SPECIAL SUPPLEMENTAL NUTRITION PROGRAM

FOR

WOMEN, INFANTS AND CHILDREN (WIC)

FFY 2013

STATE STRATEGIC PLAN

DUNS #806418075

NEW JERSEY DEPARTMENT OF HEALTH

& SENIOR SERVICES

PUBLIC HEALTH SERVICES BRANCH
FAMILY HEALTH SERVICES
WIC SERVICES
PO BOX 364
TRENTON, NEW JERSEY 08625-0364
(609) 292-9560

2013 STATE PLAN SUMMARY

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1.0 EXECUTIVE SUMMARY

1.1 Federal Overview

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) was created by Congress as a result of research findings indicating that a substantial number of pregnant, breastfeeding and postpartum women, infants and children are predisposed to inadequate nutrition due to low income. WIC was created to serve as an adjunct to good health care during critical times of growth and development, to prevent the occurrence of drug abuse and improve the health status of low income pregnant, postpartum and breastfeeding women, infants and children (Child Nutrition Act of 1966, Section 17). To address the identified and implement the mandates of the legislation, WIC:

- Provides a new WIC food package that is in line with the 2005 Dietary Guidelines for Americans and current infant feeding practice guidelines of the American Academy of Pediatrics to: better promote and support the establishment of successful long-term breastfeeding; provide WIC participants with a wider variety of food; provide WIC State agencies with greater flexibility in prescribing food packages to accommodate participants with cultural food preferences; and, serve all participants with certain medical provisions under one food package to facilitate efficient management of participants with special dietary needs.
- Issues food vouchers containing supplemental foods with essential nutrients found to be deficient or lacking in their diets. The food vouchers are redeemable at approved retail stores in New Jersey.
- Provides health and nutrition screenings for early identification or treatment of existing risk factors that contribute to poor growth rates in infants and children, poor pregnancy outcomes and poor health and nutrition status.
- Conducts nutrition/health counseling designed to improve their dietary habits and eliminate or reduce risk factors. The counseling is provided in both individual and peer/group-sessions.
- Promotes adoption **of healthy** lifestyles for prevention of diseases, improved birth outcomes and pediatric growth through nutrition education.
- Refers program participants to needed health care, social and other community services for health protection.

- Promotes and supports exclusive breastfeeding.
- Through integration of programs (National Fruit and Vegetable Program, Farmers' Market Nutrition Program and the Office of Nutrition and Fitness (ONF)) reduces barriers and strengthens the abilities of program participants to adopt lifelong dietary practices for health promotion.
- Provides nutrition education tailored to participants' risk factors and interests.

WIC is considered one of the most successful public health programs. Numerous research findings show that WIC contributes to improved health and nutritional status of pregnant women, postpartum and breastfeeding women in low socioeconomic status, infants and children. Also, studies conducted by United States Department of Agriculture (USDA) Food and Nutrition Services (FNS), other non-government entities (Mathematica) and University of Medicine and Dentistry of New Jersey show that WIC is a cost-effective nutrition intervention program. The following summarizes some of the findings that support the effectiveness of WIC Services:

Improved Birth Outcomes and Savings in Health Care Costs

National and statewide studies that have evaluated the cost-benefit of WIC prenatal participation have consistently shown that dollars invested in WIC significantly contributed to savings in medical care costs for infants. Prenatal WIC participation also contributes to improved birth weight, gestational age and infant mortality. The association between better birth outcomes and cost savings and WIC prenatal participation is stronger for Black than non Black (ref. #1-#6)

Improved Diet and Health-Related Outcomes

WIC reduces obstacles that low-income population encounter in adopting healthy diets. Such obstacles include lack of knowledge and access to nutritious foods. Apart from the vouchers containing the supplemental foods, the WIC program implements the Farmers Market Nutrition Program that increases access to a locally grown fresh fruits and vegetables combined. The Farmers Market Nutrition Program also incorporates nutrition education that strengthens the abilities of program participants to adopt lifelong dietary practices necessary to prevent the onset of chronic diseases. Through the New Jersey WIC Farmers Market Nutrition Program, WIC educates the program participants about the relationship of nutrition to chronic disease prevention, promotes consumption of locally grown produce and contributes to increases in revenues for participating New

Jersey farmers. In 2011, 248 New Jersey farmers served as vendors for the Farmers Market Nutrition Program and redeemed vouchers worth over $0.6 million dollars.

Improved Infant Feeding Practices

WIC promotes breastfeeding as the normal method of infant feeding. WIC participants who report having received advice to breastfeed their babies from the peer counselors at WIC clinic are more likely to breastfeed than other WIC participants or eligible non-participants.

Improved Immunization Rates and Regular Source of Medical Care

The Centers for Disease for Disease Control and Prevention and the American Academy of Pediatrics recommend that young children between birth and 24 months be immunized against nine infectious diseases. WIC provides immunization screenings to ensure that infants and children participating in the program are fully immunized. Studies on the impact of WIC participation on childhood immunization rates show WIC participation improved rates of childhood immunization from 24 to 33 percentage points within 12-15 months of starting interventions. WIC staff also, assists the program participants to apply for medical care coverage through the NJ FamilyCare. Enrollment into the NJ FamilyCare program provides access to primary care services, regular provider of medical care and reduces the burden of emergency care use (ref. #7).

CONCLUSION: WIC is a multi-component, comprehensive, effective, cost-saving intervention public health nutrition program designed to address the specific health and nutrition needs of at risk pregnant, postpartum, and breastfeeding women, and infants and children of low socioeconomic status.

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1.2 State Overview

The New Jersey Department of Health and Senior Services (NJDHSS) was one of the first ten State agencies in the nation to administer the WIC Program. The Department currently provides WIC services to the entire State of New Jersey through health service grants awarded to eighteen local agencies and three Maternal and Child Health Consortia. Ten agencies are local/county health departments, three are hospitals, and five agencies are private/nonprofit organizations. The Maternal and Child Health Consortia provide breastfeeding education and support services for WIC participants in their service areas. As the DHSS moves forward with initiatives for a healthier New Jersey, WIC Services will play a key role to assure better health and improved nutritional status of low-income women, infants and young children.

It is the goal of New Jersey WIC Services to utilize varied strategies to reduce the risk of poor pregnancy outcomes, facilitate the improvement of nutritional status by identifying and providing services to prevent nutritional problems/challenges that impact on the nutritional and health status of low income pregnant, postpartum, breastfeeding women, infants and children participating in New Jersey WIC program. In 2011, New Jersey WIC Services through the local WIC agencies served 295,191 pregnant, postpartum, breastfeeding women, infants and children up to age five who have low incomes, medical and/or nutrition risk factors. The ethnic distribution of the WIC Program participants was 51.25% Hispanic/Latino and 48.75% Non-Hispanic/Latino. Race distribution of New Jersey WIC participants: 3.40% American Indians and Alaska Native; 3.02% Asian; 25.47% African American; 1.48% Native Hawaiians or Pacific Islander, 64.44% White; and 2.20% Other. In 2005, according to data from the Electronic Birth Certificate, 23% of all New Jersey live births were by WIC mothers.

1.3 Local Agency Overview

Local WIC agencies in New Jersey serve as a gateway to primary preventive health care for many of the State's vulnerable pregnant, postpartum and breastfeeding women, infants and children. New Jersey WIC Services provides a unique opportunity through which program participants receive access to primary preventive health care and referrals to human services programs. The State and local WIC agencies continue to work collaboratively to ensure a participant focused delivery system through the promotion and expansion of one-stop service and integration of services at conveniently located facilities.

The local WIC agencies establish accessible WIC clinic site locations throughout their service area in collaboration with health related organizations, community and non-profit organizations, and county and local municipalities. The local agencies employ over 300 staff to certify the WIC participants using the WIC ACCESS computer system on state owned computers. WIC services must be provided by approved nutrition professionals and nurses and support staff. Local agencies provide extended hours for working participants.

One-sixth of the services offered to WIC participants must be in nutrition education. Local agency staff utilize a variety of materials to encourage healthy eating habits.

1.4 New Jersey WIC Advisory Council Overview

The purpose of the WIC Advisory Council is to bring together representatives from statewide organizations and constituencies that have an interest in the nutritional status of mothers and children by performing the following functions:

- Contribute to the promotion of the New Jersey WIC Services;
- Provide support and make recommendations to New Jersey WIC Services for the operation of an effective program;
- Act as a clearinghouse for the exchange of ideas and information; and
- Provide an articulate voice for consumers in areas affecting WIC, nutrition and health.

The responsibility of the Council is to collaborate with and advise the New Jersey Department of Health and Senior Services through the Director of WIC Services in the delivery of quality services to WIC clients. The areas include: Targeting, Caseload Management, Outreach, Coordination of WIC with other community health services, Vendor Operations, Nutrition Policy, Program Planning, and Budgetary Management.

The New Jersey WIC Advisory Council is comprised of member representatives from numerous providers and advocacy areas, such as: Maternal Health, Pediatric Health, Nutrition, Vendors, Participant Representative (Urban), Participant Representative (Rural), the WIC Forum (President/Designee), a Local Agency Representative, a Health Officer, MCH Regional Consortia, WIC Advocates, New Jersey Hospital Alliance, Division of Medical Assistance, New Jersey State Assembly, New Jersey State Senate, and Managed Care.

1.5 The Division of Family Health Services' Mission Statement:

To improve the health, safety, and well-being of families and communities in New Jersey.

1.5.1 Organizational Structure

Organizational charts for WIC Services are contained in Appendix 7.1 and show the functional organization of each of the Service unit program areas. WIC Services is organizationally located within the Division of Family Health Services (FHS). Gloria Rodriguez is the Assistant Commissioner for the Division of Family Health Services.

1.6 New Jersey WIC Services' Mission Statement:

To safeguard the health of low-income women, infants, and children up to age five (5) who are at nutritional risk by providing nutritious foods to supplement diet, information on healthy eating, breastfeeding promotion and support and referrals to health care agencies.

1.7 New Jersey WIC Services' Goals

To enhance the quality of life for women, infants and children through a client centered service delivery system.

To improve the nutritional status of all low-income persons eligible to receive supplemental foods, nutrition education and accessibility to health care and other social services; and to ensure the integrity of program operations and maximize the use of funds appropriated by the United States Department of Agriculture (USDA).

The New Jersey WIC Services Strategic priority sections are addressed in 6.0 Strategies. The Strategies are: Client Services through Technology and Collaboration of Services, Value Enhanced Nutrition Assessment (VENA), Breastfeeding Exclusivity, Physical Activity in Conjunction with Nutrition Education, Vendor Cost Containment, and Program Integrity.

1.8 New Jersey WIC Services 2013 Objectives

Objectives

- To improve client services through technology and collaboration of services;
- To provide participant centered services through Value Enhanced Nutrition Assessment (VENA), improved process, content and staff skill, and the use of enhanced nutrition assessment tools;
- To promote, support and protect exclusive breastfeeding for the first six months of life and continued breastfeeding with the addition of appropriate complimentary foods for the rest of the first year and thereafter as long as mutually desired by mother and child;
- To provide fully integrated breastfeeding promotion and support services at all WIC sites;
- To promote regular physical activity in conjunction with nutrition education to aid in the prevention of overweight and obesity in WIC participants and caregivers of WIC participants.
- To continue complying with the Vendor Cost Containment rule; and
- To continue monitoring program integrity through local agency program operation monitoring and evaluations, vendor compliance buys, MIS ad hoc reporting, and program data analysis and evaluations.

2.0 ORGANIZATIONAL STRUCTURE OF NEW JERSEY WIC SERVICES

2.1 State Operations

2.1.1 Office of the Director

2.1.1.1 Administrative Section

The Office of the Director administers and manages all operations, including the four service delivery units and the 11 USDA functional areas, of New Jersey WIC Services. The four service units are Health and Ancillary Services, Monitoring and Evaluation, Food Delivery and WIC Information Technology. The 11 functional areas identified by USDA are detailed in the WIC Federal Regulations 7 CFR, Part 246. The 11 functional areas are Vendor Management, Nutrition Services, Information Systems, Organization and Management, Administrative Expenditures, Food Funds Management, Caseload Management, Certification, Eligibility and Coordination, Food Delivery/Food Instrument Accountability and Control, Monitoring and Audits and Civil Rights.

The Office of the Director is responsible for the State Plan, monitoring the budget, monitoring and reporting on annual Operational Adjustment and Infrastructure Funding, Civil Rights, USDA State Technical Assistance Reviews (STAR), fiscal reviews of grantees, all state and federal audits and reviews, internal controls, efficiency and effectiveness or program operations and responding to all inquiries, complaints or issues from participants, the public, legislators, interest groups, and state and federal agencies.

The administrative tasks include:

1) Performing payroll activities for **33** employees in New Jersey WIC Services;

2) Completing and coordinating the preparation of all personnel actions for New Jersey WIC Services;

3) Providing administrative direction to program staff concerning interpretation of policies and procedures; and

4) Other administrative functions as deemed necessary to ensure the efficiency and effectiveness of program operations.

2.1.2 Health & Ancillary Services (H&AS) Unit

2.1.2.1 Health & Ancillary Services

State WIC nutrition and breastfeeding staff in the Health and Ancillary Services Unit develops policies and procedures and provides technical assistance in nine of the eleven functional areas of the WIC program. The Health and Ancillary Services staff are responsible for nutrition education, the cornerstone of the WIC program; the oversight of breastfeeding promotion and support services; immunization screening; monitoring of local agencies to ensure that they fully perform their WIC regulatory responsibilities; the certification process; food package tailoring; nutrition surveillance; and coordination of services with health and social service agencies.

Staff conducts trainings and provides support to local agencies on health and nutrition topics including: pediatric and prenatal nutrition advances, nutrition techniques, breastfeeding, customer service, income screening, bloodwork screening, anthropometrics (weighing and measuring) and program regulations. These trainings are eligible for continuing education credits from the American Academy of Nutrition and Dietetics and other relevant credentialing organizations. Staff reviews State and local agency program data and Nutrition Services reports to evaluate the characteristics of the certified population, e.g., level of education, nutritional risk factors, breastfeeding rates and formula usage.

2.1.2.2 Nutrition Education

Health and Ancillary Services assures through time studies that 1/6th of New Jersey's Nutrition Services Administrative funds are spent on Nutrition Education and that two nutrition education contacts per certification period are provided and documented for all WIC participants, including the high risk.

In addition to the Nutrition Education Plan, Health and Ancillary Services reviews, purchases, creates and distributes nutrition education materials for local WIC agencies and translates materials into Spanish and other languages as needed. Nutrition education is provided to individuals and groups, and whenever possible, is based on the individual interests and health needs of the participant.

The three major goals of WIC nutrition education are to:

- Highlight the relationship between proper nutrition and good health with special emphasis on the nutritional needs of pregnant, postpartum, and breastfeeding women, infants, and children under five years of age;
- Assist the individual who is at nutritional risk to achieve a positive change in food habits resulting in improved nutritional status and prevention of nutrition related problems through optimal use of the supplemental foods and other nutritious foods; and
- Provide nutrition education in the context of the ethnic, cultural, and geographic preferences of the participants and with consideration for educational and environmental limitations experienced by the participants.

The Health and Ancillary Services Unit, with local agency input, develops a Statewide Nutrition Education Plan that targets nutritional problems identified in the New Jersey WIC population. Local agencies may adopt this plan, make modifications, or develop an individual plan based on an assessment of the nutritional problems of the participants in their service area subject to the review and approval of the State WIC Agency.

