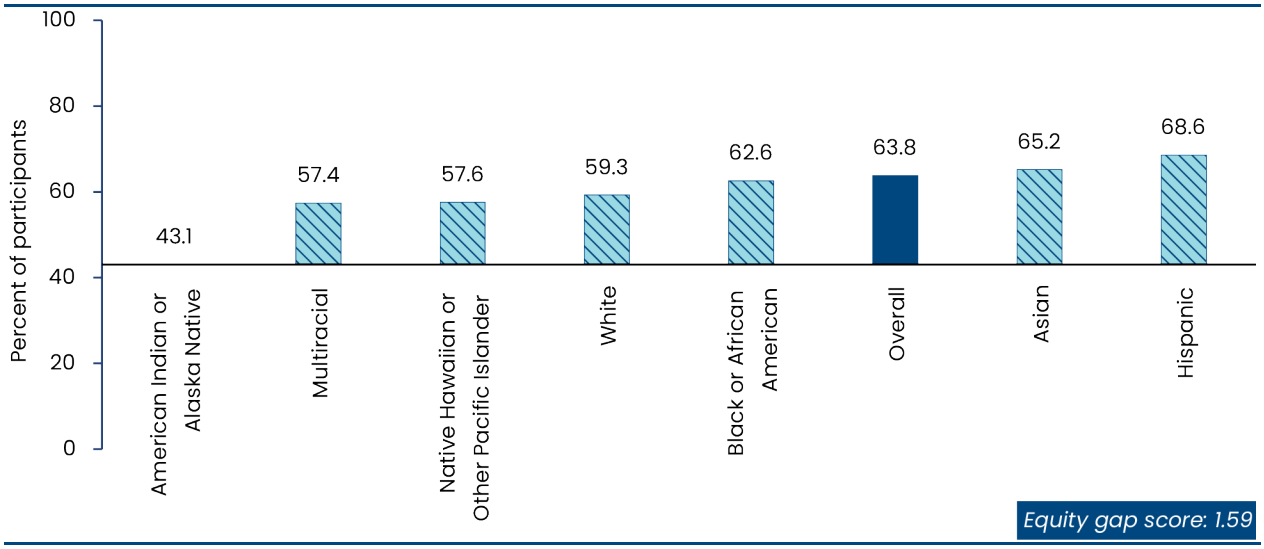


Note: Excludes 265 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, were not in the WIC Participant and Program Characteristics (WIC PC) 2022 source file, or reported no participants in April 2022; these agencies served 1,044,077 participants. Ethnoracial groups are defined as mutually exclusive. A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of participants in a local agency that took action to meet the needs of participants with gender-diverse identities was equal between ethnoracial groups. The association between these variables was statistically significant ($p < 0.001$). See appendix table E.20 for more information.
N = 5,756,612 participants overall across 1,524 local agencies
Sources: WIC BPI II Local Agency Survey question 24, WIC PC 2022

4. Meeting Needs of Participants Who Are Employed

Almost two-thirds of WIC participants (63.8 percent; see figure 5.4) were served by local agencies that implemented three or more accommodations to meet the needs of participants who are employed. By ethnoracial group, availability ranged from 43.1 percent for participants who identified as American Indian or Alaska Native to 68.6 percent for participants who identified as Hispanic, resulting in an equity gap score of 1.59.

Figure 5.4. Percentage of Participants Served by Local Agencies Offering Options to Meet the Needs of Participants Who Are Employed, by Ethnoracial Group



Note: Excludes 265 local agencies that did not respond to the WIC Breastfeeding Policy Inventory II (WIC BPI II) Local Agency Survey, were not in the WIC Participant and Program Characteristics (WIC PC) 2022 source file, or reported no participants in April 2022; these agencies served 1,044,077 participants. Ethnoracial groups are defined as mutually exclusive. A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of participants in a local agency that offered options to meet the needs of participants who are employed was equal between ethnoracial groups. The relationship between these variables was statistically significant ($p < 0.001$). See appendix table E.20 for more information.
N = 5,756,612 participants overall across 1,524 local agencies
Sources: WIC BPI II Local Agency Survey question 22, WIC PC 2022

B. Odds Local Agencies Implemented Equity-Forward Practices

This section explores the association between equity-forward practices and ethnoracial category and urbanicity using logistic regression and adjusting for FNS Region, local agency caseload size, local agency type, breastfeeding status of infants the local agency serves, and poverty status of participants the local agency serves (see appendix table E.21 for descriptive statistics).[18] Results are presented by ethnoracial group. This approach did not rely on a single ethnoracial group as a reference group but rather assessed the availability of equity-forward policies separately for each ethnoracial group. The analysis was conducted at the local agency level because equity-forward practices are observed at the local agency. See appendix B for additional details on the logistic regression analysis.

