



Shopping With Kids

Patrice Thomsen, MS, RD, LD

The following was contributed to the Iowa State University Extension *Spend Smart. Eat Smart.* blog by Joyce Greving.

<http://blogs.extension.iastate.edu/foodsavings/2009/06/11/shopping-with-kids/>

We all know it is much easier to shop without kids along, but sometimes it can't be avoided.

Recently, Ruby, an Extension staff member, shared how she dealt with this issue as a single parent. Together, she and her pre-school daughter planned their meals and snacks, wrote their grocery list and then went to the store. When the four-year old saw something she wanted, they'd check the list. If it wasn't on the list, they didn't buy it.

The list was specific. If they needed cereal, the brand was included. No more 'middle of the cereal aisle' arguments as to whether to buy plain Cheerios® or a pre-sweetened cereal with a favorite character on the package front. Yes, the four-year-old sometimes said "we need to put that cereal on the list next time," but generally forgot about it when time came for the next planning session.

Snacks were part of the planned list, too. It is much easier to guide a child's snack choices at home where healthy snacks can be planned for, than in front of the tempting candy or chip section at the store.

What about toys, books, and other trinkets? Since they didn't eat them, they weren't on the list!

Looking back, Ruby realizes this strategy has lots of benefits. They stayed within their limited food budget, ate healthier food choices, her daughter learned discipline at an early age and they shared a pleasant time together.

What do you do to make shopping with kids a little easier?

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The Intricate Association Between Breastfeeding and Bed-sharing

Janine Messersmith, RD, LD, IBCLC, WIC Coordinator, Lyon County

(Janine attended this conference with funding provided through policy ADM 11.02.00 Financial Support for Local Agency On-Going Training.) I would like to thank Dave Thomason and the state WIC staff for giving me the opportunity to attend the International Lactation Consultant Annual Conference. I have attended this conference in the past and I always learn something new. I find the pre-conference Clinical Skills Workshop to be especially useful. It is a great chance to learn new skills from other lactation consultants as well as reaffirm my own skills.



A session that I found particularly interesting dealt with where babies sleep at night and the intricate association between breastfeeding and bed-sharing. The Oregon Prams Survey showed that 77 percent of families bed-share. Sleep studies have shown that breastfeeding moms all tend to sleep in the same position while bed-sharing with their infant. Moms sleep on their side facing the baby almost all night long. Their legs were drawn up toward the baby's feet. The lower arm is bent with the elbow and arm above the infants head and hand above her head. The top arm comes across the baby with the hand resting on baby's back. This position seems to be instinctive and creates a protective space for the infant. The infant is well away from the pillow. The breastfeeding moms rarely changed position the entire night. They responded to the slightest movement by their infant, usually by patting on the back.

By contrast formula feeding mothers slept differently. The babies were up closer to the pillow. The moms slept with their back to the baby much of the time. They did not create a constrained space for the infant. It took longer for the mom to respond to the infant's movement and in many cases the baby was actively crying before the mom responded.

Human brain growth continues at the same rate as fetal brain growth until one year of age. After one year, the brain growth slows. Infant physiology is regulated by the mother. Infants need to be in close contact with their mother 24 hours a day. Lauren Porter, BS, MSW, Professor of Anthropology, Durham University, Durham United Kingdom says, "A ban on a relationship-focused philosophy of infant sleep management potentially undermines both the infant's burgeoning sleep and regulation skills as well as the parent's attuned communication abilities."

The sleep mechanism is not fully developed until five years of age. Self soothing and settling occur when the baby feels safe. Infants spend 50 percent of their sleep time in REM sleep. Infants have 50 minute sleep cycles vs. 90 minutes for adults. Studies on New Zealand babies showed that at two months 74 percent were waking 1+ times/night and at six months it actually increased to 79 percent. By 9-12 months 74-80 percent still woke 1+ time/night. Night time sleep hours ranged from seven to thirteen.