Value Enhanced Nutrition Assessment (VENA) is part of the Revitalizing Quality Nutrition Services in WIC Initiative. The goal is to improve nutrition and health assessment for the purposes of directing client centered nutrition education and services.

In November 2009, the NJ WIC Program launched an interactive customized nutrition education website, NJWIConline.org. New Jersey WIC participants can utilize this website with internet access to satisfy their secondary nutrition education contact. In December 2010, KIOSKS were placed at all the WIC local agency administrative offices. These KIOSKS contain the NJ WICOnline.org website for WIC Participants to complete their secondary nutrition contact. See Section 5 Milestones.

2.1.2.3 Breastfeeding Promotion and Support

The State WIC office oversees all breastfeeding promotion and support services provided for WIC participants by the local agencies and three Maternal and Child Health consortia by monitoring, reviewing, and evaluating the services provided. The State is responsible for technical assistance and training; responding to requests for information from the public and organizations both within and

outside of State government; developing policies and procedures based on Federal regulations and guidelines from the National WIC Association; coordinating with private and public health care systems and other organizations and programs to promote and support breastfeeding; contributing to the Nutrition Education Plan; tracking and compiling the breastfeeding rates and trends; and purchasing breast pumps.

2.1.2.4 WIC Food Packages

The Health and Ancillary Services Unit identifies and provides local agencies with a list of the foods that are acceptable for issuance to program participants; at least one item from each food group in the WIC food package prescription must be available. The unit monitors local agencies to assure that supplemental foods are made available in the quantity and form necessary to satisfy the individual nutritional needs and cultural preferences of each participant, taking into consideration the participant's age and dietary needs. The new WIC food package was implemented statewide October 1, 2009.

2.1.2.5 Certification/Eligibility Determination

Participation in the WIC program is limited to pregnant, postpartum and breastfeeding women, infants, and children up to the age of five years from low-income families who are determined to be at nutritional risk by a competent professional authority (CPA). Health and Ancillary Services oversees the eligibility process (income screening, residency, identity, adjunctive eligibility, nutritional assessment, and risk determination).

2.1.2.6 Access to Health Care

The WIC Program serves as an adjunct to primary preventive health care during critical times of fetal development, and the growth and development of infants and children. This component of the WIC Program functions to prevent the occurrence of health problems and to improve the health status of these vulnerable populations.

Local WIC agencies refer participants to healthcare and, as appropriate, to substance abuse counseling and ensure access at no cost or at a reduced cost. During certification, information is given to participant regarding the type of healthcare services available, where free immunizations can be obtained, how to obtain services, and why these services should be used. Standardized New Jersey WIC referral forms are used by all local agencies to collect screening and healthcare referral data.

HealthStart uses the WIC referral form to facilitate the enrollment of eligible pregnant women in each program and reduce the duplication of services. Pregnant women who are eligible for HealthStart are adjunctively eligible for WIC. Many local WIC agencies refer WIC staff to HealthStart clinics to enroll pregnant women in WIC. The health and nutrition information provided by HealthStart staff on the referral form facilitates the WIC certification process and this coordination will continue during FFY 2013.

The State and local agencies in New Jersey work in cooperation with healthcare and social service providers, SNAP, Medicaid, New Jersey FamilyCare, federally funded community health centers, county welfare agencies, Head Start, HealthStart, child health conferences in local health departments, private physicians, and managed care providers. The co-location of WIC with other services increases the WIC eligible population's utilization of both services.

Health and Ancillary Services Unit staff works collaboratively with local agencies to ensure a participant-focused delivery system through the promotion and expansion of one-stop service and co-location of services at conveniently located facilities. New Jersey WIC Services has 112 clinic sites of which 48 are co-located with other health and/or human services programs. Health and Ancillary Services staff monitors and approves the opening and closing of WIC clinic sites. Innovative initiatives to improve access, provide services, and increase efficiency have been integrated to improve both the health and nutritional status of the "at risk" WIC population.

These initiatives include the following:

- Co-location with preventive and primary healthcare; (Newark WIC Program)
- Utilization of two mobile WIC clinics to provide increased access to services in underserved areas (Tri-County and North Hudson WIC Programs);
- Provision of immunization education and referral to children's medical homes or health departments;
- Provision of breastfeeding promotion and support services through WIC local agencies and regional Maternal and Child Health Consortia;
- Coordination with the New Jersey Chapter of the American Academy of Pediatrics to increase immunization rates;
- Hematological testing of WIC participants without referral data from healthcare providers;
- Coordination with Health Maintenance Organizations;

- Co-location or referral linkages to Federally Qualified Health Centers;
- Initiatives to promote awareness of increased fruit and vegetable consumption; and
- Coordination with Medicaid to improve Early Periodic Screening Diagnosis Treatment rates.

2.1.2.7 Outreach and Coordination Network

New Jersey WIC Services and local WIC agencies annually publicize the availability of WIC Program benefits, including eligibility criteria and the location of local agencies operating the program, through offices and organizations that deal with significant numbers of potentially WIC-eligible people. These health and social service organizations and offices are part of the WIC outreach coordination network. Health and Ancillary Services and local agencies work closely with these groups to assure their understanding of WIC and to promote referrals across programs. State and local WIC agencies develop an annual targeting plan to promote WIC awareness, enhance access to WIC services, ensure continuity of WIC services, and coordinate WIC operations with other services or programs that benefit WIC participants. New Jersey WIC will advertise on movie screens throughout New Jersey, in FFY 2012.

2.1.2.8 Voter Registration

New Jersey WIC Services provides voter registration services at all WIC clinic sites in compliance with the National Voter Registration Act of 1993. WIC applicants and participants are asked via a voter registration opportunity form that is available at all clinics if they are eligible to vote and would like to register to vote, assistance is available for completing these forms. New Jersey WIC Services coordinates with the Department of Law and Public Safety, Division of Elections, in submitting the quarterly reports from all New Jersey WIC agencies obtaining voter registration forms and provides relevant information to local WIC agencies on voter registration. Voter registration coordinators at local agencies train local staff and State staff are available for technical assistance.

2.1.2.9 MARWIC TIMES Newsletter

Since 1995, New Jersey WIC Services has produced the MARWIC Times newsletter for the United States Department of Agriculture (USDA) Mid Atlantic Region. This quarterly newsletter captures regional USDA news and the news and activities of the nine WIC states in the region: New Jersey, Pennsylvania, Delaware, Maryland, Virginia, West Virginia, the District of Columbia, Puerto Rico and the Virgin Islands. The newsletter was sent to all the WIC directors, nutritionists and breastfeeding coordinators nationally, all the USDA regional offices, and USDA headquarters. The

MARWIC Times is supported by an annual grant to New Jersey WIC from the USDA Mid-Atlantic Regional Office. The Newsletter is available on WIC Works.

2.1.3 Monitoring and Evaluation Services

The Monitoring and Evaluation Services Unit (M&E) ensures the appropriate management and utilization of administrative and food funds by local grantees.

WIC Nutrition Services Administration (NSA) funds are stringently monitored before, during, and after grants are awarded and when funds are expended. The M&E Unit determines an initial NSA grant amount for grantees consistent with the WIC Federal regulations for the distribution of funds through the fiscal budget process. The Department of Health and Senior Services Financial Services mandates and enforces State and Federal requirements for contracting with local grantees through the Notice of Grant Availability, Spending Plan and the Health Service Grant (HSG) process. USDA dictates specific WIC provisions.

The M&E Unit incorporates all requirements into the annual grant application packet and provides an information session to all interested applicants in March 2012. Staff reviews the grant applications for compliance with both program and fiscal requirements and prepare them for departmental review, approval and award. Staff monitors the grants through the expenditure process and sends a report of expenditures to the USDA monthly. If additional funds become available during the fiscal year, the M&E Unit determines the distribution of funds to local grantees and notifies the agencies to prepare a budget modification. Staff review and process grant modifications the same as initial grant applications. The M&E Unit determines the initial and reallocation of USDA funds for food costs to local grantees. Staff prepare, maintain, and monitor monthly State and local agency spreadsheets for projected and actual food dollar expenditures.

Another area of critical program monitoring is caseload management. Staff charts, updates monthly, and monitors program enrollment and participation data to ensure between 97 and 100 percent expenditure of funds without overspending the grant award. Staff distributes a packet of caseload management charts and policy directives to local agency coordinators monthly. Staff frequently discusses with local agency sponsors and coordinators the issues affecting caseload and food dollar expenditures and specific corrective actions needed. Caseload is an agenda topic for each of the bi-monthly administrative meeting with local agency coordinators. Staff also communicates with local grantees via conference calls and special meetings as needed.

The M&E Unit coordinates the Infant Formula Rebate contract and monthly billing to obtain rebate funds as part of the USDA Federal regulations requirement for infant formula rebate cost containment. Staff charts, monitors, and reports the infant formula rebate dollars to USDA monthly. The unit prepares an invoice and submits it to the infant formula contract vendor by the 15th of each month. The rebate dollars are deposited in the bank by the 15th business day of the month and are used for reduction of food expenditures. The unit is responsible for preparing the infant formula rebate Request for Proposal (RFP) in accordance with State purchasing requirements and USDA Federal regulations.

The M&E Unit prepares and issues the Affirmative Action Plan for NJ WIC Services. This plan analyzes health data for the New Jersey WIC eligible population by municipality and county. The unit utilizes the data to develop intervention strategies to improve services to the WIC eligible population.

Another function of the M&E Unit is the preparation of the USDA WIC State Plan Application. Unit staff collects and incorporate all the information relative to management and monitoring of NSA funds and food dollars. In addition, the data on the WIC eligible population is calculated to determine the areas of most need in the State. This information is critical for obtaining approval by USDA for the fiscal year grant award.

2.1.4 Food Delivery Services

The Food Delivery Services Unit (FD) has the primary responsibility to ensure the accountability, payment and reconciliation of 100 percent of all WIC checks distributed, printed, issued, voided, redeemed or rejected. The **17** local agencies have over **33** administrative (permanent, fixed) service sites and 79 satellite clinics throughout the state that provide direct benefits to approximately **295,191** women, infants, and children annually. Benefits are delivered through the issuance of checks for specific foods. Checks are cashed at vendors (retail grocery stores) under contract with WIC. WIC Services presently issues over 7,000,000 checks per year and these checks have a value of more than $131 million per year. The FD Unit oversees the operations of all local WIC agencies and their service sites with particular emphasis on check reconciliation and payment. Food Delivery also monitors more than **850** contracted WIC grocery stores (vendors) to ensure compliance with the Vendor Agreement and program integrity.

All new vendors participating in the program for six (6) months must submit their quarterly New Jersey Division of Taxation Sales and Use Tax forms (ST 50 forms or monthly UZ forms) to ensure that the vendors annual WIC food sales are not above-50-percent of their annual food sales. Vendors that are above-50-percent shall be disqualified from the program.

Ensuring compliance is accomplished through a variety of activities including: review of local WIC agencies Program operations; comprehensive review of vendor operations; management and review of the banking contract and procedures for processing checks; and analysis of computer reports from WIC's Automated Client Centered Electronic Services System (ACCESS) and Solutran, our banking contractor.

The local WIC agency review is a comprehensive assessment of the agency's total operations that focuses on compliance with regulations regarding the check issuance process, service delivery, customer service, orientation and training for new participants, and one-to-one reconciliation of all checks. The process includes extensive computer report analysis, onsite visits to sites statewide, development and provision of technical assistance and training to local WIC agency staff, and corrective action plans for bringing an agency into compliance.

Food Delivery personnel oversee the local WIC agency onsite process for WIC Services. The process includes developing the biennial schedule, sending out questionnaires, letters and reports to local

grantee sponsors and coordinators, and tracking and filing all documents. The onsite review process incorporates 11 Functional Areas that are defined by USDA for the WIC Supplemental Nutrition Program. The methods used by staff include on-site visits, completion of questionnaires by local grantees and State staff, desk reviews of grantee-submitted documents, on-line analysis of electronic data, and desk reviews of electronic reports.

Vendor management activities include collecting, processing, maintaining the paperwork, files and computer database necessary to manage contracted vendors; developing and providing training seminars statewide; conducting extensive computer report analysis; performing onsite monitoring of vendors statewide; collecting and analyzing commodity prices throughout the state; and conducting both training and covert compliance buys.

Food Delivery unit personnel review daily monthly bank reports and have the ability to electronically access and review images of all checks the bank has processed for the past seven years. Staff can also electronically access account information for all New Jersey WIC's bank accounts for up-to-date activity.

Food Delivery personnel develop ad hoc computer reports to identify, analyze and use as a tool to change and/or develop policies that will have a positive impact on service delivery for WIC participants. They develop and write comprehensive reports on local grantee or vendor operations; evaluate annual grant applications and grant modifications; and develop and provide technical training seminars for vendors.

Food Delivery personnel oversee the ordering, printing and distribution of various program materials, including all check stock used for WIC participant ID folders, participant rights and obligations forms, participant fact sheets, vendor food lists, vendor store signs, vendor stamps, and all forms related to the vendor application process.

Food Delivery personnel co-chair the Food List Committee along with the Health and Ancillary Services Unit. This group evaluates all items chosen for inclusion on the list of WIC approved foods. FD personnel bring their knowledge of statewide availability of items, variations in pricing at vendors across the state, and participant preferences.

Food Delivery personnel oversee the Special Infant Formula purchase system, whereby at-risk infants received medical infant formula shipped either to their homes or to their local WIC Agency. The State has a vendor agreement with a formula warehouse company in Lancaster, PA, for the purchase and shipment of special formula. This system has been in place for several years and has provided a much-needed service to WIC's neediest population.

Food Delivery personnel are responsible for the semiannual exchange of participant information with the Commonwealth of Pennsylvania. Date files are compared to discern whether any of NJ's WIC participants are enrolled in the PA WIC Program at the same time (dual participation). Through the efforts of WIC's computer system contractor, CMA, this data exchange has been enhanced and improved.

Food Delivery personnel are crossed trained to perform FD Unit and Vendor Management Unit functions. The cross training is enhancing the skills and knowledge of the staff, which is needed to maximize productivity.

2.1.5 WIC Information Technology

The WIC Information Technology (IT) Unit is responsible for all data and technology functions for New Jersey WIC Services. IT is responsible for three areas of program concern in support of WIC's Automated Client Centered Electronic Service System (WIC ACCESS): Operations, Maintenance/Project Management, Field Support and Quality Assurance. In addition to the WIC ACCESS system, the IT Unit supports the computers and associated computing equipment such as printers and scanners used by State WIC staff for program management and operations. The IT Unit is responsible for identification, evaluation, and implementation of a technologically current application to replace WIC ACCESS. The WIC IT unit also administers and is responsible for the Vendor database and application for monitoring and reporting.

2.1.5.1 Operations and Maintenance/Project Management of WIC ACCESS

All automated data processing operations and development is provided and supported by WIC's application service provider (ASP) according to specifications developed by New Jersey WIC Services. A critical role of the IT Unit is to coordinate, monitor and manage current ASP operations and identify issues to improve the efficiency of WIC ACCESS. Areas included in these efforts are monitoring of help desk operations, software "bug" identification, enhancements, application implementation, resource management and liaison for the State and local agencies to the ASP.

The IT Unit provides the necessary evaluation tools and training in use of the Local Agency Service Site Module, System Administration Module, and Central Administrative Module needed by State and local agency management and staff to monitor enrollment participation, food instrument cost, caseload management, food funds issuance, funds reconciliation and Local Agency staff member management. IT Unit also audits local agencies for compliance with Federal regulations that are considered IT in nature.