Odds Ratios

Results from the logistic regressions are reported as odds ratios. Odds ratios describe the probability of a local agency serving more than 10 percent of participants who identified with an ethnoracial group having an equity-forward practice compared with the probability of a local agency serving less than 10 percent of these participants having the same practice.

[18] Because of the high correlation between a WIC local agency type of Native American or Tribal Organization and the percentage of participants who identified as American Indian or Alaska Native, the model for this ethnoracial group does adjust for local agency type (Native American or Tribal Organizations, Federally qualified health center, hospital, community-based organization, nonprofit organization, and other).

After adjusting for FNS Region, local agency caseload size, local agency type, breastfeeding status of infants served, and poverty status of participants served, the odds a local agency implemented an equity-forward practice differed by local agency ethnoracial composition. Because the models adjusted for local agency characteristics, these results suggest some local agencies face structural barriers in implementing these equity-forward practices that are unaccounted for in the model. These structural factors may include WIC State agency decisions about distribution of breastfeeding peer counselor funding; community factors, such as internet connectivity; or social norms. Results by ethnoracial group follow.

- Few local agencies had a caseload where more than 10 percent of participants identified as **American Indian or Alaska Native** (6.8 percent; see appendix table E.21). These local agencies had 61 percent lower odds of operating a peer counseling program ($p < 0.001$) and lower odds of taking at least 1 action to accommodate people with gender-diverse identities ($p < 0.001$) than local agencies where less than 10 percent of their caseload identified as American Indian or Alaska Native (see appendix table E.22 and figure E.1).
- Few local agencies had a caseload where more than 10 percent of participants identified as **Asian, Hawaiian Native, or other Pacific Islander** (6.1 percent; see appendix table E.21). These local agencies did not have statistically significantly higher or lower odds of implementing any of the 4 equity-forward practices compared with local agencies that had a caseload where less than 10 percent of participants identified as Asian, Hawaiian Native, or other Pacific Islander (see appendix table E.23).
- Over one-third of local agencies had a caseload where more than 10 percent of participants identified as **Black or African American** (37.5 percent; see appendix table E.21). These local agencies had 43 percent lower odds of offering at least 3 options to meet the needs of participants who are employed compared with local agencies where less than 10 percent of participants identified as Black or African American ($p < 0.001$; see appendix table E.24 and figure E.2).
- Over one-third of local agencies had a caseload where more than 10 percent of participants identified as **Hispanic** (38.5 percent; see appendix table E.21). These local agencies had 32 percent lower odds of operating a peer counseling program compared with local agencies where less than 10 percent of participants identified as Hispanic ($p = 0.004$; see appendix table E.25 and figure E.3).
- Over four-fifths of local agencies had a caseload where more than 10 percent of participants identified as **White** (84.3 percent; see appendix table E.21). These local agencies had 79 percent higher odds of operating a peer counseling program than local agencies where less than 10 percent of participants identified as White ($p = 0.008$; see appendix table E.26 and figure E.4).
- Few local agencies had a caseload where more than 10 percent of participants identified with **multiple racial categories** (10.8 percent; see appendix table E.21). These local agencies had 80 percent higher odds of operating a peer counselor program ($p = 0.007$) and 131 percent higher odds of offering live virtual breastfeeding services ($p = 0.008$) compared with local agencies where less than 10 percent of participants identified with multiple racial categories (see appendix table E.27 and figure E.5).

C. Results From Urbanicity Analysis

Participants served by local agencies located in metropolitan areas had consistently greater availability of equity-forward practices (see appendix table E.28). The study team then estimated the association between equity-forward practices and local agency urbanicity using logistic regression. The model adjusted for FNS Region, local agency caseload size, local agency type, breastfeeding status of infants the local agency serves, and poverty status of participants the local agency serves. Before including local agency characteristics in the model, local agencies in urban areas had higher odds of implementing all four equity-forward practices compared to local agencies in rural areas. After adjusting for local agency characteristics, there were no statistically significant differences in the implementation of equity-forward practices by urbanicity (see appendix table E.29).

D. Other Notable Findings

The study research questions focused on differences in availability of equity-forward practices related to ethnoracial category and urbanicity. The logistic regression model results suggest that other local agency characteristics are related to the availability of these practices.