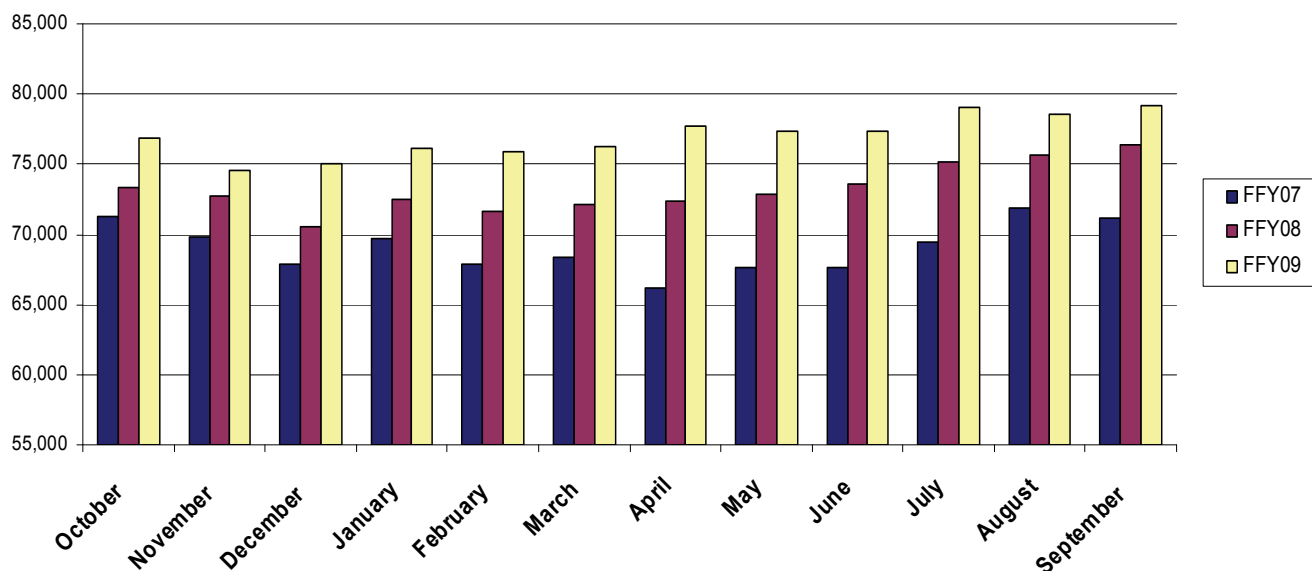
This data supports an observance that I have made with my own children and what many moms report in the clinic. It is normal for infants and small children to wake at night.

Kansas WIC Numbers on the Rise—An Update

Rachelle Hazelton, Program Consultant

In Kansas, the number of WIC participants keeps going up and up. In Federal fiscal year (FFY) 2007, the highest number of participants served was in August 2007, with 71,922. In FFY2008, the highest number of participants served happened in September 2008, with 76,318, although this number continued to grow slightly into October 2008 (FFY2009), with 76,820 participants. The following month, November 2008, experienced a slight decrease, but has been on the rebound ever since. In September 2009, the Kansas WIC program peaked with 79,150 participants. It’s very difficult to predict where our participant numbers will go throughout FFY2010, but we will keep you informed.

Kansas WIC Participation FFY2007 to FFY2009



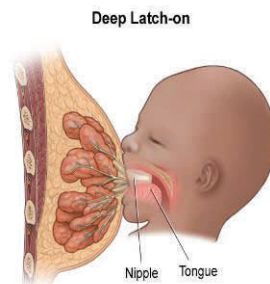
Quick Reminders to Guide Breastfeeding Moms

Penney Bennett, WIC Clerk, Dickinson County

Penney shares these quick tips from her CBE training.

- Four A’s help guide assessment
1. ALIGNMENT
 2. AREOLAR GRASP
 3. AREOLAR COMPRESSION
 4. AUDIBLE SWALLOWING

- A visual check for four-point contact between baby’s mouth and mother’s breast:
1. Nose tip to breast
 2. Upper lip flanged out
 3. Lower lip flanged out
 4. Chin touching breast



Weighing and Measuring Children With Special Health Care Needs

Sandy Perkins, MS, RD, LD, CBE

It is critical that the growth of children with chronic illnesses or developmental disabilities be monitored and evaluated at regularly specified intervals since they may be at greater risk of growth problems. Unfortunately, some children cannot be weighed or measured using standard procedures and the purchase of special weighing and measuring equipment is not usually feasible. The following recommendations are offered which do not require the purchase of expensive equipment. It is necessary to use professional judgment in deciding which method is most appropriate for each situation. The technique used should be indicated on the growth chart to allow for consistency. If none of the recommendations seem appropriate, it is recommended that local providers contact the specialized clinic serving the child and arrange for the child to be measured at that facility at regular intervals.