IT is responsible for identifying emerging technologies that will enhance cost-effective service delivery to WIC participants and improve information management. There are a number of initiatives currently under development that are directly related to implementation of new technologies or the utilization of current technologies in a different solution that will improve the operating efficiency of WIC ACCESS.

The IT Unit, working with other State Office Units, manages the modification of WIC ACCESS to meet the changing requirements of the WIC program. The IT Unit provides business requirements definition support for modifications to the WIC ACCESS application. These modifications are predominately in response to new or modified USDA requirements, in support of normal updates or new WIC initiatives, or to improve efficiency of operations. WIC ACCESS provides automated support for all aspects of WIC and must continuously evolve as WIC evolves.

2.1.5.2 Quality Assurance

The WIC Information Technology Unit utilizes internal resources to test any modifications to the WIC ACCESS application, including regression testing to assure that the modifications do not affect existing functionality. Formal test scripts are developed by Quality Assurance staff to fully exercise each change in the new build and to assure that the entire application continues to operate properly with the inclusion of the changes. Tests are run in a standalone Test Lab using copies of selected Local Agency systems and databases. After testing is complete in controlled conditions, pilot testing is conducted at two local agency administrative sites before any new modification is implemented statewide. The pilot test period is closely monitored by Quality Assurance staff to verify that the new version of the software operates without problems in the production environment.

2.1.5.3 Field Support

The WIC Information Technology Unit provides technical and logistical support to the State and local agency staff and its associated facilities. In conjunction with the ASP help desk, IT staff provides field support hardware and software assistance to local agencies at 33 administrative sites and 110 clinic satellite sites throughout the State of New Jersey. IT also provides the same support to State WIC personnel located at WIC's State Office facilities.

2.1.5.4.1 General Support of Client

IT staff identifies and develops all specifications and allocations for new hardware and software applications. IT staff researches and processes all purchase orders for necessary equipment and services. The IT Unit also keeps an electronic inventory on all State and local agency hardware and software.

IT will continue to explore new technology that can be tailored to the delivery of WIC services. New generations of hardware and software applications are constantly being tested and reviewed as to their appropriateness for WIC services at both the State and local levels.

New Jersey WIC is in the process of issuing a Request for Proposal for the continued operations and maintenance of WIC ACCESS.

New Jersey WIC is also in the process of issuing a Request for Proposal for a web based replacement system for WIC ACCESS.

2.1.5.5 New Jersey WIC Website

The New Jersey WIC website is an excellent resource for WIC participants, health professionals, and the public in general for information on the New Jersey WIC Program and for links to other public health nutrition programs and information. The site is being regularly updated because it is an effective outreach tool as evidenced by the higher number of visits each month.

The web address is www.state.nj.us/health/fns/wic/index.shtml

2.2 Local Agency Operations

Direct WIC services are provided on a monthly basis to approximately **295,191** women, infants, and children at **112** administrative and clinic sites in the **17** local agencies listed below. The agency sponsors consist of three hospitals, nine municipal/county health departments, and five private/nonprofit organizations.

Local Agency	Type of Agency	# Of Administrative/Satellite Clinics
Atlantic City	Local Government	2/0
Burlington County	Local Government	1/10
East Orange	Local Government	2/1
Tri-County/Gateway CAP	Non Profit	7/6
Gloucester County	Local Government	1/2
Newark	Local Government	4/3
Jersey City	Local Government	1/4
North Hudson Community Action Corporation	Non Profit	1/6
NORWESCAP	Non Profit	3/4
Plainfield	Local Government	1/0
St. Joseph's Regional Medical Center	Hospital	1/14
Concerned Citizens of Ewing	Non Profit	1/4
UMDNJ	Hospital	1/3
Ocean County	Local Government	2/6
Passaic	Local Government	1/0
Trinitas	Hospital	1/3
Visiting Nurse Association of C-NJ	Non Profit	3/13

33 admin/79 satellite= 112 sites

2.3 New Jersey Advocacy Operations

2.3.1 New Jersey WIC Advisory Council

The bylaws of the Council set forth the purpose, organization and council responsibilities, of its membership which are identified in **Section 1.4**.

3.0 FINANCIAL MANAGEMENT

New Jersey WIC Services receives USDA funding to administer the WIC Program throughout New Jersey as well as funding from other sources to enhance benefits to participants when available. New Jersey WIC Services establishes its financial plan in accordance with federal and State regulations and policies.

3.1 Federal Funding Process

3.1.1 Federal Regulations

Section 17 of the Child Nutrition Act of 1966, as amended, provides payment of cash grants to State agencies that administer the WIC Program through local agencies at no cost to eligible persons. Congress provides an annual appropriation for WIC, usually in the fall, for the current fiscal year. States usually receive official notification of the fiscal year award in February. Congress passes a continuing resolution at the beginning of the fiscal year to temporarily continue the Program until the budget is approved.

Federal Regulations 7 CFR Part 246.16 describes the distribution of the funds. Food funds consist of the current year appropriation plus any amount appropriated from the preceding fiscal year. Nutrition services and administration (NSA) funds consist of an amount sufficient to guarantee a national average per participant grant, as adjusted for inflation. A State agency may spend forward unspent NSA funds up to an amount equal to three percent of its total grant (both food and NSA) in any fiscal year. With prior FNS approval, the State agency may spend forward additional NSA funds up to an amount equal to one-half of one percent of its total grant for the development of a MIS system.

3.1.2 Distribution of USDA Funds to State Agencies

The Nutrition Services Administration (NSA) funding formula incorporates these provisions:

- Base funding level – each State agency shall receive an amount equal to 100% of the final formula-calculated NSA grant of the preceding fiscal year, prior to any operational adjustment funding allocations, to the extent funds are available.
- Fair share allocation – any remaining funds are allocated to each State to bring it closer to its NSA fair share target funding level. This calculation is the difference between the NSA fair share target funding level and the base funding level.

- Operational adjustment funds – up to 10% of the final NSA grant is reserved for FNS regions to allocate to State agencies according to national guidelines and State needs.
- Operational level – level funding from year to year unless State agency's per participant NSA expenditure is more than 10 percent higher than its per participant NSA grant.

The food funding formula includes the following provisions:

- Fair share target funding – each State agency's population of persons categorically eligible for WIC which are at or below 185% of poverty proportionate to the national aggregate population of persons who are income eligible to participate in the program based on 185% of poverty criterion.
- Prior year grant level allocation - each State agency shall receive prior year final grant allocation, to the extent funds are available.
- Inflation/fair share allocation - remaining funds are allocated by using an anticipated rate of food cost inflation to all State agencies in proportionate shares, to State agencies with a grant level less than its fair share target funding level and to State agencies that can document the need for additional funds.

Breastfeeding Promotion and Support Funding

- The funding formula is based on the average number of pregnant and breastfeeding women participating in the program in May, June and July of the previous year multiplied by the USDA annual rate to allow for inflation.
- This is the minimum that the State must spend on breastfeeding promotion and support.
- The State may grant additional State administrative funds, which allow for an anticipated increase in the number of pregnant and breastfeeding women served.

The Breastfeeding Peer Counseling (BFPC) funding formula is also based on the average number of pregnant and breastfeeding women participating in the program in May, June and July of the previous year. States are awarded a percent amount based on the total amount allocated by Congress. If the USDA targeted breastfeeding funds and the BFPC funds are not spent in their entirety, the State is subject to a decrease in funding in the following year.

The USDA is authorized to recover or reallocate State funds in the following situations:

- Recovery - funds distributed to a State agency are returned to the USDA. The USDA determines that the State agency is not expending funds at a rate commensurate with the amount of funds distributed. Recovery may be voluntary or involuntary.
- Reallocation – food funds recovered from State agencies are distributed to State agencies through application of appropriate funding formulas.
- Performance standard of food funds expenditures – 97 percent of food funds allocation. Food funds allocation in a current fiscal year will be reduced if the prior year expenditures do not equal or exceed 97 percent of the amount allocated.
- Reduction of NSA grant – State agency per participant NSA expenditure is more than 10 percent higher than its per participant NSA grant.
- Conversion of food funds to NSA funds – State agency may submit a plan to reduce average food costs per participant and increase participation above the FNS- projected level. "State agency may also earn conversion authority based on actual participation exceeding the Federally-projected participation level calculated in the NSA funding formula."
- Congress provides a contingency fund to be allocated, as the Secretary of the USDA deems necessary, to support participation should cost or participation exceed budget estimates to avoid waiting lists and to ensure that all eligible women, infants and children receive benefits.

The USDA will grant spendforward requests from states when funds are available. States may request to spendforward unspent prior year grant funds up to 3% of the prior year's grant. In addition, states may request to spendforward an additional ½ % unspent prior year grant funds to use on MIS projects.

Additional NSA funds can be requested through the prepayment vendor collections. States can report the amount of unallowable food funds that are not paid to a vendor, as identified in a pre-edit check system. The food funds are converted to NSA funds.

3.1.3 Infant Formula Rebate and other Supplemental Foods Rebates

Infant formula procurement – all States are required, unless granted a waiver, to implement infant formula cost containment measures for each of the types and forms of infant formula prescribed to the majority of participants. New Jersey WIC Services awarded a three-year contract to Ross Products Division, Abbot Laboratories effective October 1, 2007 to September 30, 2010. Two one-year extensions of the contract by mutual agreement are granted by the terms of the contract. WIC is presently in the second year extension. The infant formula rebate funds are used to cover food costs thereby reducing the USDA food grant. USDA encourages states to implement additional food rebate cost containment systems for other supplemental foods, such as infant cereal.

3.1.4 Other USDA Funding

Other USDA funds, which vary from year to year, are allocated to provide for special USDA, State, and LA projects such as the following:

- USDA Operational Adjustment (OA) Projects provide funds to support USDA approved local agency and State agency special projects.
- USDA Infrastructure funds are two year grants for special competitive projects.

3.2 State Funding Process

3.2.1 State Requirements

New Jersey State Plan Section II, Policy and Procedures 5.00 through 5.24 and Section III.V., Administrative Expenditures, provide requirements for local agency administrative expenditures. New Jersey State Plan Section III.VI, Food Funds Management, describes the State implementation of Federal requirements for food funds management.

3.2.2 Distribution of USDA Funds to Local Agency Grantees

New Jersey WIC Services distributes the Federal funds annually to WIC local agencies. The State advises the local agencies of an initial recommended administrative funding amount each spring to use for completion of the annual Health Service Grant application. The application is due in June and the State provides a provisional grant award October 1. Once the USDA funding award is officially communicated, any additional funding, such as discretionary/operational adjustment funds, is allocated to the local agencies through a grant modification award. Should any other funds become available during the fiscal year they are also awarded to the local agencies through a grant modification.

3.2.3 Funding Formula

The New Jersey WIC Services funding formula is consistent with the USDA funding formula methodology. New Jersey WIC Services appointed a WIC Funding Formula Committee in July 2002, to assess the current funding formula criteria and formulate a new WIC Administrative Funding Formula to most equitably fund the **17** local WIC grantees that provide direct services to WIC eligible applicants in New Jersey. The committee was composed of local WIC agency coordinators, WIC Advisory Council representatives and State staff. The formula was finalized in March 2004, and has been used as a guide to fund the agencies since that time.

The funding formula uses each agency's most recent closeout year reported participation and the fiscal year base grant to determine each agency's Administrative Grant per Participant (AGP). The highest, median and lowest AGPs are used to fund three participation bands to provide an "AGP" base grant. The current base funding is compared to the new base grant to determine those over or under. The grants for all agencies are adjusted, either increased or decreased, depending upon the availability of federal funds.

3.2.4 Breastfeeding Promotion and Support

USDA funding supports breastfeeding promotion and support services for WIC participants. Ten local agencies and three Maternal and Child Health Consortia are funded to provide breastfeeding services at WIC sites throughout the State. All USDA breastfeeding funds awarded to New Jersey WIC are distributed to breastfeeding grantees.

Since 2004, Congress has annually appropriated Breastfeeding Peer Counselor Funds (BFPC) to enable State agencies to implement an effective and comprehensive peer counseling program and/or enhance an existing breastfeeding peer counseling program. Breastfeeding peer counseling services are a core service in New Jersey WIC and there is a strong management component. The BFPC funds are provided to agencies to enhance breastfeeding services originally funded with the USDA breastfeeding funds. WIC grantees are required to provide services consistent with *Loving Support© through Peer Counseling: A Journey Together – for WIC Managers.*

3.2.5 Distribution of Funds to Support Local Agency Operations

New Jersey WIC Services incorporates funding into the State operating budget funding to support LA service delivery to participants. LA operations funded by State budget monies include the following:

- Computer system monthly operational costs, hardware and software costs, and maintenance costs;
- Bank check processing and vendor payment monthly costs;
- Nutrition education materials and supplies that are purchased for participants; and
- A hotline for participants to obtain local agency addresses and telephone numbers.

3.2.6 Distribution of Funds to Support State Agency Operations

A portion of the Federal funds support State agency operations such as salaries, fringe, indirect costs, telephone and computer communication services, equipment, printing, supplies, travel, and training, etc.

3.2.7 Distribution of Other Funds to Support Local Agency Operations

Funding from "other" sources is sometimes available to provide additional services to WIC participants at the WIC sites. These include the following:

- CDC Immunization funds, when available, contain a 10% reserve for WIC and are provided via the CDC Immunization grant to the New Jersey Department of Health and Senior Services (DHSS).
- MCH Services funds are State appropriated funds provided to local grantees to enhance services to WIC participants when available.
- COLA (Cost of Living Adjustments) funds provided from the State budget to support grantee services to WIC participants when available.

3.3 Preliminary FFY 2012 and FFY 2013 Funding

3.3.1 Preliminary Funding

The preliminary budget for FFY 2012 is determined from specific correspondences provided to the State Agency from the USDA. Per federal regulation, the guarantee base grant is based on the previous year base caseload. That preliminary amount is shown in Table 1.

3.3.2 Preliminary Funding Tables and Charts

The following tables detail the preliminary FFY 2013 budget and the succeeding FFY 2012 budget with charts depicting the funding sources and amounts in relation to the total pot of funds and the various contributing funding sources.