The logistic regression indicated **local agency type**[19] was an important factor related to the availability of equity-forward practices, potentially because non-WIC infrastructure and resources may vary by local agency setting (see appendix tables E.23–E.26). For example, Federally qualified health centers aim to meet the needs of underserved and underinsured populations, which may include participants with gender-diverse identities (Hudson, 2017). Some local agency types (e.g., community-based health centers) may be better equipped or face fewer bureaucratic hurdles to offering certain services, such as early morning, late evening, and weekend services to better meet the needs of participants who are employed. Results follow:

- Local agencies that were Native American or Tribal Organizations or Federally qualified health centers had lower odds of operating a breastfeeding peer counselor program than city/county/State health departments.
- Community-based health centers had higher odds of offering three or more options to meet the needs of participants who are employed than city/county/State health departments.
- Local agencies that were Native American or Tribal Organizations had lower odds and Federally qualified health centers had higher odds of taking actions to meet the needs of participants with gender-diverse identities than city/county/State health departments.

The logistic regressions consistently found **local agency caseload size** to be positively associated with the presence of most equity-forward practices (see appendix tables E.22–E.26 and E.28). Specifically, medium (1,000–4,999 participants) and large (more than 5,000 participants) local agencies had statistically significantly higher odds of offering live virtual breastfeeding services, operating a peer counseling program, and offering options to meet the needs of participants who are employed compared with small local agencies (fewer than 1,000 participants). Local agencies with larger caseloads may have access to more resources, which may explain the differences observed in the adoption of equity-forward practices. Local agency size was not a statistically significant predictor of a local agency

[19] Local agencies were categorized as city/county/State health department; Native American or Tribal Organization; Federally qualified health center; hospital; community-based health center; nonprofit organization; or other local agency type.

taking actions to meet the needs of participants with gender-diverse identities. This may be because practices to meet the needs of participants with gender-diverse identities (e.g., use of inclusive language on forms, asking participants their preferred pronouns) require fewer financial resources than hiring peer counselors or offering evening hours.

Local agencies with **breastfeeding initiation rates** over 70 percent among 6- to 13-month-old infants had statistically significantly higher odds of offering live virtual breastfeeding services and options to meet the needs of participants who are employed compared with local agencies with lower breastfeeding initiation rates among 6- to 13-month-old infants (see appendix tables E.22–E.27 and E.29).

Chapter 6. Conclusion

Over the past decade, WIC has undergone important changes that affect how WIC State and local agencies promote and support breastfeeding. These changes include increases in WIC breastfeeding initiation rates, rollout of FNS breastfeeding resources, more widespread use of technology to communicate with and educate WIC participants remotely, and a 50 percent increase in funding from Congress for the WIC Breastfeeding Peer Counseling Program. Designed to minimize burden on WIC State and local agencies, WIC BPI II provides the first comprehensive update on WIC breastfeeding policies, procedures, and practices since these changes were implemented and the WIC BPI I report was published in 2015.

A. Key Findings

Because WIC BPI II is an inventory, study findings focus on the presence or absence of policies and practices rather than participant and staff experiences. Highlights of this report's findings on policies and practices at the local agency level follow.

Breastfeeding Peer Counseling Program, Designated Breastfeeding Experts, and Community Partnerships

- Almost three-quarters of local agencies (71.4 percent) operated a peer counseling program. Fewer small local agencies (fewer than 1,000 participants) operated this program compared with medium (1,000–4,999 participants) and large local agencies (5,000 or more participants). On average, local agencies had 2.1 peer counselor FTEs, serving an average of 202 breastfeeding women per peer counselor FTE. Over 40 percent of local agencies believed they do not have enough breastfeeding counselors to meet participant need.
- Almost 90 percent of local agencies provided training and continuing education to peer counselors at regularly scheduled meetings; nearly 80 percent provided training using FNS-developed curricula.
- WIC breastfeeding peer counselors typically work in various community settings to support breastfeeding participants. Local agencies most frequently reported that peer counselors provided services at WIC sites (77.3 percent). Less frequently reported settings included community locations other than WIC sites (e.g., libraries, parks, community centers; 27.5 percent), hospitals (15.1 percent), and participants' homes (14.3 percent).
- Eighty percent of local agencies worked with a DBE. On average, local agencies had 1.74 DBE FTEs.
- To further promote breastfeeding in their communities, local agencies commonly engaged with a breastfeeding coalition (56.7 percent). Local agencies facilitated, convened, or participated in coalition meetings.

