

**Partnering4Health**  
**Ways the National WIC Association (NWA)**  
**Supported its 31 Communities**

The National WIC Association (NWA) is a non-profit membership organization representing people delivering the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to clients across the nation. Its members include state WIC agency directors and staff, local WIC agency directors and staff, clinic staff, industry partners, advocacy partners, and research partners. WIC providers traditionally work one-on-one with clients—women, infants, and children in poverty and in under-resourced communities. They are knowledgeable about nutrition and the benefits of physical activity. NWA’s Community Partnerships for Healthy Mothers and Children (CPHMC) project worked in thirty-one (31) communities to improve access to nutritious foods and beverages including breast milk for infants and improve linkages between community organizations and clinicians, especially those who were members of NWA’s project partner the American College of Obstetricians and Gynecologists (ACOG). NWA’s Communities are local WIC agencies. They are legally independent of NWA, hire their own staff, and have their own governance – often governmental.

<b>NWA Table 1: Community Recruitment and Areas of Focus</b>			
	Cohort 1	Cohort 2	Total
# of communities selected	17	15	31
# strengthening farmers & mobile markets	2	7	9
# improving retail/corner store offerings	13	13	26
# creating community gardens	0	4	4
# working on community food systems	2	0	2
# increasing support for breastfeeding	1	15	16
# increasing referrals to & from WIC & MD	11	15	26

The original staffing included a project director, 2 program managers who provided technical assistance to the funded communities, and a program associate focused on communications, training, and reporting. Existing NWA staff would serve as a communications advisor and a technical assistance specialist and advisor. Two months into the project, however, the communications advisor left the organization, the technical assistance specialist no longer had much capacity to advise, and some project staff assumed additional responsibilities within NWA responsibilities to make up for the missing position. Because of those changes and a better understanding of the project’s needs, NWA hired a

consultant who could train about fiscal matters and review the budgets and fiscal reports from the funded communities. A year into the project, NWA hired an operations management consultant who took on logistics such as a weekly newsletter, collecting and organizing reports and other documents, managing financial reporting reviews, making travel arrangements, arranging training and technical assistance opportunities, and creating and updating the public-facing website. Two years into the project, the project director/principal investigator moved away and transitioned into a consulting role. NWA then hired a reporting assistant to help with communications and reporting for the project.

To orient communities, NWA provided webinars on budgeting, reporting, PSE approaches, the socio-ecological model, coalition building, performing a community needs assessment, and creating a community action plan (CAP). Each NWA program manager had an initial and several capacity-building technical assistance phone calls with the WIC agency in each selected community. The WIC agency staff working on this project from each selected community attended an additional in-person training during a pre-conference session at NWA's annual conference. The process took about 6 months for cohort #1 and about 3 months for cohort #2. Although NWA spent a lot of time in the capacity-building phase, the investment paid off in impressive successes and many initiatives continuing and thriving beyond the project period. Several NWA community initiatives expanded to include other communities and influence state programs.

To help each community develop its Community Action Plan (CAP), NWA provided a CAP template (see [Appendix CAP Template](#)) for communities to use in formulating objectives, activities, timelines, and measures based on results of their needs assessments. The average time between initial CAP training and final CAP approval was 2-3 months. For Cohort 2, NWA's onboarding process added peer mentoring with cohort #1 agencies through calls, webinars, and an in-person training.

NWA's technical assistance included one-on-one calls; site visits; regularly posted office hours; bi-weekly email newsletters; mid-project performance reviews; facilitated peer calls; and availability via phone and email. In the beginning, NWA project staff could not keep pace with the questions coming from the communities, which led to hosting office hours for group Q and A after training on a new topic. Another early challenge came from sending a blast email for every new update or resource. Such blasts became unnecessary with the creation of a biweekly newsletter that included project updates, trainings, resources available from DHPE and SOPHE and other partners, and external funding opportunities.