Table 1. Preliminary FFY 2012 and FFY 2013 Funding Sources

PRELIMINARY FFY 2013 USDA FUNDING						
FFY 2012 FUNDING	**FOOD**	**NSA**	**TOTAL Food & NSA**	**Projected Infant Formula Rebate**	**TOTAL Food, NSA & Rebate**	**TOTAL Food & Rebate**
(a)	(b)	(c)	(d)	(e)	(f)	(g)
			(b + c)		(d + e)	(b + e)
Base Grant	**$98,441,622**	**$32,229,289**	**$130,670,911**	**$32,500,000**	**$163,170,911**	**$130,941,622**
Jan. Reallocation	$588,895	$211,128				
Mar. Reallocation		$1,951,168				
Apr. Reallocation						
Grant to date	**$99,030,517**	**$34,391,585**	**$133,422,102**	**$32,500,000**	**$165,922,102**	**$131,530,517**
Operation Adjustment Funding						
OA Projects		$173,633				
PRELIMINARY FFY 2013 USDA FUNDING						
Base Grant	**$98,441,622**	**$32,229,289**	**$130,670,911**	**$32,500,000**	**$163,170,911**	**$130,941,622**
OA	Not Guaranteed					
Jan. Reallocation	Not Guaranteed					
Grand Total	**$98,441,622**	**$32,229,289**	**$130,670,911**	**$32,500,000**	**$163,170,911**	**$130,941,622**
PRELIMINARY FUNDS from OTHER SOURCES						
			FFY 2012		**FFY 2013**	
MCH			$0	0.00%	Not Guaranteed	
WIC Infrastructure			$0	0.00%	Not Guaranteed	
USDA BF PEER COUNSELOR			$2,417,692	6.57%	Not Guaranteed	
Total Other Funds			**$2,417,692**	6.57%	**$0**	0.00%
Preliminary USDA NSA Grant			**$34,391,585**	93.43%	$32,229,289	100.00%
Total NSA & Other Funds			**$36,809,277**	**100.00%**	**$32,229,289**	**100.00%**

Table 2. Preliminary FFY 2012 and FFY 2013 Funding Distribution

	FFY 2012	Percent	FFY 2013	Percent
Guaranteed NSA Base to Grantees				
Local WIC Agencies Base	$22,773,968	66.22%	$22,773,968	66.38%
LA Base BF Initiative	$772,700	2.25%	$772,700	2.25%
MCH Consortia Base BF Initiative	$467,300	1.36%	$467,300	1.36%
Sub-Total	**$24,013,968**	69.83%	**$ 24,013,968**	70.00%
Other USDA Funding				
Add-on LA Projects + Hot Line	$38,200	0.11%	Not Guaranteed	
Operational Adjustment (OA)	$13,732	0.04%	Not Guaranteed	
Sub-Total	**$51,932**	0.15%	**$0**	
Sub-Total Funding to LA Grantees	**$24,065,900**	69.98%	**$24,013,968**	70.00%
State Budget to Support Grantee Operations				
Computer and Banking Services	$3,749,000	10.90%	$3,749,000	10.93%
Nutrition Education Materials/Equipment	$35,000	0.10%	$35,000	0.10%
Grants In Aid Audit Fee	$0	0.00%	$0	0.00%
Sub-Total	**$3,784,000**	11.00%	**$3,784,000**	11.03%
Sub-Total Funding for LA Operations	**$27,849,900**	80.98%	**$27,797,968**	81.03%
State Budget State Operations				
Salaries, Fringe Benefits, and Indirect	$4,866,830	14.15%	$4,833,830	14.09%
Other Support Services	$1,674,855	4.87%	$1,674,855	4.88%
Sub-Total	**$6,541,685**	19.02%	**$6,508,685**	18.97%
Total USDA Funding	**$34,391,585**	100%	**$34,306,653**	100%
State Operations	$6,541,685	19.02%		
Local Agency Operations	$24,065,900	69.98%		
Local Agency Support	$3,784,000	11.00%		
	$34,391,585			
	FFY 2012	Percent		
Guaranteed NSA Base to Grantees				
Local WIC Agencies Base	$22,773,968	94.63%		
LA Base BF Initiative	$772,700	3.21%		
MCH Consortia Base BF Initiative	$467,300	1.94%		
Add-on LA Projects + Hot Line	$38,200	0.16%		
Operational Adjustment (OA)	$13,732	0.06%		
	$24,065,900			

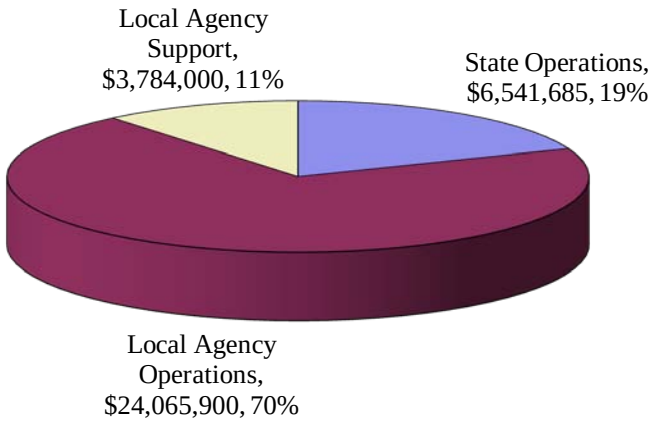

Local Agency Support, $3,784,000, 11%
State Operations, $6,541,685, 19%
Local Agency Operations, $24,065,900, 70%

Table 3: Grantee Preliminary NSA Base Funding

Agencies	Preliminary Grant Award FFY 2012	Preliminary Grant Award FFY 2013
Atlantic	$690,700	$690,700
Burlington County	$1,166,600	$1,166,600
Tri County*	$2,839,800	$2,839,800
East Orange	$1,005,800	$1,005,800
Gloucester County	$705,200	$705,200
Jersey City	$1,632,000	$1,632,000
Visiting Nurse Association*	$2,353,600	$2,353,600
Newark	$1,584,000	$1,584,000
North Hudson Community Action Program*	$1,535,800	$1,535,800
NORWESCAP*	$748,100	$748,100
Plainfield*	$691,500	$691,500
St. Joseph's Hospital and Medical Center*	$2,537,900	$2,537,900
Concerned Citizens of Ewing*	$1,074,800	$1,074,800
UMDNJ	$945,900	$945,900
Ocean County*	$2,046,100	$2,046,100
Passaic*	$749,768	$749,768
Trinitas*	$1,239,100	$1,239,100
WIC Grantee Total	$23,546,668	$23,546,668
Southern NJ Perinatal Cooperative, Inc.*	$101,300	$101,300
Hudson Perinatal Consortium, Inc.*	$64,100	$64,100
Gateway Northwest MCH Network*	$301,900	$301,900
GRAND TOTAL	**$24,013,968**	**$24,013,968**

*Provides Breastfeeding Initiative Services

Table 4.	**ESTIMATED FOOD DOLLAR BREAKDOWN**			
	FOOD		**REPORTED**	
	DOLLARS	**PERCENT**	**PARTICIPATION**	Served by
USDA FOOD GRANT	$111,195,367	77.42%	1,613,127	USDA Grant
EST. FORMULA REBATE 3-23-12	$32,435,524	22.58%	470,547	Formula Rebate
TOTAL DOLLARS	**$143,630,891**		**2,083,674**	

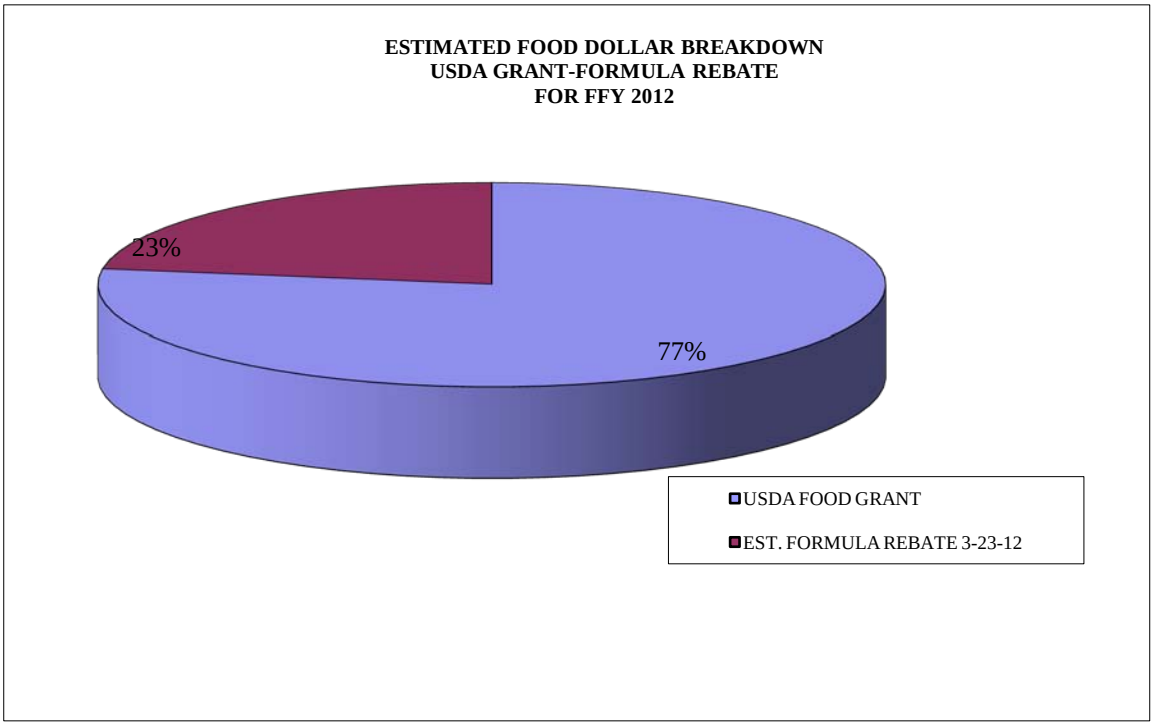


Table 5. NJ WIC USDA PARTICIPATION BY REGION DECEMBER 2011

REGION	YEAR 2000 CENSUS POPULATION	% POPULATION	USDA PARTICIPATION	% USDA PARTICIPATION
NORTH	3,245,987	38.58%	70,707	41.75%
CENTRAL	2,904,847	34.52%	46,323	27.35%
SOUTH	2,263,516	26.90%	52,347	30.91%
STATE	8,414,350		169,377	

NORTH		CENTRAL		SOUTH	
LOCALS	**COUNTIES**	**LOCALS**	**COUNTIES**	**LOCALS**	**COUNTIES**
E. Orange	Bergen	VNA	Hunterdon	Atlantic	Atlantic
Jersey City	Essex	NORWESCAP	Mercer	Burlington	Burlington
Newark	Hudson	Plainfield	Middlesex	Test City	Camden
North Hudson	Morris	CC of Ewing	Monmouth	Gloucester	Cape May
S. Joseph's	Passaic	Trinitas	Somerset	Ocean	Cumberland
UMDNJ			Sussex		Gloucester
Passaic			Union		Ocean
			Warren		Salem

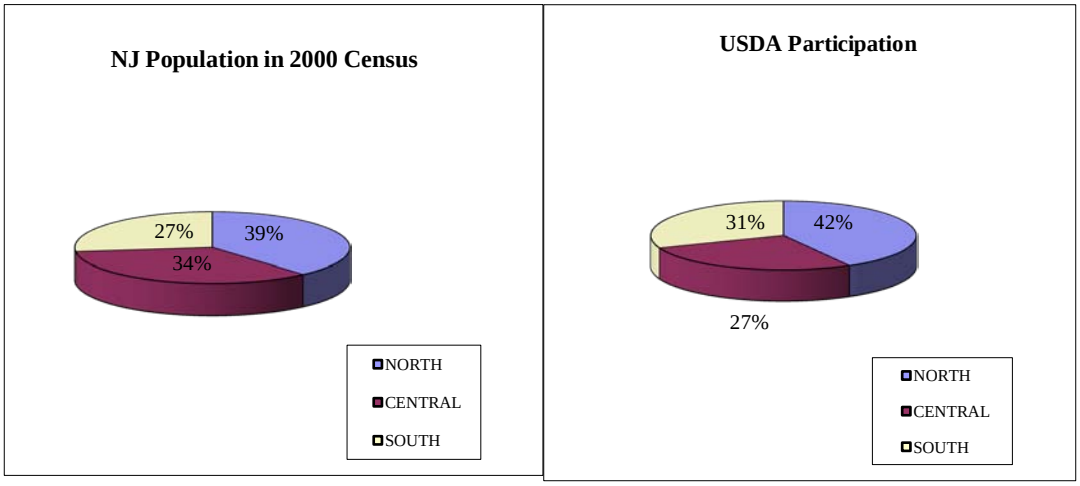


Chart 1 Preliminary FFY 2012 Funding Sources

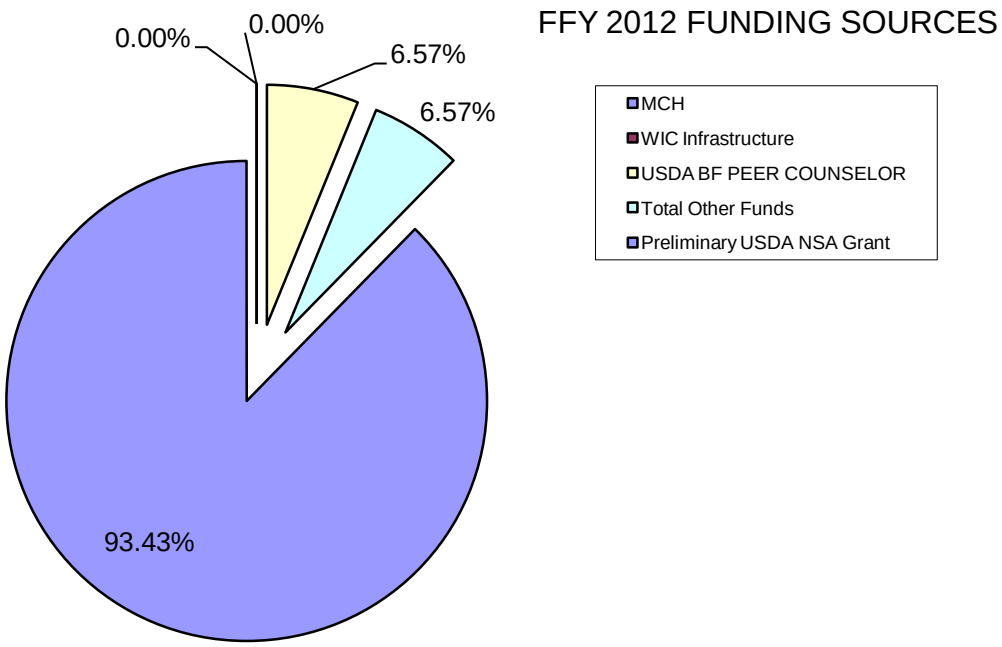


Chart 2. FFY 2012 Preliminary USDA NSA Distribution

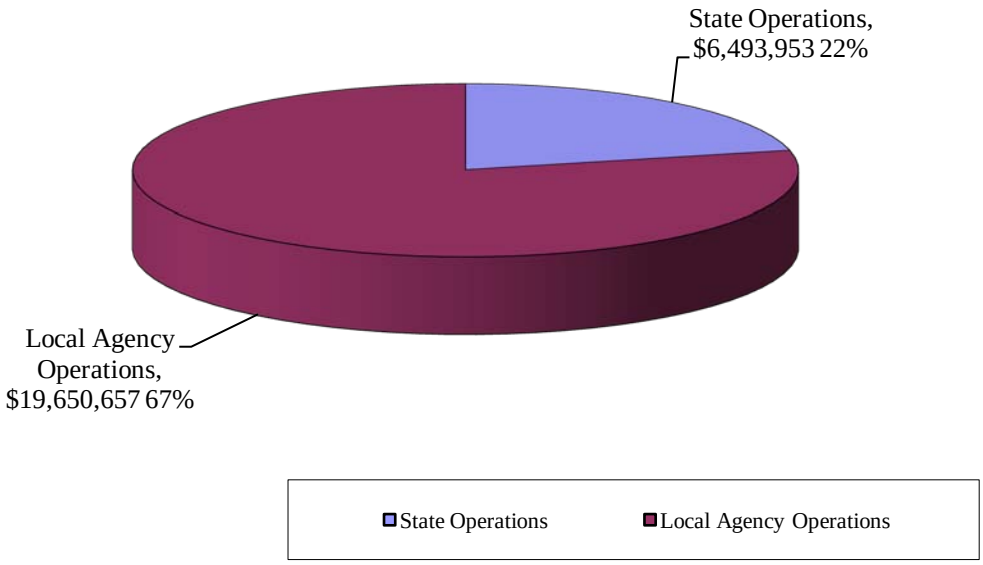
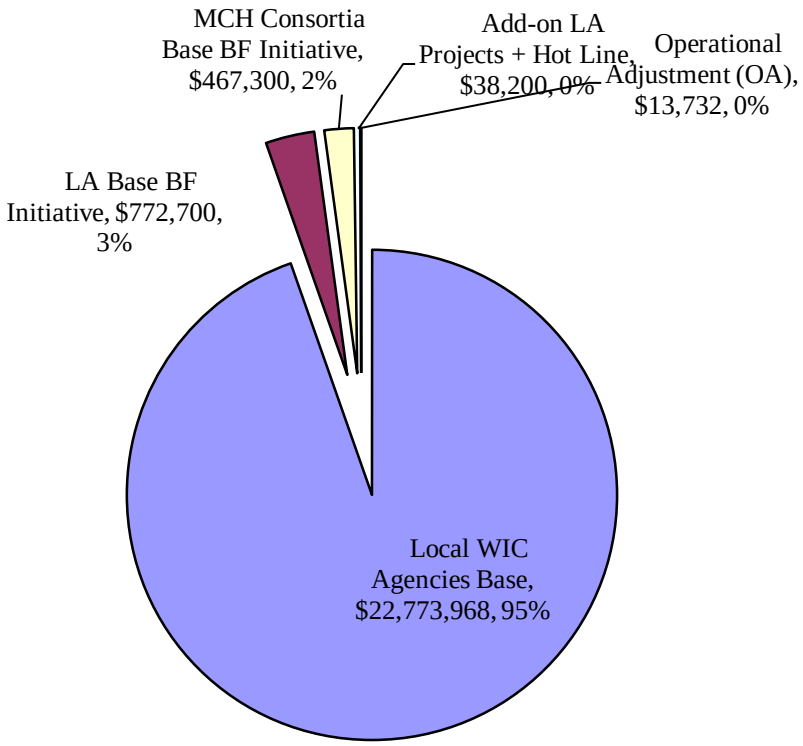


Chart 3. Grantee Preliminary FFY 2012 USDA Funded Activities



3.4 Vendor Analysis

New Jersey WIC Services has full responsibility for selecting vendors and ensuring that authorized WIC vendors provide nutritious authorized WIC foods to WIC participants. WIC participants are issued approximately 4 or 5 checks per month at the programs **17** local agencies. Participants may cash their checks at any of the **850** authorized retail groceries or commissaries that were authorized during the FFY 2009 contract period.