Weight

Children who cannot stand should be weighed on the infant scale regardless of their age. Children who are too large to be weighed on the infant scales can be weighed by weighing the parent and child. Weigh the parent alone and then subtract the parent's weight from the first weight to obtain the child's weight.

If a child has had an amputation, multiply the individual's actual weight by the percentage representing the missing body segment(s). (See table) Calculate an adjusted weight by adding that figure to the individual's weight. The adjusted weight can then be plotted on a standard growth chart.

Body Segment	Estimated % Total Body Weight
Hand	0.3
Forearm	2.6
Entire Arm	6.2
Foot	1.7
Below Knee	7.0
Above Knee	11.0
Entire Leg	18.6

Certain conditions, such as wearing a cast, are temporary. If it is a temporary problem, it would be most practical to reschedule the visit for the child to be weighed and measured after the cast is removed.

Stature

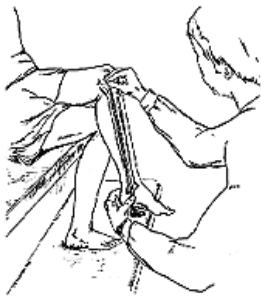
Children who are unable to stand should be measured using a recumbent length as long as possible. If a child has legs of unequal length, measure the longer leg.

When a child is too long to measure on the infant measuring board, an arm span measure can be used. Arm span measurements are made from the tip of the middle finger on the right hand to the tip of the middle finger of the left hand across the back. Arm span correlates well with height on a 1:1 ratio and can be plotted on a standard growth chart.

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Weighing and Measuring Children With Special Health Care Needs (continued)

When a child cannot be measured linearly with accuracy and has arm contractures which will not allow for accurate arm span measurements, a segmental length, tibial length or crown-rump length, should be measured.



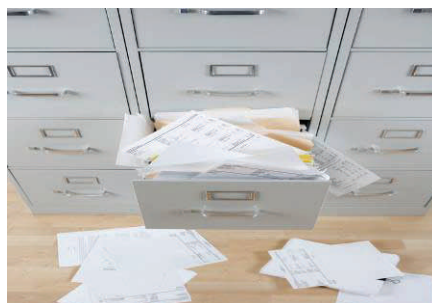
A tibial length (TL) can be used to estimate stature. The child may be either lying on a table or sitting upright with both the knee and ankle at ninety degree angles. Socks and shoes should be removed. Pants should be removed or rolled up past the knee. Measure from ankle to the joint line of the knee. To estimate stature in centimeters, multiply the tibial length (in cm) by 3.26 and add 30.8 ($3.26 \times TL + 30.8$). This figure can be plotted on a standard growth chart.

A crown-rump length cannot be used to estimate stature, but it can assess linear growth over time. The equipment and technique are the same as for measuring length, except bend the child's legs and bring the footboard up against the buttocks. This measurement should be plotted on a standard growth chart, it will fall well below the 5th percentile but increases should follow the curve.

How Long Do I Have to Keep This?

Brad Iams, Vendor Manager

While conducting management evaluations around the state, a common question is: "How long do I have to keep this paperwork?" The Record Retention policy in the Policy and Procedure Manual (PPM) states that all supporting documentation and records shall be retained for four years (current Federal Fiscal Year plus prior three Federal Fiscal Years). **The only exception is for Voter Declination forms, which only have to be retained for two calendar years.** This means that any records older than October 1, 2006 can be discarded, and any Voter Declination forms older than January 1, 2007 can also be discarded. It is important to remember that any documentation containing confidential WIC client information must be shredded. This includes the Voter Declination forms. Take some time at the beginning of this new Federal Fiscal Year to clean out the storage room and get rid of the boxes and boxes of old records that are collecting dust and taking up space. After that task is done you can start in on your own desk, because if it looks anything like mine it could use some attention too. Here's to the start of a new fiscal year and a clean and clutter-free office space!