Virtual Services

- Local agency provision of remote breastfeeding counseling and support services remained similar at the time of the survey (fall 2022) compared with earlier in the PHE (spring 2021), with some exceptions. Most notably, the use of interactive online platforms decreased by about 70 percent between the 2 periods.
- Over 80 percent of local agencies reported that staff document virtual breastfeeding counseling sessions in the same manner as in-person sessions, and all staff have access to information about any given participant's virtual counseling sessions for continuity of care.
- Though the use of virtual services continued to be high among local agencies, findings from both the WIC State agency and the local agency surveys suggest that further resources are needed to bolster virtual services. Approximately 81 percent of WIC State agencies[20] indicated they need training or resources on how to effectively engage or share program materials with participants in a virtual setting, and only about half of local agencies (50.3 percent) reported current availability of specific training related to providing virtual breastfeeding support and counseling.

Practices to Promote Equity and Inclusion

- Almost half of local agencies (47.3 percent) employed Spanish-speaking multilingual staff, and almost all provided written materials in Spanish (92.8 percent). Local agencies less commonly employed staff who spoke other languages (17.3 percent) or provided WIC materials in languages other than English or Spanish (39.3 percent). Almost all local agencies provided access to a language line or translation service to accommodate the needs and preferences of participants who speak a language other than English (87.0 percent).
- To meet the needs of participants who are employed, 75.9 percent of local agencies provided services during early morning or evening hours by appointment, and 48.5 percent provided early morning or evening hours on a walk-in basis. Commonly, local agencies also offered priority appointment scheduling during regular clinic operations for participants who are employed (72.4 percent), provided virtual breastfeeding services (68.4 percent), and offered evening or weekend breastfeeding support (63.0 percent).
- To meet the needs of participants with gender-diverse identities, local agencies provided tailored counseling (56.3 percent), used inclusive language on forms and communication materials (47.6 percent), and updated their bathroom signage (42.1 percent). In an open-ended survey question, local agencies shared any current discussions and/or interest they had in addressing these needs; many local agencies stated that they provide, receive, or desire additional training or information on the topic.
- Nearly 60 percent of local agencies required staff to complete health equity training, while a quarter offered it as an optional opportunity. Local agencies most often used materials they received from the State to train staff (68.5 percent).

[20] State agency-level findings are presented in a separate report.

Availability of Equity-Forward Practices

- Based on the results of the equity gap score analysis, the availability of equity-forward practices[21] varied by ethnoracial group. However, the equity gap score for each practice was never greater than 2. This means no ethnoracial group had twice the availability of any of these practices compared with any other ethnoracial group. After adjusting for local agency characteristics using logistic regression, the odds a local agency implemented an equity-forward practice continued to differ by the local agency ethnoracial composition. Differences could not be explained by the following local agency characteristics: FNS Regions, local agency type, local agency caseload size, breastfeeding status of infants the local agency serves, and poverty status of participants the local agency serves. These results suggest some local agencies may face structural barriers in implementing equity-forward practices (e.g., funding, social norms, internet connectivity) that lead to differences in the availability of practices by race and ethnicity.
- Across the four equity-forward practices, practices that meet the needs of participants with gender-diverse identities or who are employed result in the highest equity gap scores by ethnoracial group and the lowest overall availability. Fewer WIC participants are served by local agencies with these practices (i.e., overall availability) and the percentage point difference in availability by ethnoracial group is the largest for these practices (i.e., differential availability).
- Participants served by local agencies located in metropolitan areas had consistently greater availability of equity-forward practices. However, when adjusting for local agency characteristics, there were no statistically significant differences in the implementation of these practices by urbanicity.
- Across all the regression models, local agency size was a statistically significant predictor of the availability of equity-forward practices. Medium (1,000–4,999 participants) and large (5,000 or more participants) local agencies had statistically significantly higher odds of offering live virtual breastfeeding services, operating a peer counseling program, and offering options to meet the needs of participants who are employed compared with small local agencies (fewer than 1,000 participants). Local agencies with larger caseloads may have access to more resources, which may explain the differences observed in the adoption of equity-forward practices.