Authorized vendors deposit the checks (which include Food Instruments and Cash-Value Vouchers) daily at a bank of their choice and receive immediate reimbursement. The vendor's bank then routes the redeemed checks to New Jersey WIC Services contract bank. The bank maintains daily files of all check redemptions and transmits the information daily to WIC ACCESS contract vendors who provides one-to-one reconciliation and generates vendor reports.

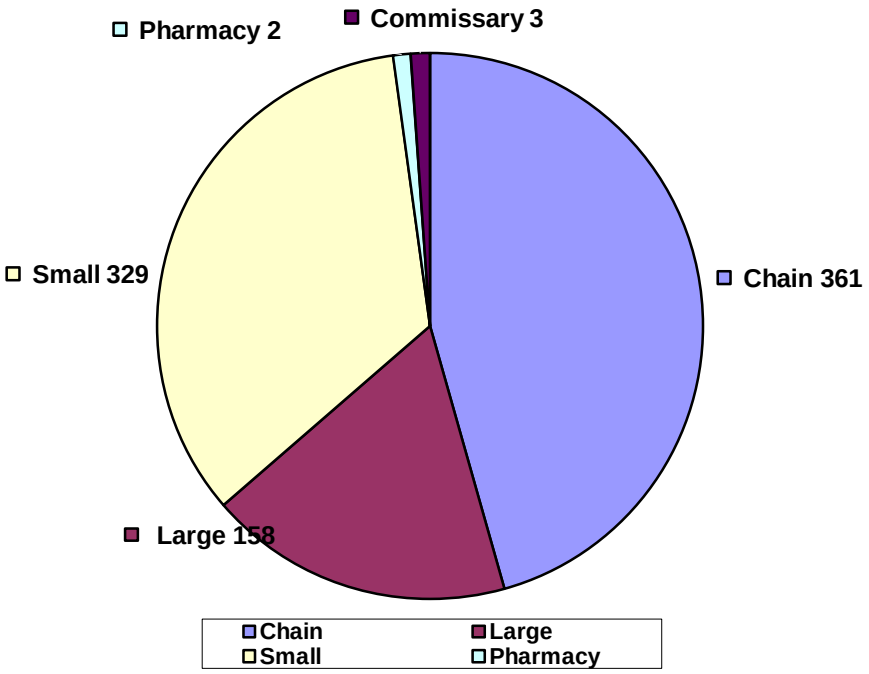
The vendors are categorized into peer groups of similar type with comparable prices. Peer group 1 is chain vendors who are a corporation that own 11 or more stores. Peer group 2 is large independent vendors that have 3 or more registers. Peer group 3 is small independent vendors that have 1-2 registers. Peer group 4 is pharmacies that are authorized to provide only special formulas. Peer group 5 is commissaries, which provide WIC authorized food items only to WIC participants that are affiliated with the military.

New Jersey WIC Services monitors the vendors through computer reports and with onsite visits to ensure compliance with federal and state requirements. Vendor prices are collected quarterly and monitored to prevent overcharging.

The vendor summary for FY 2011 provided the total number of checks and dollar amounts for the checks. The vendors redeemed 7,012,149 checks in the amount of approximately $131,245,739. (Refer to Charts 1 and 2). The State agency does not have above-50-percent vendors participating as authorized vendors.

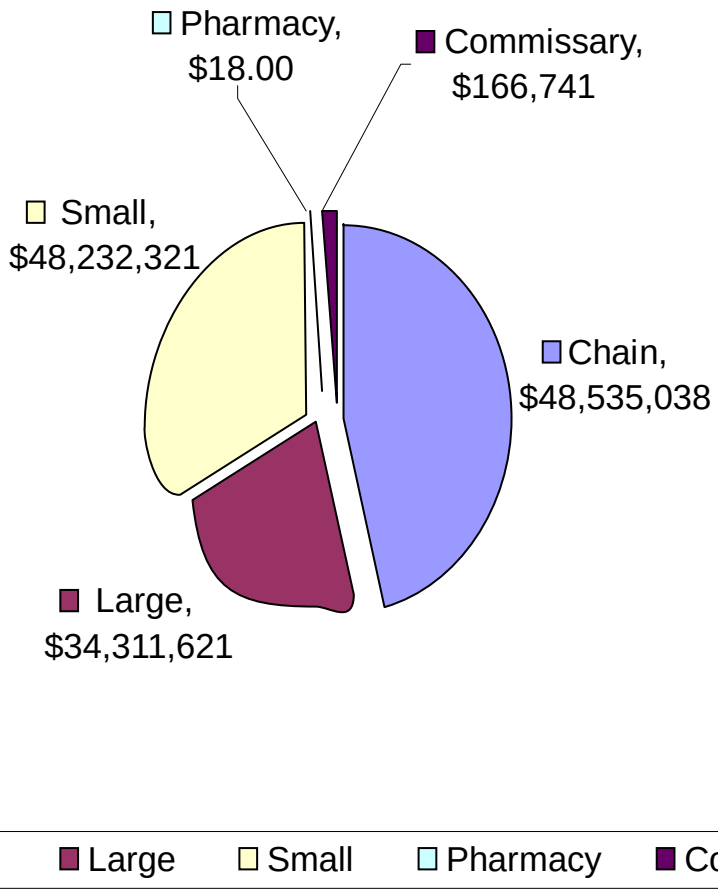
Number of Vendors By Store Type FFY 2011

CHART 1



Vendor Redemptions FFY 2011

Chart 2



4.0 Population Analysis

The data for Population Analysis has been updated for the first time since 2007.

4.1 New Jersey WIC Services Affirmative Action Plan Statistical Methodology

The New Jersey WIC Affirmative Action Plan is based on five criteria variables:

- Infant Death Rate: Infant death rate is the number of infant deaths per 1,000 live births.
- Perinatal Death Rate: Perinatal death rate is the number of fetal and neonatal deaths per 1,000 live births and fetal deaths.
- Low Birthweight Rate: Low birthweight rate is the number of births weighing less than 5-lbs. 8oz. per 1,000 live births.
- Low-Income Rate: Low-income rate is the percentage of persons below 200% of the 1999 poverty level as reported by the 2000 Census of Population
- Births to Teenage Mothers Ratio: Teenage mothers birth ratio is the number of births to mothers under 20 years of age per 1,000 live births.

Data on sixty-nine (69) municipalities and twenty-one counties (21) were obtained for each criterion variable. Municipalities with populations of 30,000 or more persons, based upon the 2000 Census were included in this analysis. County figures are for the entire county or in counties where individual municipalities were included, the balance of the county. Specifically, composite rate for the years 2005, 2006, and 2007, were computed for infant deaths, perinatal deaths, low birth weight infants, and births to teenage mothers. This data was obtained from official New Jersey vital statistics. The low-income data was obtained from the 2000 Census of Population. The vital rates were based on pooled data to increase the stability of the estimates. Furthermore, data from each year weighted the same in the computation of the composite rates.

The five criteria variables were converted to standard scores. That is,

$$\mathbf{Zi = (Xi-X)/S}$$

The rate minus the mean rate divided by the standard deviation of the rate. The purpose of the conversion to standard scores was to have the rates in a common scale with a mean of zero and a variance of one. Such standardization allows one to assign weights to each variable to produce a

composite score for each area that is not influenced by the variance of the individual criterion variable. The composite score is the weighted sum of the five criteria variables:

$$\mathbf{Tj = WIZIj + W2Z2j + W5z5j.}$$

After considerable deliberation, it was decided to assign the greatest weight to low birthweight because this variable was judged more indicative of nutritional risk than any of the other four variables. The low birthweight rate was assigned the weight of 1.00. The weights of the other variables were set equal to their Pearsonian correlation coefficients with low birthweight rate for the municipalities and counties or balance of counties. Specifically, the weights are: infant death rate (0.793), perinatal death rate (0.738), low-income rate (0.814), and births to teenage mothers ratio (0.772).

New Jersey has been successful in distributing WIC services Statewide and generally in proportion to need throughout the State. New Jersey WIC Services will continue to inform non-WIC agencies and the public regarding the availability of program benefits through a variety of communication sources. Media comparisons may include, but are not limited to, public service announcements, information dissemination via posters and flyers, in-service sessions and presentations to health maintenance organizations, and community outreach efforts by local WIC agencies. The Affirmative Action Priority Ranking (unofficial) may be used as a factor in future determinations for program resource allocations, collocation expansions and prioritization of services to women, infants and children.

Refer to Tables 1-5. **An asterisk (*)** denotes a municipality over 30,000 for the first time in the 2000 census.

Table 1 New Jersey WIC Affirmative Action Ranking for FFY 2013

Table 2 Infant Perinatal Data

Table 3 Neonatal and Infant Deaths

Table 4 Birth Data

Table 5 Infant Rates and Birth Ratio Data

Table 1. New Jersey WIC Affirmative Action Ranking For FFY 2013

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK
Camden City	6.622	1
East Orange City	6.424	2
Trenton City	6.174	3
Irvington Town	5.974	4
Newark City	5.854	5
Willingboro Township	5.600	6
Atlantic City	4.973	7
*Orange City	4.751	8
CUMBERLAND COUNTY (Balance)	4.506	9
Pennsauken Township	4.241	10
Paterson City	3.289	11
Ewing Township	3.248	12
Jersey City	3.028	13
SALEM COUNTY (Total)	2.585	14
Perth Amboy City	2.192	15
Vineland City	2.105	16
New Brunswick City	2.048	17
Elizabeth City	1.847	18
Hackensack City	1.629	19
Winslow Township	1.588	20
ATLANTIC COUNTY (Balance)	1.490	21
Linden City	1.443	22
Plainfield City	1.235	23
Hamilton Township	1.114	24
*Galloway Township	0.904	25
Bayonne City	0.742	26
Montclair Town	0.639	27
CAMDEN COUNTY (Balance)	0.601	28
Passaic City	0.415	29
Bloomfield Town	0.282	30
BURLINGTON COUNTY (Balance)	0.232	31
Gloucester Township	0.073	32
*Egg Harbor Township	-0.165	33
CAPE MAY COUNTY (Total)	-0.227	34
Union Township	-0.238	35
GLOUCESTER COUNTY (Balance)	-0.243	36
Cherry Hill Township	-0.247	37
Sayreville Borough	-0.320	38
Union City	-0.409	39
Mt. Laurel Township	-0.423	40
*Long Branch City	-0.491	41

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK
Clifton City	-0.506	42
MONMOUTH COUNTY (Balance)	-0.595	43
Berkeley Township	-0.690	44
Brick Township	-0.722	45
Belleville Town	-0.811	46
*Freehold Township	-0.844	47
MIDDLESEX COUNTY (Balance)	-0.948	48
Piscataway Township	-1.006	49
West Orange Township	-1.006	50
West New York Town	-1.038	51
Manchester Township	-1.057	52
Parsippany-Troy Hills	-1.169	53
WARREN COUNTY (Total)	-1.179	54
Fair Lawn Borough	-1.199	55
Franklin Township	-1.233	56
OCEAN COUNTY (Balance)	-1.272	57
Hoboken City	-1.348	58
Kearny Town	-1.361	59
North Brunswick Township	-1.368	60
ESSEX COUNTY (Balance)	-1.426	61
UNION COUNTY (Balance)	-1.476	62
*South Brunswick Township	-1.585	63
Woodbridge Township	-1.622	64
Edison Township	-1.626	65
Old Bridge Township	-1.643	66
Fort Lee Borough	-1.699	67
SOMERSET COUNTY (Balance)	-1.717	68
PASSAIC COUNTY (Balance)	-1.746	69
Howell Township	-1.756	70
Teaneck Township	-1.827	71
Evesham Township	-1.897	72
SUSSEX COUNTY (Total)	-1.940	73
MERCER COUNTY (Balance)	-1.947	74
Dover Township	-1.963	75
East Brunswick Township	-2.116	76
*Hillsborough Township	-2.167	77

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK
Washington Township	-2.190	78
Jackson Township	-2.199	79
MORRIS COUNTY (Balance)	-2.228	80
HUDSON COUNTY (Balance)	-2.242	81
Wayne Township	-2.317	82
North Bergen Township	-2.485	83
BERGEN COUNTY (Balance)	-2.536	84
*Manalapan Township	-2.884	85
HUNTERDON COUNTY (Total)	-2.897	86
*Marlboro Township	-3.044	87
Middletown Township	-3.391	88
Bridgewater Township	-3.532	89
Lakewood Township	-3.637	90