Report from the 2009 National WIC Association Conference

Kansas had several attendees at this year's conference held in Nashville, Tenn. The September issue of Nutrition and WIC Update included several of their reports. This month more of their reports are included.

Mother Knows Breast: Helping Mothers Build Confidence in their Milk Supply

Presenters: Cathy Carothers & Kendall Cox

Comments on this session from Norma Doerksen, RD, SW Kansas WIC – Finney County

This session discussed how women “get lost” when health professionals overwhelm them with breastfeeding information. As health professionals, we want to convey all of our knowledge in 10-15 minutes of counseling. We should “sit on the other side of the desk” and see how it feels to be inundated with information that may be over our heads! We can “make it simple” by using simple language and simple visuals. Say “the dark part around the nipple” instead of “areola.”

The speakers also stated that we are visual people. Women trust what they can see, like formula in a bottle. It is harder for them to trust what they can not see, like breast milk in a breast. Our job is to educate them on what they can see when breastfeeding:

- the number of wet diapers,
- the number of dirty diapers,
- what the dirty diapers look like, and
- how many times in 24 hours the baby feeds.

To give women something visual we can give them a chart and have them keep track of the number of feeds, number of wet diapers, and number of dirty diapers for the first week or two. This will reassure them that their milk supply is adequate for their baby.

Comments on this session from Jennifer Sheble, Neosho County

This was hands down the best session I went to! The speakers were absolutely wonderful and very knowledgeable. They have many good ideas on how to talk to our mothers and mothers-to-be and also demonstrations to show them. I have already told our Breastfeeding Peer Counselor about the things I learned in this session and we are very excited about showing our clients the demonstrations!

The #1 reason that women wean – they are worried about making enough milk.

- Women have a lack of confidence in their milk supply.

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*Report from the 2009 National WIC Association Conference (continued)**Comments from Jennifer Sheble, continued*

- Keep it simple when talking with mothers:
 - Example: dark part of nipple gets darker (instead of talking about areola).
 - Example: “pimple things” appear and make secretions that cleanse the breast.
 - Can download visuals at Medela website.
- Grapes visual : use fake grapes, explain that this is how the breast works
 - Grapes are milk ducts and the vines connecting them are what connect milk ducts.
- Build a breast visual : use knee highs to be the outside of the breast
 - Put in grapes as the milk ducts.
 - Add yarn as the connectors.
 - Add cotton as the fat.
 - Put a piece of paper (circle) on the outside as the nipple.
- Talk about ways mothers can cut off milk circulation (by improperly doing manual pumping).
- Colostrum:
 - All babies need in first couple of days (show visuals of size of baby’s stomach).
 - Show how to hand express colostrum.
- Don’t use the terminology “when your milk comes in” – because they then think that their milk hasn’t arrived so baby will starve (instead talk about importance of colostrum).
- After a while endocrine switches to autocrine: so what she does will affect how much milk she produces (if she doesn’t try to feed very much then not much milk will be produced).
- The first month: baby is “placing his order” to let mom know how much milk will be needed.

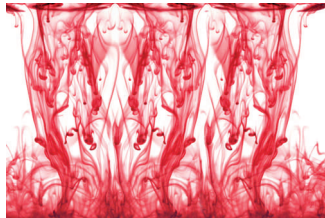


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Report from the 2009 National WIC Association Conference (continued)

Comments from Jennifer Sheble, continued

- Storage capacity: all women make about the same amount of milk (800 ml or approx 24 oz)
 - Some women have small storage capacity and may have to feed more often
 - Show visual of 24 oz being divided into 6 oz and 24 oz being divided into 8 oz (show with measuring cups).
- What about just one bottle? It can still change everything. Visual: One drop of food coloring in water. (It changes everything).