Program Managers conducted bi-weekly one-on-one calls with each community lead. The Program managers and community leads agreed on agendas in advance and included reminders of upcoming deadlines, emerging issues, project updates, major accomplishments, and current technical

assistance needs. The ACOG Program Manager also conferred with the healthcare provider from each leadership team on a monthly basis. Midway through each cohort, NWA's program managers conducted "deep dive calls" and formal program performance and expense reviews with each community. The calls included a formal assessment of each project's PSE progress with written feedback on successes and requirements plus suggestions for improvement. NWA's one-on-one calls included coaching on topics such as reach calculation and communications. NWA also facilitated biweekly peer calls on specific topics. Some included an outside expert with time for Q&A. Other peer calls were less formal and consisted of discussion on a specific topic such as healthy corner stores or breastfeeding. Regular communication helped to maintain relationships.

NWA and ACOG's Program Managers visited each site at least once, meeting with the local leadership team and key staff at the parent agency. They observed project implementation, experienced a windshield tour or field observation in the local community, observed a coalition meeting, provided guidance and technical assistance to the local coalition, and led an in-depth discussion of the local project and their technical assistance needs. Each site visit culminated in written and oral reports.

NWA hosted opportunities for their community leaders to meet in person; NWA conducted at least two pre-conference workshops for its funded communities in each cohort in conjunction with the National WIC Association annual and biennial conferences. NWA's media training part of these meetings increased participants' confidence in speaking with the media. Participants also found a workshop on writing success stories very helpful. NWA deemed its in-person trainings more valuable than webinars because of the knowledge sharing that occurred across communities. NWA's community leads actively engaged with one another and learned from one another during in-person meetings. Relationships developed among NWA's Cohort 1 communities that were geographically close such as the four Virginia CPHMC agencies.

NWA's project staff assisted by its partners provided webinars on topics the communities identified as needs. NWA recorded its webinars and made them available to community members who could not be on the live webinar. NWA's local WIC agency staff asked a lot of questions throughout the project, which helped NWA project staff determine content. NWA's main programmatic challenge was reorienting WIC staff in funded communities from a direct service model to a systemic approach to nutrition and health care that involved policy, systems, and environmental (PSE) interventions in a short amount of time. To accomplish this reorientation, NWA provided training on the socio-ecological model and PSE interventions as well as capacity-building training and technical assistance. This reorientation required customizing and tailoring many existing tools and capacity-building trainings as well as experimenting to determine which types of interventions succeeded with WIC leadership.

The tools NWA created for its communities included templates and other structured documents including the CAP template, Community Needs Assessment checklist, poster templates, sustainability planning document, FAQs about various aspects of the project and the Greater with WIC website. NWA drew heavily from CDC's materials, customizing them to meet its communities' needs. NWA's Greater with WIC [website](#) served as a repository for tools and resources.

For Cohort 1, NWA's communities submitted quarterly reports via e-mail. For Cohort 2, the reporting changed to monthly using an online template. All communities also submitted two success stories, a sustainability plan, and quarterly expense reports. NWA's evaluator, the Altarum Institute, developed and conducted surveys, interviews, and site visits to gain further insights on WIC agencies' engagement in community health projects.

NWA's partnership with ACOG included funding a position to work on the project. That partnership contributed significantly to the success of bridging public health and health care in the communities and maintaining provider engagement in the project. As a result of the project, ACOG adopted a "[maintenance of certification](#)" option (CEUs required of physicians to recertify as an OB-GYN) for participation in community health coalitions. NWA's requirement that community coalition leadership teams include a WIC staff member, a woman's health provider, and a WIC client or patient advocate contributed to success at the community level. Although each leadership team member's level of engagement varied, many communities concluded that the team's diversity contributed to the project's success, even if the shared leadership felt forced and uncomfortable at first.