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK	TOTAL ELIGIBLE WOMEN & CHILDREN	ACTIVE ENROLLEES FIRST QUARTER FFY 2012	PERCENT ELIGIBLES ACTIVE ENROLLEES
Camden City	6.622	1	8,974	**5,859**	65.29%
East Orange City	6.424	2	3,568	**2,995**	83.94%
Trenton City	6.174	3	5,715	**5,767**	100.91%
Irvington Town	5.974	4	3,094	**2,833**	91.56%
Newark City	5.854	5	19,826	**13,810**	69.66%
Willingboro Township	5.600	6	477	**916**	192.03%
Atlantic City	4.973	7	3,299	**2,323**	70.42%
*Orange City	4.751	8	1,837	**1,828**	99.51%
CUMBERLAND COUNTY (Balance)	4.506	9	4,388	**4,261**	97.11%
Pennsauken Township	4.241	10	813	**1,099**	135.18%
Paterson City	3.289	11	11,023	**10,182**	92.37%
Ewing Township	3.248	12	377	**392**	103.98%
Jersey City	3.028	13	10,648	**9,821**	92.23%
SALEM COUNTY (Total)	2.585	14	1,225	**1,353**	110.45%
Perth Amboy City	2.192	15	2,947	**3,583**	121.58%
Vineland City	2.105	16	2,394	**2,500**	104.43%
New Brunswick City	2.048	17	4,663	**4,388**	94.10%
Elizabeth City	1.847	18	7,545	**6,176**	81.86%
Hackensack City	1.629	19	1,295	**1,331**	102.78%
Winslow Township	1.588	20	714	**835**	116.95%
ATLANTIC COUNTY (Balance)	1.490	21	3,787	**3,271**	86.37%
Linden City	1.443	22	790	**759**	96.08%
Plainfield City	1.235	23	2,657	**3,327**	125.22%
Hamilton Township	1.114	24	1,049	**1,032**	98.38%
*Galloway Township	0.904	25	559	**399**	71.38%
Bayonne City	0.742	26	1,476	**1,756**	118.97%
Montclair Town	0.639	27	406	**210**	51.72%
CAMDEN COUNTY (Balance)	0.601	28	3,996	**3,884**	97.20%
Passaic City	0.415	29	6,156	**5,281**	85.79%
Bloomfield Town	0.282	30	822	**792**	96.35%
BURLINGTON COUNTY (Balance)	0.232	31	4,460	**4,643**	104.10%
Gloucester Township	0.073	32	1,039	**534**	51.40%
*Egg Harbor Township	-0.165	33	783	**675**	86.21%
CAPE MAY COUNTY (Total)	-0.227	34	1,855	**1,983**	106.90%
Union Township	-0.238	35	692	**474**	68.50%
GLOUCESTER COUNTY (Balance)	-0.243	36	3,909	**3,901**	99.80%
Cherry Hill Township	-0.247	37	598	**363**	60.70%
Sayreville Borough	-0.320	38	653	**610**	93.42%
Union City	-0.409	39	4,466	**4,282**	95.88%
Mt. Laurel Township	-0.423	40	297	**191**	64.31%
*Long Branch City	-0.491	41	1,622	**1,624**	100.12%

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK	TOTAL ELIGIBLE WOMEN & CHILDREN	ACTIVE ENROLLEES FIRST QUARTER FFY 2012	PERCENT ELIGIBLES ACTIVE ENROLLEES
Clifton City	-0.506	42	1,684	**1,768**	104.99%
MONMOUTH COUNTY (Balance)	-0.595	43	6,188	**6,324**	102.20%
Berkeley Township	-0.690	44	498	**253**	50.80%
Brick Township	-0.722	45	1,010	**615**	60.89%
Belleville Town	-0.811	46	865	**686**	79.31%
*Freehold Township	-0.844	47	238	**32**	13.45%
MIDDLESEX COUNTY (Balance)	-0.948	48	2,816	**2,503**	88.88%
Piscataway Township	-1.006	49	636	**30**	4.72%
West Orange Township	-1.006	50	781	**643**	82.33%
West New York Town	-1.038	51	2,779	**2,911**	104.75%
Manchester Township	-1.057	52	408	**159**	38.97%
Parsippany-Troy Hills	-1.169	53	550	**268**	48.73%
WARREN COUNTY (Total)	-1.179	54	1,543	**1,456**	94.36%
Fair Lawn Borough	-1.199	55	240	**105**	43.75%
Franklin Township	-1.233	56	1,131	**959**	84.79%
OCEAN COUNTY (Balance)	-1.272	57	2,688	**2,201**	81.88%
Hoboken City	-1.348	58	902	**303**	33.59%
Kearny Town	-1.361	59	890	**929**	104.38%
North Brunswick Township	-1.368	60	676	**825**	122.04%
ESSEX COUNTY (Balance)	-1.426	61	1,392	**641**	46.05%
UNION COUNTY (Balance)	-1.476	62	3,086	**2,194**	71.10%
*South Brunswick Township	-1.585	63	364	**235**	64.56%
Woodbridge Township	-1.622	64	1,413	**1,111**	78.63%
Edison Township	-1.626	65	1,419	**1,424**	100.35%
Old Bridge Township	-1.643	66	720	**60**	8.33%
Fort Lee Borough	-1.699	67	476	**121**	25.42%
SOMERSET COUNTY (Balance)	-1.717	68	2,159	**2,313**	107.13%
PASSAIC COUNTY (Balance)	-1.746	69	1,866	**1,370**	73.42%
Howell Township	-1.756	70	578	**296**	51.21%
Teaneck Township	-1.827	71	404	**384**	95.05%
Evesham Township	-1.897	72	336	**210**	62.50%
SUSSEX COUNTY (Total)	-1.940	73	1,503	**1,072**	71.32%
MERCER COUNTY (Balance)	-1.947	74	1,524	**921**	60.43%
Toms River Township	-1.963	75	1,302	**1,284**	98.62%
East Brunswick Township	-2.116	76	287	**433**	150.87%
*Hillsborough Township	-2.167	77	266	**211**	79.32%

AREA	WEIGHTED TOTAL SCORE 2005-2007	RANK	TOTAL ELIGIBLE WOMEN & CHILDREN	ACTIVE ENROLLEES FIRST QUARTER FFY 2012	PERCENT ELIGIBLES ACTIVE ENROLLEES
Washington Township	-2.190	78	351	**140**	39.89%
Jackson Township	-2.199	79	541	**424**	78.37%
MORRIS COUNTY (Balance)	-2.228	80	4,141	**2,797**	67.54%
HUDSON COUNTY (Balance)	-2.242	81	1,391	**1,414**	101.65%
Wayne Township	-2.317	82	296	**179**	60.47%
North Bergen Township	-2.485	83	1,978	**2,002**	101.21%
BERGEN COUNTY (Balance)	-2.536	84	8,385	**5,943**	70.88%
*Manalapan Township	-2.884	85	239	**83**	34.73%
HUNTERDON COUNTY (Total)	-2.897	86	875	**522**	59.66%
*Marlboro Township	-3.044	87	219	**50**	22.83%
Middletown Township	-3.391	88	518	**251**	48.46%
Bridgewater Township	-3.532	89	296	**141**	47.64%
Lakewood Township	-3.637	90	9,938	**14,131**	142.19%
TOTAL			211,680	**187,570**	88.61%

Table 2. Infant Perinatal Data

AREA	CENSUS POPULATION 2000	LIVE BIRTHS 2007	2006	2005	FETAL DEATHS 2007	2006	2005
Atlantic City	40,517	819	793	759	9	14	10
*Egg Harbor Township	30,726	515	527	583	1	3	3
*Galloway Township	31,209	343	389	370	2	1	2
ATLANTIC COUNTY (Balance)	150,100	1,880	1,866	1,835	19	10	15
Fair Lawn Borough	31,637	295	308	278	3	2	3
Fort Lee Borough	35,461	305	324	289	2	1	0
Hackensack City	42,677	654	613	640	7	9	5
Teaneck Township	39,260	434	417	468	6	5	3
BERGEN COUNTY (Balance)	735,083	7,533	7,406	7,420	45	41	35
Evesham Township	42,275	517	474	491	6	2	3
Mt. Laurel Township	40,221	418	414	428	0	1	1
Willingboro Township	33,008	397	372	363	3	5	4
BURLINGTON COUNTY (Balance)	307,890	3,598	3,622	3,606	36	32	22
Camden City	79,904	1,831	1,707	1,677	17	17	13
Cherry Hill Township	69,965	647	659	609	0	1	3
Gloucester Township	64,350	773	772	769	6	2	5
Pennsauken Township	35,737	481	461	499	5	9	1
Winslow Township	34,611	551	594	514	4	4	7
CAMDEN COUNTY (Balance)	224,365	2,667	2,608	2,695	17	18	16
CAPE MAY COUNTY (Total)	102,326	947	892	922	6	8	3
Vineland City	56,271	902	843	925	6	6	5
CUMBERLAND COUNTY (Balance)	90,167	1,603	1,503	1,495	20	9	14
Belleville Town	35,928	498	475	487	0	6	2
Bloomfield Town	47,683	666	626	609	5	0	4
East Orange City	69,824	1,059	1,040	1,008	21	14	11
Irvington Town	60,695	1,044	971	1,058	22	15	20
Montclair Town	38,977	366	347	370	3	4	2
Newark City	273,546	4,779	4,851	4,537	75	80	59
*Orange City	32,868	574	568	545	5	8	15
West Orange Township	44,943	602	641	598	3	5	3
ESSEX COUNTY (Balance)	189,169	1,914	1,945	1,908	6	13	9

AREA	CENSUS POPULATION 2000	LIVE BIRTHS 2007	2006	2005	FETAL DEATHS 2007	2006	2005
Washington Township	47,114	425	435	464	2	2	2
GLOUCESTER COUNTY (Balance)	207,559	2,676	2,696	2,498	11	14	17
Bayonne City	61,842	695	709	722	6	4	7
Hoboken City	38,577	526	452	413	5	3	3
Jersey City	240,055	3,427	3,361	3,285	27	40	24
Kearny Town	40,513	463	465	485	1	2	1
North Bergen Township	58,092	745	801	747	4	3	4
Union City	67,088	1,037	1,102	1,089	7	8	8
West New York Town	45,768	747	709	692	5	3	7
HUDSON COUNTY (Balance)	57,040	609	649	595	1	3	4
HUNTERDON COUNTY (Total)	121,989	1,133	1,243	1,293	6	2	3
Ewing Township	35,707	352	344	303	2	3	4
Hamilton Township	87,109	924	979	913	9	8	4
Trenton City	85,403	1,606	1,547	1,467	17	12	16
MERCER COUNTY (Balance)	142,542	1,720	1,646	1,742	11	13	7
East Brunswick Township	46,756	377	428	373	1	2	1
Edison Township	97,687	1,379	1,350	1,333	10	7	5
New Brunswick City	48,573	1,123	1,106	1,052	7	6	4
North Brunswick Township	36,287	637	644	553	2	5	2
Old Bridge Township	60,456	747	708	705	5	1	1
Perth Amboy City	47,303	883	855	896	4	8	3
Piscataway Township	50,482	748	636	672	3	1	7
Sayreville Borough	40,377	597	594	555	5	2	1
*South Brunswick Township	37,734	485	488	498	1	4	1
Woodbridge Township	97,203	1,241	1,281	1,193	8	7	5
MIDDLESEX COUNTY (Balance)	187,304	2,432	2,390	2,357	10	13	16
*Freehold Township	31,537	330	317	320	2	5	0
Howell Township	48,903	589	574	570	1	2	9
*Long Branch City	31,340	514	574	524	6	9	2
*Manalapan Township	33,423	319	280	335	1	1	0
*Marlboro Township	36,398	306	341	365	2	0	1
Middletown Township	66,327	686	695	705	5	1	2
MONMOUTH COUNTY (Balance)	367,373	4,158	4,334	4,405	29	33	29

	CENSUS POPULATION	LIVE BIRTHS			FETAL DEATHS		
AREA	**2000**	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Parsippany-Troy Hills	50,649	628	631	652	4	3	7
MORRIS COUNTY (Balance)	419,563	4,762	5,025	5,022	23	18	29
Berkeley Township	39,991	306	279	293	2	4	2
Brick Township	76,119	792	736	783	5	2	4
Toms River Township	89,706	990	951	953	2	7	6
Jackson Township	42,816	556	589	615	5	2	3
Lakewood Township	60,352	3,237	2,934	2,839	11	13	11
Manchester Township	38,928	233	218	221	0	1	1
OCEAN COUNTY (Balance)	163,004	1,838	1,799	1,834	14	10	8
Clifton City	78,672	1,181	1,068	1,027	4	7	9
Passaic City	67,861	1,602	1,467	1,565	7	6	7
Paterson City	149,222	2,834	2,806	2,725	27	19	14
Wayne Township	54,069	452	461	473	4	3	3
PASSAIC COUNTY (Balance)	139,225	1,663	1,657	1,709	8	14	8
SALEM COUNTY (Total)	64,285	627	646	634	5	9	6
Bridgewater Township	42,940	472	442	525	2	2	1
Franklin Township	36,634	1,008	954	905	8	2	6
*Hillsborough Township	50,903	395	428	460	3	2	0
SOMERSET COUNTY (Balance)	167,013	2,133	2,136	2,227	17	7	9
SUSSEX COUNTY (Total)	144,166	1,501	1,618	1,556	7	7	10
Elizabeth City	120,568	2,299	2,218	2,101	22	17	14
Linden City	39,394	483	454	421	4	5	5
Plainfield City	47,829	929	975	935	10	4	4
Union Township	54,405	634	575	578	2	6	3
UNION COUNTY (Balance)	260,345	3,098	3,196	3,151	18	15	17
WARREN COUNTY (Total)	102,437	1,143	1,221	1,180	5	8	8
	8,414,350	110,044	109,245	108,258	793	765	693

Table 3. Neonatal and Infant Deaths

	NEONATAL DEATHS			INFANT DEATHS		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Atlantic City	5	4	3	6	5	6
*Egg Harbor Township	6	6	0	6	7	1
*Galloway Township	5	1	1	5	3	2
ATLANTIC COUNTY (Balance)	10	14	14	14	16	15
Fair Lawn Borough	1	0	1	1	0	1
Fort Lee Borough	2	2	2	3	2	3
Hackensack City	2	5	4	3	6	5
Teaneck Township	0	1	1	0	1	1
BERGEN COUNTY (Balance)	13	17	6	24	21	13
Evesham Township	1	1	2	1	1	4
Mt. Laurel Township	1	3	2	1	4	2
Willingboro Township	4	3	3	5	3	5
BURLINGTON COUNTY (Balance)	15	20	13	19	28	17
Camden City	14	16	18	20	21	29
Cherry Hill Township	5	3	3	5	6	5
Gloucester Township	0	4	4	1	5	4
Pennsauken Township	3	5	4	5	6	5
Winslow Township	1	4	4	2	5	5
CAMDEN COUNTY (Balance)	15	11	18	20	18	23
CAPE MAY COUNTY (Total)	4	6	3	6	7	4
Vineland City	9	1	5	12	1	5
CUMBERLAND COUNTY (Balance)	13	9	13	16	13	18
Belleville Town	1	1	2	1	0	1
Bloomfield Town	3	5	2	6	6	2
East Orange City	6	3	7	9	7	11
Irvington Town	2	4	2	9	9	10
Montclair Town	2	2	2	2	3	3
Newark City	27	14	19	49	25	34
*Orange City	5	3	2	5	6	6
West Orange Township	0	2	1	1	3	2
ESSEX COUNTY (Balance)	3	7	2	7	10	4

	NEONATAL DEATHS			INFANT DEATHS		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Washington Township	2	0	1	2	1	1
GLOUCESTER COUNTY (Balance)	7	10	17	12	14	22
Bayonne City	2	4	1	3	8	3
Hoboken City	3	0	2	3	0	2
Jersey City	13	17	17	20	32	30
Kearny Town	0	1	2	0	2	3
North Bergen Township	0	0	2	0	0	5
Union City	5	3	1	7	3	6
West New York Town	6	1	2	6	1	2
HUDSON COUNTY (Balance)	0	0	1	0	0	2
HUNTERDON COUNTY (Total)	3	4	3	3	4	4
Ewing Township	1	6	3	2	6	4
Hamilton Township	6	7	7	9	8	7
Trenton City	12	13	12	18	19	17
MERCER COUNTY (Balance)	4	4	4	6	6	6
East Brunswick Township	1	0	0	1	0	1
Edison Township	2	2	3	2	3	3
New Brunswick City	8	9	3	8	14	5
North Brunswick Township	3	0	2	3	0	3
Old Bridge Township	0	2	5	0	2	6
Perth Amboy City	2	9	8	7	10	9
Piscataway Township	2	2	1	3	2	2
Sayreville Borough	3	5	3	4	8	5
*South Brunswick Township	0	2	2	1	2	3
Woodbridge Township	2	0	5	2	2	7
MIDDLESEX COUNTY (Balance)	8	8	6	10	11	10
*Freehold Township	0	1	1	0	1	3
Howell Township	3	0	1	4	2	2
*Long Branch City	1	1	0	2	2	2
*Manalapan Township	0	1	0	0	1	0
*Marlboro Township	0	1	0	0	1	1
Middletown Township	0	0	1	1	1	3
MONMOUTH COUNTY (Balance)	8	22	18	17	27	24