- When you give more formula—body only replaces amount of breast milk given.
 - Visual: have salt shaker filled up with white rice (this is how much breast milk is being given – so this is how much your body will replace). Then fill up with mostly rice and then brown beans (brown bean representing formula). The rice (breast milk) is all you’re giving so this is how much you will replace.

Preschoolers and Activity Levels at Play

Pat Dunavan, MS, RD, LD, CBE

A study in the January/February issue of *Child Development* found that contrary to the belief of many parents, preschool-aged children are often sedentary during their play. In observing a group of about 540 preschoolers from various preschools, researchers recorded and examined almost 265,000, 30-minute segments of the children’s indoor activities and 30,000, 30-minute segments of outdoor activity. Based upon the observations, the researchers determined that during the course of a typical day, 89 percent of children’s activities were sedentary, 8 percent were lightly active and 3 percent were moderately to vigorously active. They also found that 94 percent of indoor activities were sedentary and 1 percent involved moderate to vigorous activity. In comparison, 56 percent of outdoor activities were sedentary and 17 percent were moderate to vigorous activity. The researchers recommended that teachers and parents should organize, model and encourage physical activity during both indoor and outdoor activity times and attempt to increase the amount of outdoor play time as much as possible.



Kids in the Kitchen

Pat Dunavan, MS, RD, LD, CBE

In 2006, the Junior League of America began a new website dedicated to supporting families in making healthy food choices and encouraging family mealtime. The website, www.kidsinthekitchen.org still remains popular. They provide tips on healthy eating and habits from the American Dietetic Association, games and activities for children and families, recipes for meals, snacks and special occasions, and much more. Most of the recipes use foods found in the WIC food package and are child-friendly, using minimal ingredients. Share this resource with your families and try some of the recipes at your next nutrition education offering.

Banana Sushi

4 slices whole wheat bread

2 bananas, peeled

½ cup creamy peanut butter



Lay two slices of the whole wheat bread on a flat surface so that they lay slightly overlapping on one edge. Using a rolling pin, gently flatten the slices, pressing the seam together. Gently spread peanut butter over the bread and lay a banana in the middle of the slices. Carefully roll the bread around the banana. Slice into 1 to 1 ½ inch pieces. Repeat with remaining ingredients and serve. Makes two generous servings.

The Infant Feeding Practices Study II

Martha Hagen, MS, RD, LD, IBCLC

CDC recently published data from the Infant Feeding Practices Study II (IFPS II) online at www.cdc.gov/Features/Breastfeeding. Key points from the IFPS II include:

- *More than four out of five pregnant women want to breastfeed.
- *Hospitals whose policies and environment were unsupportive of breastfeeding greatly affected breastfeeding rates. Moms who gave birth in unsupportive hospitals were eight times more likely to stop breastfeeding early.
- *83 percent of new mothers received infant formula or coupons for infant formula in a gift or diaper bag from the hospital or birthing center. This practice is known to decrease breastfeeding duration rates.
- *Maternity leave affects breastfeeding initiation and duration rates. Only about 1/3 of women were eligible for fully paid maternity leave. On average, fully paid maternity leave was only 2.2 weeks long and partially paid was 1.5 weeks long. Fifty-three percent of women with children under age three are employed so maternity leave affects many women and infants.

Kudos to KPHA Award Winners

Patrice Thomsen, MS, RD, LD

The Kansas Public Health Association presented its 2009 awards on September 24 in Wichita. We're pleased to congratulate two of the award winners associated with the WIC Program.

Samuel J. Crumbine Medal

Linda Kenney received the 2009 Samuel Crumbine Medal for her dedication and achievement in the field of maternal and child health. Over the course of her career, she has provided leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families. Linda serves as the Director of the Bureau of Family Health as well as the Kansas Title V Director at KDHE, a position she has held since 2000. Nutrition and WIC Services (one of the sections within the Bureau of Family Health) has directly benefited from Linda's commitment to all programs, including WIC.

Virginia Lockhart Health Education Award

For her longtime service as a public health educator, Karen Oller was presented the Virginia Lockhart Health Education Award. Currently, Karen serves as the administrator of the Comanche County Health Department. She wears many hats in this position including WIC Coordinator, WIC Breastfeeding Coordinator, public health nurse, school nurse, public health educator and others!