A sampling of successes by Community Partnerships for Healthy Mothers and Children communities includes:

- To overcome store owners' concerns about losing money on perishable foods, Richmond City Health District (RCHD) initiated a buy-back program. Once or twice a week, it delivered fresh produce to participating stores. Owners marked down anything that did not sell before going bad and the project bought back up to \$150 of unsold goods. The project tracked what was sold versus what was bought back and provided store owners with monthly reports, demonstrating that nutritious foods can sell and make money.
- The Five Sandoval Indian Pueblos project developed a toolkit for local farmers on producing culturally acceptable nutritious foods and marketing them to small local outlets. When a local food distributor stopped offering fresh produce, the project approached small stores about creating a co-op that could purchase in bulk and supply smaller quantities to individual stores.

- Several WIC agencies helped vendors navigate redemption of WIC vouchers and/or SNAP/WIC electronic benefits (EBT). In one community, farmers who were reluctant to participate in a farm stand in front of a WIC clinic found that both WIC clients and clinic neighbors were excellent patrons; farmers soon vied to participate. Plans were underway for adding another day per week while shortening hours.
- Marketing included partnering with a local university to create an app that shows WIC benefits and where to locate markets, creation of banners that a city hangs on market days, creation of a farmer's market guide in Spanish for the entire county that included seasonal produce and a map, and changing times to coincide with other weekly community events that attracted crowds.
- At San Juan Basin Health Department, a free farm stand coordinated timing with school pick up times and boosted participation, removing some stigma of going to a stand.
- One community created a scavenger hunt for children to use at farmers markets that helped increase sales of featured items.
- A WIC agency in Louisiana informed clients that they could get reimbursed for produce if they breastfed.
- An Illinois community found that creation of a food hub where farmers could deliver produce was attractive; it reduced farmers' and procurers' transportation costs; it also offered an opportunity to provide education about marketing, growing, and safe food handling.
- To support breastfeeding, communities used a variety of strategies including:
  - Giving breastfeeding decals for their windows to restaurants and other local businesses agreeing to be breastfeeding friendly and meeting a set of breastfeeding friendly criteria
  - Creating a toolkit for local businesses with guidelines for supporting breastfeeding moms
  - Assessing health care providers' baseline knowledge about breastfeeding
  - Creating and distributing a breastfeeding toolkit to health care providers
  - Providing Certified Lactation Counselor training; then inviting providers who sent an employee to join the coalition
  - Partnering with the county health department
  - Setting up demonstration Nursing Stations with resources available about how to talk about breastfeeding
  - Identifying breastfeeding friendly areas in government buildings

- Helping to craft and pass a comprehensive lactation support policy for all county government employees, including establishing a lactation room
- Providing mini-grants to businesses for creating lactation areas with comfortable chairs, mini fridge and posters
- Consulting breastfeeding mothers about what brought them comfort and partnering with a pillow company to provide pillows for arm support
- Conducting a State of the State of Breastfeeding conference with guest speakers, health professionals, and parents of young children
- Creating scripts to normalize breastfeeding discussions and language
- Collaborating with area hospitals to send peer counselors into the maternity wards
- Initiating a rotation for pediatric residents through a WIC clinic that included shadowing lactation counselors
- Coordinating with a pharmacist to provide lactation consultation
- Co-locating a WIC provider and lactation consultant in a pediatrician’s office. In that location, women could obtain breast pumps and their rate of post-partum follow up increased.
- The Richmond VA project went into the prisons and met with entering pregnant women. For those still in prison after they gave birth, the project gave the women breast pumps and arranged for relatives to take the milk to their baby.
- After adding a lactation consultant and changing some processes at a WIC clinic, participation increased by over 100 women in just four months.

Experience showed that keys to success included the quality of interpersonal relationships, collaboration with nontraditional partners, leveraging existing resources, being flexible, getting and using input from those being served, reaching beyond the point of entry for services, providing support to larger organizations and healthcare providers, inviting WIC centers into the teams, and removing silos between partners. Several communities experienced success in the short time of the project.