	NEONATAL DEATHS			INFANT DEATHS		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Parsippany-Troy Hills	0	6	2	2	6	2
MORRIS COUNTY (Balance)	14	7	14	20	10	16
Berkeley Township	1	2	0	2	2	1
Brick Township	4	4	1	4	6	2
Toms River Township	1	4	2	3	4	3
Jackson Township	1	0	2	1	1	4
Lakewood Township	7	5	1	13	8	7
Manchester Township	1	0	0	1	1	0
OCEAN COUNTY (Balance)	5	9	5	9	9	10
Clifton City	3	4	2	9	5	3
Passaic City	3	6	8	5	9	9
Paterson City	9	14	5	20	21	13
Wayne Township	0	3	1	0	3	1
PASSAIC COUNTY (Balance)	2	3	5	4	5	8
SALEM COUNTY (Total)	5	6	2	9	8	6
Bridgewater Township	0	0	0	0	1	0
Franklin Township	1	3	2	2	6	2
*Hillsborough Township	0	0	1	1	1	2
SOMERSET COUNTY (Balance)	5	6	2	7	8	4
SUSSEX COUNTY (Total)	3	4	3	4	7	5
Elizabeth City	8	10	11	13	13	13
Linden City	6	0	2	7	1	2
Plainfield City	2	2	3	2	4	6
Union Township	2	5	2	2	6	2
UNION COUNTY (Balance)	14	10	13	21	13	17
WARREN COUNTY (Total)	6	4	2	9	5	3
	388	429	388	590	604	590

Table 4. Birth Data

	LOW BIRTH WEIGHT			BIRTHS TO TEENS (UNDER 20 YEARS)		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Atlantic City	88	86	79	127	127	123
*Egg Harbor Township	50	32	31	40	33	38
*Galloway Township	31	34	30	13	24	24
ATLANTIC COUNTY (Balance)	166	156	147	187	185	166
Fair Lawn Borough	21	20	30	2	0	3
Fort Lee Borough	28	13	17	2	1	3
Hackensack City	54	63	57	31	28	46
Teaneck Township	41	34	26	6	8	10
BERGEN COUNTY (Balance)	529	536	497	172	141	170
Evesham Township	35	36	32	8	11	7
Mt. Laurel Township	35	41	49	3	15	10
Willingboro Township	59	41	42	48	42	42
BURLINGTON COUNTY (Balance)	301	313	280	199	210	227
Camden City	208	175	153	413	397	386
Cherry Hill Township	72	49	48	27	15	9
Gloucester Township	78	65	71	43	59	40
Pennsauken Township	53	49	51	50	67	64
Winslow Township	46	62	47	39	47	25
CAMDEN COUNTY (Balance)	206	228	232	174	155	178
CAPE MAY COUNTY (Total)	69	54	68	88	89	79
Vineland City	78	79	80	143	127	130
CUMBERLAND COUNTY (Balance)	170	169	132	263	239	282
Belleville Town	39	48	41	23	33	15
Bloomfield Town	48	56	56	19	22	22
East Orange City	128	154	122	140	135	131
Irvington Town	122	115	140	91	114	103
Montclair Town	37	30	29	15	15	6
Newark City	556	607	540	710	675	601
*Orange City	71	57	49	46	39	49
West Orange Township	58	47	51	16	23	15
ESSEX COUNTY (Balance)	171	174	147	19	13	13

	LOW BIRTH WEIGHT			BIRTHS TO TEENS (UNDER 20 YEARS)		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Washington Township	24	32	39	23	19	18
GLOUCESTER COUNTY (Balance)	208	217	206	161	171	145
Bayonne City	65	67	58	53	48	31
Hoboken City	34	33	33	21	11	17
Jersey City	352	342	316	354	354	353
Kearny Town	38	45	30	31	22	29
North Bergen Township	45	47	44	50	56	41
Union City	76	78	46	107	125	115
West New York Town	47	30	41	66	66	60
HUDSON COUNTY (Balance)	51	40	46	27	35	37
HUNTERDON COUNTY (Total)	86	83	85	16	15	13
Ewing Township	38	35	27	12	19	16
Hamilton Township	76	90	82	49	53	45
Trenton City	165	182	179	300	264	255
MERCER COUNTY (Balance)	115	139	132	36	34	33
East Brunswick Township	29	39	36	3	8	6
Edison Township	123	129	97	26	27	25
New Brunswick City	80	109	92	113	140	155
North Brunswick Township	42	65	44	17	25	17
Old Bridge Township	56	51	62	17	15	16
Perth Amboy City	67	79	72	124	108	124
Piscataway Township	63	61	59	15	13	19
Sayreville Borough	48	42	42	11	13	8
*South Brunswick Township	35	54	34	6	7	7
Woodbridge Township	96	95	112	36	25	38
MIDDLESEX COUNTY (Balance)	209	210	183	81	66	71
*Freehold Township	23	36	28	8	2	6
Howell Township	48	35	43	9	17	13
*Long Branch City	32	42	34	47	68	48
*Manalapan Township	21	22	32	4	3	3
*Marlboro Township	18	27	32	1	0	1
Middletown Township	48	50	38	9	12	14
MONMOUTH COUNTY (Balance)	299	382	315	232	247	228

	LOW BIRTH WEIGHT			BIRTHS TO TEENS (UNDER 20 YEARS)		
AREA	**2007**	**2006**	**2005**	**2007**	**2006**	**2005**
Parsippany-Troy Hills	47	53	47	7	5	9
MORRIS COUNTY (Balance)	381	336	362	102	102	103
Berkeley Township	21	18	25	16	17	17
Brick Township	73	57	58	26	19	30
Toms River Township	70	73	58	50	42	42
Jackson Township	44	45	41	18	15	12
Lakewood Township	143	109	121	132	147	144
Manchester Township	31	12	13	9	15	7
OCEAN COUNTY (Balance)	130	121	125	98	99	104
Clifton City	100	87	86	67	53	51
Passaic City	138	108	119	196	173	184
Paterson City	318	306	276	404	401	391
Wayne Township	34	28	36	3	2	6
PASSAIC COUNTY (Balance)	132	114	135	53	48	40
SALEM COUNTY (Total)	55	51	40	84	70	79
Bridgewater Township	36	39	25	7	6	5
Franklin Township	67	86	86	48	38	28
*Hillsborough Township	35	35	36	7	9	7
SOMERSET COUNTY (Balance)	158	183	178	70	60	70
SUSSEX COUNTY (Total)	121	118	103	49	59	34
Elizabeth City	195	174	221	261	234	215
Linden City	47	32	39	39	26	20
Plainfield City	86	72	105	91	120	105
Union Township	50	54	48	14	33	18
UNION COUNTY (Balance)	220	229	230	111	94	87
WARREN COUNTY (Total)	86	93	85	65	55	45
	9,223	9,244	8,791	7,249	7,119	6,877

Table 5. Infant Rates and Birth Ratio Data

AREA	LOW BIRTH WEIGHT RATE 2005-2007	INFANT DEATH RATE 2005-2007	PERINATAL DEATH RATE 2005-2007	TEEN BIRTH RATIO 2005-2007	1999 200% POVERTY RATE
Atlantic City	106.7	7.2	23.2	159.0	**49.9%**
*Egg Harbor Township	69.5	8.6	13.5	68.3	**18.0%**
*Galloway Township	86.2	9.1	13.5	55.4	**18.8%**
ATLANTIC COUNTY (Balance)	84.0	8.1	16.2	96.4	**24.7%**
Fair Lawn Borough	80.6	2.3	15.7	5.7	**9.8%**
Fort Lee Borough	63.2	8.7	9.8	6.5	**18.6%**
Hackensack City	91.2	7.3	18.1	55.1	**24.2%**
Teaneck Township	76.6	1.5	12.7	18.2	**10.9%**
BERGEN COUNTY (Balance)	69.9	2.6	8.5	21.6	**13.1%**
Evesham Township	69.5	4.0	12.7	17.5	**8.0%**
Mt. Laurel Township	99.2	5.6	6.3	22.2	**8.5%**
Willingboro Township	125.4	11.5	21.8	116.6	**15.2%**
BURLINGTON COUNTY (Balance)	82.6	5.9	15.2	58.7	**14.7%**
Camden City	102.8	13.4	20.8	229.3	**62.4%**
Cherry Hill Township	88.3	8.4	8.3	26.6	**11.4%**
Gloucester Township	92.5	4.3	10.7	61.4	**16.4%**
Pennsauken Township	106.2	11.1	19.9	125.6	**21.1%**
Winslow Township	93.4	7.2	17.3	66.9	**16.1%**
CAMDEN COUNTY (Balance)	83.6	7.7	13.9	63.6	**18.5%**
CAPE MAY COUNTY (Total)	69.2	6.2	13.6	92.7	**24.1%**
Vineland City	88.8	6.7	14.5	149.8	**33.3%**
CUMBERLAND COUNTY (Balance)	102.4	10.2	18.9	170.4	**35.7%**
Belleville Town	87.7	1.4	10.9	48.6	**21.1%**
Bloomfield Town	84.2	7.4	14.6	33.1	**15.8%**
East Orange City	130.0	8.7	24.3	130.7	**40.5%**
Irvington Town	122.7	9.1	27.3	100.2	**35.8%**
Montclair Town	88.6	7.4	15.5	33.2	**12.8%**
Newark City	120.2	7.6	23.9	140.2	**38.8%**
*Orange City	104.9	10.1	26.7	79.4	**50.4%**
West Orange Township	84.7	3.3	10.8	29.3	**15.1%**
ESSEX COUNTY (Balance)	85.3	3.6	9.6	7.8	**8.4%**

AREA	LOW BIRTH WEIGHT RATE 2005-2007	INFANT DEATH RATE 2005-2007	PERINATAL DEATH RATE 2005-2007	TEEN BIRTH RATIO 2005-2007	1999 200% POVERTY RATE
Washington Township	71.8	3.0	8.3	45.3	**9.3%**
GLOUCESTER COUNTY (Balance)	80.2	6.1	11.7	60.6	**18.1%**
Bayonne City	89.4	6.6	12.6	62.1	**25.3%**
Hoboken City	71.9	3.6	12.1	35.2	**24.1%**
Jersey City	100.3	8.1	16.6	105.3	**38.2%**
Kearny Town	80.0	3.5	6.3	58.0	**22.8%**
North Bergen Township	59.3	2.2	8.2	64.1	**30.9%**
Union City	62.0	5.0	12.0	107.5	**49.8%**
West New York Town	54.9	4.2	13.8	89.4	**46.7%**
HUDSON COUNTY (Balance)	73.9	1.1	5.9	53.4	**26.6%**
HUNTERDON COUNTY (Total)	69.2	3.0	7.1	12.0	**8.4%**
Ewing Township	100.1	12.0	21.8	47.0	**14.0%**
Hamilton Township	88.1	8.5	16.2	52.2	**13.3%**
Trenton City	113.9	11.7	21.6	177.3	**45.3%**
MERCER COUNTY (Balance)	75.6	3.5	9.3	20.2	**10.6%**
East Brunswick Township	88.3	1.7	5.1	14.4	**8.5%**
Edison Township	85.9	2.0	8.6	19.2	**12.5%**
New Brunswick City	85.6	8.2	12.4	124.4	**51.7%**
North Brunswick Township	82.3	3.3	9.2	32.2	**13.6%**
Old Bridge Township	78.2	3.7	9.7	22.2	**11.9%**
Perth Amboy City	82.8	9.9	13.6	135.2	**40.9%**
Piscataway Township	89.0	3.4	9.7	22.9	**10.9%**
Sayreville Borough	75.6	9.7	12.5	18.3	**13.4%**
*South Brunswick Township	83.6	4.1	8.1	13.6	**8.7%**
Woodbridge Township	81.6	3.0	8.6	26.6	**13.6%**
MIDDLESEX COUNTY (Balance)	83.9	4.3	10.2	30.4	**14.0%**
*Freehold Township	90.0	4.1	10.3	16.5	**8.7%**
Howell Township	72.7	4.6	10.3	22.5	**11.6%**
*Long Branch City	67.0	3.7	13.5	101.1	**36.0%**
*Manalapan Township	80.3	1.1	4.3	10.7	**9.4%**
*Marlboro Township	76.1	2.0	4.9	2.0	**7.5%**
Middletown Township	65.2	2.4	5.7	16.8	**8.7%**
MONMOUTH COUNTY (Balance)	77.2	5.3	12.4	54.8	**17.0%**

AREA	LOW BIRTH WEIGHT RATE 2005-2007	INFANT DEATH RATE 2005-2007	PERINATAL DEATH RATE 2005-2007	TEEN BIRTH RATIO 2005-2007	1999 200% POVERTY RATE
Parsippany-Troy Hills	76.9	5.2	13.0	11.0	**10.3%**
MORRIS COUNTY (Balance)	72.9	3.1	9.3	20.7	**9.7%**
Berkeley Township	72.9	5.7	12.4	56.9	**20.7%**
Brick Township	81.4	5.2	11.6	32.5	**15.2%**
Toms River Township	69.5	3.5	9.3	46.3	**16.2%**
Jackson Township	73.9	3.4	7.9	25.6	**11.0%**
Lakewood Township	41.4	3.1	6.7	46.9	**41.3%**
Manchester Township	83.3	3.0	8.9	46.1	**22.3%**
OCEAN COUNTY (Balance)	68.7	5.1	11.6	55.0	**17.5%**
Clifton City	83.3	5.2	10.0	52.2	**18.8%**
Passaic City	78.8	5.0	9.0	119.3	**48.6%**
Paterson City	107.6	6.5	12.7	143.0	**47.0%**
Wayne Township	70.7	2.9	11.4	7.9	**7.3%**
PASSAIC COUNTY (Balance)	75.8	3.4	9.9	28.0	**13.3%**
SALEM COUNTY (Total)	76.6	12.1	20.7	122.2	**23.3%**
Bridgewater Township	69.5	0.7	5.5	12.5	**7.2%**
Franklin Township	83.4	3.5	8.7	39.8	**14.3%**
*Hillsborough Township	82.6	3.1	5.4	17.9	**7.2%**
SOMERSET COUNTY (Balance)	79.9	2.9	8.7	30.8	**11.6%**
SUSSEX COUNTY (Total)	73.2	3.4	9.8	30.4	**11.4%**
Elizabeth City	89.2	5.9	15.7	107.3	**41.2%**
Linden City	86.9	7.4	18.9	62.6	**20.4%**
Plainfield City	92.6	4.2	12.6	111.3	**33.9%**
Union Township	85.1	5.6	12.8	36.4	**13.8%**
UNION COUNTY (Balance)	71.9	5.4	11.0	30.9	**11.6%**
WARREN COUNTY (Total)	74.5	4.8	10.9	46.6	**15.4%**

4.2 Estimated Eligible WIC Participants Methodology for FFY 2013

The estimated total number of woman and children in New Jersey eligible for WIC participation as of January 1, 2013, was 211,680. Refer to Tables 6-8. This figure includes 169,054 children less than 5 years of age and 42,626 women. Estimates were made for 69 municipalities and 21 counties, or the balance of counties in which municipalities were separately estimated. Municipalities with a population of 30,000 or more according to the 2000 Census of Population were selected for estimation.