Kansas Public Health Leadership Institute

We'd also like to recognize the following individuals, for their commitment to public health by participating in the Kansas Public Health Leadership Institute. The KPHLI fellows are drawn from among the state's leaders in public health. The KPHLI curriculum requires the support of participants' organizations as well as an investment of effort from the fellows themselves. The program is an opportunity to improve the knowledge and leadership skills of organizations as well as individuals. The following are all WIC Coordinators in addition to their other duties.

Cycle VI Graduates

- Lorraine Baughman, Rooks County Health Dept.
- Paula Rowden, Stevens County Health Dept.

Cycle VI Scholar

- Patricia Dowlin, Mitchell County Health Dept.



Cost Allocation—What's That?

Rachelle Halzelton, Program Consultant

There are many things that are used for WIC that are also used for other programs within a Local Agency's Health Department, such as supplies, whether they are medical or normal office supplies. Some other common items that are shared amongst various programs would be office equipment, new carpeting, building costs, utilities and even employees salaries. It's important to remember that all of these things can be used by more than one program within the Health Department. This is when cost allocation comes into play.

Cost allocation should result in an equitable distribution of cost to programs utilizing the shared item. Expenses used for a specific program should be charged directly to that program. If an item benefits more than one program, then the cost of that item should be allocated based on the ratio of each program's use to the total expense.



For example, if WIC wanted to purchase a \$300 activity play cube for the waiting room area with WIC infrastructure funds and this area was also used by other programs, then the cost for the activity play cube should be cost allocated. WIC would not reimburse 100 percent of the cost since the activity play cube would be placed in a shared waiting room space that would be used by clients other than WIC clients. If WIC provided services on a monthly or bi-monthly basis at the Health Department, then the cost allocation would reflect more accurately by applying a 10 - 25 percent cost allocation versus 100 percent cost allocation for the activity play cube. However, if the waiting room was only utilized by WIC clients, then 100 percent of the expense would be allocated to WIC funds.

I would challenge each Local Agency to review what has been submitted on the Local Agency Budget for FFY2010 and ask yourself the questions, "Have I allocated my costs correctly?" and "Will or could the item(s) be utilized in a shared environment?" If necessary, the "% WIC" on page 3 of the Plan for Additional Funding of the Budget Summary for FFY 2010, may need to be corrected.

Advice Regarding Breastfeeding for Mothers With Possible H1N1 Infection

Ruth A. Lawrence, MD, FAAP and John S. Bradley, MD, FAAP

Neonates and infants younger than six months of age are at risk for complications from seasonal influenza and presumably 2009 H1N1 influenza (swine flu), although the morbidity and mortality from this new virus have not yet been described.

While the advantages of breastfeeding are well-known, this close interaction of mother and newborn also can facilitate transmission of influenza virus. The benefits and the risks of close contact must be considered carefully.

Continued on next page

Advice Regarding Breastfeeding for Mothers With Possible H1N1 Infection (continued)

To protect the infant from possible serious infection while allowing essential and encouraged mother-infant bonding to occur, a compromise is required until more data is available. The following precautions are suggested to minimize the risk of infection to the infant, particularly while still in the hospital and while the mother is symptomatic with fever and coryza:

- Pay careful attention to handwashing prior to any contact.
- Prior to breastfeeding, wash the breast with mild soap and water; rinse well.
- The mother should wear a surgical mask to prevent nasal secretions and the spontaneous cough or sneeze from inoculating the infant.
- Use clean blankets and burp cloths for each contact.
- Monitor the maternal-infant interaction on perinatal floors for compliance with the above precautions.

These precautions are designed to minimize the risk of transmission until mother's immune response to H1N1 influenza is established, and increased, specific immune protection may be provided by breast milk. Note that influenza virus does not pass through breast milk.

Although the most effective way to prevent influenza transmission is complete separation from her infant when a mother is receiving antiviral treatment, separation may create more long-term problems in breastfeeding success and mother-infant bonding than any potential benefit achieved from avoiding infection in the newborn infant.