B. Limitations and Considerations

WIC BPI II is as comprehensive as possible given the study constraints, which include sourcing data from multiple extant sources, including responses to question 24 from the FFCRA WIC Local Agency Waiver Use Survey and data from WIC PC 2022 and the FNS-798. FNS required a census of WIC State and local agencies but specified, in an effort to minimize respondent burden, that the survey should only be used to fill gaps in information not otherwise available from extant data sources and could not exceed 20 minutes in length. For this reason, some findings in this report are based on information contained in these existing data sources, while others are based on the WIC BPI II Local Agency Survey. The survey provides a snapshot of breastfeeding support in summer 2022 and does not necessarily represent all support provided in FY 2022. Neither the survey nor the existing data sources provide a comprehensive analysis of how local agencies deliver WIC services to participants. Much of the information presented in

[21] The four practices are a Breastfeeding Peer Counseling Program; live virtual breastfeeding services; accommodations to meet the needs of participants who are employed (e.g., morning or evening hours); and accommodations to meet the needs of participants with gender-diverse identities (e.g., gender-inclusive language, bathroom signage)

this report is purely descriptive, and, because of the nature of survey research, cannot provide further insights into why local agencies have or have not implemented particular policies or practices.

To better understand equity in the availability of breastfeeding support that results from local and WIC State agency policies and practices, the study team conducted equity gap and regression analyses. A key limitation to these analyses is that the equity-forward policies and practices were identified based on the data collected. This study does not examine the effectiveness or importance of these policies and practices. Each analysis has its own additional set of limitations. The equity gap score describes the difference in the percentage of participants served by a local agency with a policy or practice. The results should be interpreted as a descriptive metric of availability. Findings should not be interpreted as a measure of access to the policies and practices. The logistic regressions estimate the association between the presence of the policies and practices and the ethnoracial composition of a local agency. The results cannot be interpreted as causal nor can the model identify the underlying factors resulting in persistent differences in availability by ethnoracial group. Because of the limitations of this analysis, the study team is unable to make recommendations or inference statements based on the results.

C. Suggestions for Future Research

This study, which used a survey of a census of local agencies as well as other extant materials, provides updated descriptive statistics on local agency breastfeeding policies and practices. Findings suggest that there is a gap in the availability of resources across ethnoracial groups. This is an important first step in understanding the equity landscape in WIC. However, it was beyond the scope of the study to understand why some local agencies implement certain practices but not others. The following suggestions for future research can help researchers, policymakers, and practitioners better understand local agency motivations, needs, and resource gaps.

- Virtual breastfeeding services have become more prevalent since the onset of the COVID-19 PHE. Findings from both the WIC State and local agency surveys suggest that staff require further training and resources to effectively provide virtual breastfeeding services. Additional research is needed to understand which WIC services are most suited to virtual provision, whether participant experiences and outcomes vary by in-person or remote services, and how to best engage with participants virtually. Research on the types of WIC services most suited to virtual provision could also help explain some findings from this report, such as the 70 percent decrease in the use of interactive online platforms between March 2021 and Fall 2022 (see table 3.1).
- According to the local agency survey, 42.9 percent of local agencies provided peer counselors with training or continuing education toward a breastfeeding/lactation support certificate program, such as a Certified Lactation Consultant (see figure 2.4). Given the relatively high percentage of peer counselors offered continuing education, further research could explore the trajectories of peer counselors, how long they remain in their role, and how many advance in their careers with the aid of the education and training they receive via WIC. This research could help WIC State and local agencies in their peer counselor recruitment and retention efforts.
- The study team chose the four equity-forward practices included in the analysis (operating a peer counseling program, offering live virtual breastfeeding services, making accommodations to meet the needs of participants who are employed, and taking actions to meet the needs of participants with gender-diverse identities) based on available data from the WIC BPI II Local Agency Survey and whether there was sufficient variation in the presence of a practice among

local agencies to facilitate analysis. While the study team hypothesized that each of these practices may alleviate common barriers to program participation and breastfeeding, further research is needed to understand the most effective breastfeeding policies, interventions, and supports, and understand the equity gaps associated with each practice.

- The equity gap score and regression analyses revealed that some ethnoracial groups have lower availability of equity-forward breastfeeding practices than other groups. However, neither of our analyses were able to determine why. Future qualitative research, including interviews with WIC State and local agency staff and participants, could help shed light on the lack of availability to services for some participants. Additionally, this study was only able to look at availability, not access, to practices. Further qualitative research could help us understand to what extent participants in local agencies with a certain equity-forward practice have access to that practice.
- Local agency caseload size was a consistently statistically significant explanatory variable in our regression models. Further research is necessary to explore the impact of local agency size on agency resources, and how FNS and WIC State agencies could better support small local agencies.

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