For any mother with H1N1 influenza infection who presents in labor to a health care institution, testing and empirically starting therapy for influenza with an antiviral is suggested. Oseltamivir (Tamiflu) or zanamivir (Relenza) will hasten resolution of symptoms and infectivity, particularly if treatment is started within 48 hours of onset of illness. Neonatal exposure to oseltamivir (Tamiflu) excreted in breast milk is extremely low.

Immediately following delivery, the precautions listed above should be instituted as the newborn infant is first placed into mother's arms. These precautions should be followed until mother's illness is resolved, i.e., no fever, as measured without antipyretics, for 24 hours.

While no data exist to support these suggestions, it is believed that these represent an appropriate balance between the benefits of mother-infant interaction and the risks of serious neonatal infection. Institutions may wish to modify these suggestions to address their needs and medical practices.

Dr. Lawrence is chair of the AAP Section on Breastfeeding executive committee. Dr. Bradley is a member of the AAP Committee on Infectious Diseases

Educate to Empower: Wyandotte Initiates a Three Month Intensive Food Package Training

Nancy Sanchez, RD, LD, WIC Coordinator, Wyandotte County and Pamela Combes, WIC Program Consultant



Wyandotte County approached the task of training 8,000 clients about the new WIC food packages in a very innovative manner. Training this many clients presented a challenge. A three-month intensive check and food package training was developed and initiated on August 3 with the roll-out of the new WIC food packages. Training was conducted in groups of approximately four to six families. The Check Pick-Up (CPU) appointments were altered, occurring every half hour, to accommodate the training sessions. The CPU area was rearranged, adding two tables and more seating. The training sessions were presented in English and Spanish, tailoring to the needs of their diverse population.

Foods from the new WIC food packages such as: canned fruit and vegetables; canned beans; fat-free refried beans; a variety of whole grain products, such as whole wheat tortillas, whole wheat bread, and oatmeal; baby food fruit, vegetables, and meat were purchased and used during the training sessions. These foods were integrated into the presentations, along with several foods that are not allowed, such as flour tortillas. A description of why the non-allowable foods were not acceptable was put on a table tent by each of the foods. To further educate clients, dietitians also used a smaller variety of food samples kept inside shopping bags to assist in describing the food package contents during certification appointments.

Posters were created to show the quantity of foods that could be purchased with a \$6.00 Fruit and Vegetable Check (FVC). They also educated clients about the differences of purchasing fresh, frozen and canned fruits or vegetables.



To promote breastfeeding, a poster was designed to show the advantages in benefits received while breastfeeding.

To avoid duplication of training session attendance by families with multiple WIC participants, clerks documented in notes that a shopping bag had been given. This indicated that the family had received all appropriate training and materials.

The Wyandotte County Staff have worked diligently to accomplish their goal of educating their clients and empowering them to use their new WIC checks appropriately.

Nutrition and WIC Services

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WE'RE ON THE WEB!

WWW.KDHEKS.GOV/NWS-WIC

Growing healthy Kansas families



Our Vision: Healthy Kansans living in safe and sustainable environments

Local Agency News

We welcome these new WIC employees:

Cowley County, Jennifer Zuercher, RD
Ft. Riley, Becky Snyder, Clerk
Ft. Riley, Shelly Lusk, Clerk
Gray County, Silvia Perez, Clerk

Harvey County, Meridith Gierhart, RD
Johnson County, Claudia Ortiz-Medrano, Clerk
Stevens County, Aurora Tinoco, Clerk

Congratulations to: Sandy Reece, RD, Johnson County on the birth of her twins, William Jonathan and Benjamin James.

We extend our sympathy to: the family and friends of Joyce Allen, who passed away. Joyce was a former Sedgwick County Administrator.

We say goodbye to these WIC friends:

Butler County, Yevonne Gorman, Breastfeeding Peer Counselor
Cowley County, Joy Trollman, Clerk
Ft. Riley, Erin Gambino, Clerk
Gray County, Diana Harter, Clerk

Harvey County, Paula Wedel, RD
Johnson County, Maria O'Sullivan, Clerk
Reno County, Toni VanWey, Clerk
Stevens County, Lynette Maytum, Clerk