These estimates were computed by the following procedures:

- The number of children under 5 years of age equals the sum of the number of live births for the years 2003-2007 minus the sum of the number of infant deaths for the same years. This was done for each area shown in the table.
- The estimated number of pregnant and postpartum women is the sum of the estimated number of pregnant women, which is 75% of the live births in 2007, and the estimated number of postpartum women, which is 50% of the number of live births and fetal deaths in 2006.

The low-income rates in the Table 6 are derived from the percentage of all people in the area below 200% of the 1999 poverty level, based on the 2000 Census of Population. The estimated number of WIC eligible children was calculated in two stages:

1. The number of children under 5 years of age was multiplied by the low-income rate; and
2. The figure obtained in stage one was adjusted to the State total.

The adjustment factor was the ratio of the sum of eligibles over all areas in stage one to the State total obtained by multiplying by 31%. For 2007, this ratio was 1.343621813. For example, the estimated WIC eligible children for Atlantic City equal:

Stage 1: 3,920 x 0.499 = 1,956

Stage 2: 1,956 x 1.343621813 = 2,628

Similarly, the estimated WIC eligible women were also done in two stages:

1. The number of pregnant and postpartum women was multiplied by the low income rate for all persons; and
2. The figure obtained in stage one was adjusted to the State total by multiplying by an adjustment factor.

The total number of WIC eligible women for Atlantic City equal:

Stage 1: 1,016 x 0.499 = 507

Stage 2: 507 x 1.324439258 = 671

The total number of WIC eligible women and children is the number of eligible children plus the number of eligible women. In Atlantic City, for example: 2,628 + 671 = 3,299.

The estimated eligible infants were determined by taking the number of live births for the year 2007 minus the number of infant deaths for 2007. The estimated eligible infants were calculated in the same manner as was children and women. The two stages are:

1. The number of infants was multiplied by the low income rate for all persons; and
2. The figure obtained in stage one was adjusted to the State total by multiplying by an adjustment factor.

The adjustment factor was the ratio of the sum of eligible infants over all areas from stage one to the State total obtained by multiplying the State total estimate of infants by 31%. The ratio was 1.321511 in 2007.

For example, the estimated WIC eligible infants for Atlantic City equal:

Stage 1: 813 x 0.499 = 406

Stage 2: 406 x 1.321511 = 536

List of Tables:

Table 6. Estimated Number of Women, Infants and Children Eligible for WIC Services

AREA	CHILDREN UNDER 5 YEARS OLD	ESTIMATED ELIGIBLE CHILDREN	ESTIMATED ELIGIBLE INFANTS	PREGNANT & POSTPARTUM WOMEN	ESTIMATED ELIGIBLE WOMEN	TOTAL ESTIMATED ELIGIBLE WOMEN & CHILDREN	1999 200% POVERTY RATE
Atlantic City	3,920	2,628	536	1,016	671	3,299	49.9%
*Egg Harbor Township	2,596	628	121	651	155	783	18.0%
*Galloway Township	1,767	446	84	453	113	559	18.8%
ATLANTIC COUNTY (Balance)	9,093	3,018	609	2,351	769	3,787	24.7%
Fair Lawn Borough	1,450	191	38	377	49	240	9.8%
Fort Lee Borough	1,520	380	74	391	96	476	18.6%
Hackensack City	3,196	1,039	208	800	256	1,295	24.2%
Teaneck Township	2,236	327	63	536	77	404	10.9%
BERGEN COUNTY (Balance)	38,403	6,759	1,300	9,370	1,626	8,385	13.1%
Evesham Township	2,515	270	55	626	66	336	8.0%
Mt. Laurel Township	2,087	238	47	521	59	297	8.5%
Willingboro Township	1,855	379	79	486	98	477	15.2%
BURLINGTON COUNTY (Balance)	18,127	3,580	695	4,521	880	4,460	14.7%
Camden City	8,503	7,129	1,493	2,233	1,845	8,974	62.4%
Cherry Hill Township	3,099	475	97	816	123	598	11.4%
Gloucester Township	3,763	829	167	968	210	1,039	16.4%
Pennsauken Township	2,285	648	133	592	165	813	21.1%
Winslow Township	2,599	562	117	714	152	714	16.1%
CAMDEN COUNTY (Balance)	12,808	3,184	647	3,312	812	3,996	18.5%
CAPE MAY COUNTY (Total)	4,586	1,485	300	1,158	370	1,855	24.1%
Vineland City	4,265	1,908	392	1,101	486	2,394	33.3%
CUMBERLAND COUNTY (Balance)	7,216	3,461	749	1,961	927	4,388	35.7%

AREA	CHILDREN UNDER 5 YEARS OLD	ESTIMATED ELIGIBLE CHILDREN	ESTIMATED ELIGIBLE INFANTS	PREGNANT & POSTPARTUM WOMEN	ESTIMATED ELIGIBLE WOMEN	TOTAL ESTIMATED ELIGIBLE WOMEN & CHILDREN	1999 200% POVERTY RATE
Belleville Town	2,447	694	139	612	171	865	21.1%
Bloomfield Town	3,067	651	138	815	171	822	15.8%
East Orange City	5,255	2,860	562	1,320	708	3,568	40.5%
Irvington Town	5,172	2,488	490	1,279	606	3,094	35.8%
Montclair Town	1,918	330	62	449	76	406	12.8%
Newark City	23,324	15,795	3,150	6,039	4,031	19,826	38.8%
*Orange City	2,813	1,466	292	722	371	1,837	50.4%
West Orange Township	3,086	626	120	774	155	781	15.1%
ESSEX COUNTY (Balance)	9,959	1,124	212	2,413	268	1,392	8.4%
Washington Township	2,278	285	52	537	66	351	9.3%
GLOUCESTER COUNTY (Balance)	12,758	3,103	637	3,364	806	3,909	18.1%
Bayonne City	3,475	1,181	231	879	295	1,476	25.3%
Hoboken City	2,171	703	167	622	199	902	24.1%
Jersey City	16,544	8,491	1,720	4,263	2,157	10,648	38.2%
Kearny Town	2,333	715	140	580	175	890	22.8%
North Bergen Township	3,818	1,585	304	961	393	1,978	30.9%
Union City	5,360	3,587	678	1,333	879	4,466	49.8%
West New York Town	3,524	2,211	457	918	568	2,779	46.7%
HUDSON COUNTY (Balance)	3,119	1,115	214	783	276	1,391	26.6%
HUNTERDON COUNTY (Total)	6,297	711	125	1,473	164	875	8.4%
Ewing Township	1,571	296	65	438	81	377	14.0%
Hamilton Township	4,698	840	161	1,185	209	1,049	13.3%
Trenton City	7,431	4,523	951	1,986	1,192	5,715	45.3%
MERCER COUNTY (Balance)	8,613	1,227	240	2,117	297	1,524	10.6%

AREA	CHILDREN UNDER 5 YEARS OLD	ESTIMATED ELIGIBLE CHILDREN	ESTIMATED ELIGIBLE INFANTS	PREGNANT & POSTPARTUM WOMEN	ESTIMATED ELIGIBLE WOMEN	TOTAL ESTIMATED ELIGIBLE WOMEN & CHILDREN	1999 200% POVERTY RATE
East Brunswick Township	2,024	231	42	497	56	287	8.5%
Edison Township	6,766	1,136	227	1,712	283	1,419	12.5%
New Brunswick City	5,335	3,706	762	1,397	957	4,663	51.7%
North Brunswick Township	2,909	532	114	801	144	676	13.6%
Old Bridge Township	3,605	576	117	915	144	720	11.9%
Perth Amboy City	4,288	2,356	473	1,091	591	2,947	40.9%
Piscataway Township	3,478	509	107	883	127	636	10.9%
Sayreville Borough	2,896	521	105	745	132	653	13.4%
*South Brunswick Township	2,519	294	56	608	70	364	8.7%
Woodbridge Township	6,181	1,129	223	1,574	284	1,413	13.6%
MIDDLESEX COUNTY (Balance)	11,988	2,255	448	3,027	561	2,816	14.0%
*Freehold Township	1,631	191	38	406	47	238	8.7%
Howell Township	2,982	465	90	733	113	578	11.6%
*Long Branch City	2,689	1,301	244	674	321	1,622	36.0%
*Manalapan Township	1,519	192	40	379	47	239	9.4%
*Marlboro Township	1,775	179	30	401	40	219	7.5%
Middletown Township	3,581	419	79	863	99	518	8.7%
MONMOUTH COUNTY (Balance)	21,868	4,995	930	5,300	1,193	6,188	17.0%
Parsippany-Troy Hills	3,197	442	85	790	108	550	10.3%
MORRIS COUNTY (Balance)	25,754	3,357	608	6,099	784	4,141	9.7%

AREA	CHILDREN UNDER 5 YEARS OLD	ESTIMATED ELIGIBLE CHILDREN	ESTIMATED ELIGIBLE INFANTS	PREGNANT & POSTPARTUM WOMEN	ESTIMATED ELIGIBLE WOMEN	TOTAL ESTIMATED ELIGIBLE WOMEN & CHILDREN	1999 (200%) POVERTY RATE
Berkeley Township	1,428	397	83	370	101	498	20.7%
Brick Township	3,996	816	158	964	194	1,010	15.2%
Toms River Township	4,777	1,040	211	1,221	262	1,302	16.2%
Jackson Township	2,958	437	81	713	104	541	11.0%
Lakewood Township	14,065	7,805	1,760	3,900	2,133	9,938	41.3%
Manchester Township	1,082	324	68	284	84	408	22.3%
OCEAN COUNTY (Balance)	9,183	2,159	423	2,282	529	2,688	17.5%
Clifton City	5,261	1,329	291	1,424	355	1,684	18.8%
Passaic City	7,516	4,908	1,026	1,939	1,248	6,156	48.6%
Paterson City	13,970	8,822	1,748	3,536	2,201	11,023	47.0%
Wayne Township	2,455	241	44	571	55	296	7.3%
PASSAIC COUNTY (Balance)	8,395	1,500	292	2,080	366	1,866	13.3%
SALEM COUNTY (Total)	3,128	979	190	796	246	1,225	23.3%
Bridgewater Township	2,490	241	45	576	55	296	7.2%
Franklin Township	4,667	897	190	1,236	234	1,131	14.3%
*Hillsborough Township	2,242	217	37	510	49	266	7.2%
SOMERSET COUNTY (Balance)	11,218	1,748	326	2,672	411	2,159	11.6%
SUSSEX COUNTY (Total)	7,898	1,210	226	1,940	293	1,503	11.4%
Elizabeth City	10,829	5,995	1,245	2,840	1,550	7,545	41.2%
Linden City	2,297	630	128	592	160	790	20.4%
Plainfield City	4,665	2,125	415	1,186	532	2,657	33.9%
Union Township	2,978	552	115	765	140	692	13.8%
UNION COUNTY (Balance)	15,927	2,482	472	3,930	604	3,086	11.6%
WARREN COUNTY (Total)	6,008	1,243	231	1,472	300	1,543	15.4%
	545,338	169,054	33,934	137,510	42,626	211,680	

Table 7: Pregnant and Postpartum Women

AREA	ESTIMATED ELIGIBLE PREGNANT WOMEN	ESTIMATED ELIGIBLE POSTPARTUM WOMEN	WOMEN TOTAL
Atlantic City	404	267	671
*Egg Harbor Township	92	63	155
*Galloway Township	64	49	113
ATLANTIC COUNTY (Balance)	460	309	769
Fair Lawn Borough	29	20	49
Fort Lee Borough	56	40	96
Hackensack City	156	100	256
Teaneck Township	47	30	77
BERGEN COUNTY (Balance)	977	649	1,626
Evesham Township	41	25	66
Mt. Laurel Township	35	24	59
Willingboro Township	60	38	98
BURLINGTON COUNTY (Balance)	524	356	880
Camden City	1,131	714	1,845
Cherry Hill Township	73	50	123
Gloucester Township	125	85	210
Pennsauken Township	100	65	165
Winslow Township	88	64	152
CAMDEN COUNTY (Balance)	489	323	812
CAPE MAY COUNTY (Total)	226	144	370
Vineland City	298	188	486
CUMBERLAND COUNTY (Balance)	567	360	927
Belleville Town	104	67	171
Bloomfield Town	104	67	171
East Orange City	424	284	708
Irvington Town	370	236	606
Montclair Town	46	30	76
Newark City	2,385	1,646	4,031
*Orange City	220	151	371
West Orange Township	90	65	155
ESSEX COUNTY (Balance)	159	109	268

AREA	ESTIMATED ELIGIBLE PREGNANT WOMEN	ESTIMATED ELIGIBLE POSTPARTUM WOMEN	WOMEN TOTAL
Parsippany-Troy Hills	64	44	108
MORRIS COUNTY (Balance)	458	326	784
Berkeley Township	62	39	101
Brick Township	119	75	194
Dover Township	159	103	262
Jackson Township	61	43	104
Lakewood Township	1,323	810	2,133
Manchester Township	52	32	84
OCEAN COUNTY (Balance)	319	210	529
Clifton City	220	135	355
Passaic City	771	477	1,248
Paterson City	1,319	882	2,201
Wayne Township	33	22	55
PASSAIC COUNTY (Balance)	219	147	366
SALEM COUNTY (Total)	145	101	246
Bridgewater Township	34	21	55
Franklin Township	143	91	234
*Hillsborough Township	28	21	49
SOMERSET COUNTY (Balance)	245	166	411
SUSSEX COUNTY (Total)	169	124	293
Elizabeth City	938	612	1,550
Linden City	98	62	160
Plainfield City	312	220	532
Union Township	87	53	140
UNION COUNTY (Balance)	356	248	604
WARREN COUNTY (Total)	174	126	300
	25,586	17,040	42,626

AREA	ESTIMATED ELIGIBLE PREGNANT WOMEN	ESTIMATED ELIGIBLE POSTPARTUM WOMEN	WOMEN TOTAL
Washington Township	39	27	66
GLOUCESTER COUNTY (Balance)	480	326	806
Bayonne City	174	121	295
Hoboken City	126	73	199
Jersey City	1,296	861	2,157
Kearny Town	104	71	175
North Bergen Township	227	166	393
Union City	511	368	879
West New York Town	345	223	568
HUDSON COUNTY (Balance)	160	116	276
HUNTERDON COUNTY (Total)	94	70	164
Ewing Township	49	32	81
Hamilton Township	122	87	209
Trenton City	721	471	1,192
MERCER COUNTY (Balance)	181	116	297
East Brunswick Township	32	24	56
Edison Township	170	113	283
New Brunswick City	575	382	957
North Brunswick Township	86	58	144
Old Bridge Township	88	56	144
Perth Amboy City	357	234	591
Piscataway Township	80	47	127
Sayreville Borough	79	53	132
*South Brunswick Township	42	28	70
Woodbridge Township	168	116	284
MIDDLESEX COUNTY (Balance)	337	224	561
*Freehold Township	29	18	47
Howell Township	68	45	113
*Long Branch City	183	138	321
*Manalapan Township	29	18	47
*Marlboro Township	23	17	40
Middletown Township	59	40	99
MONMOUTH COUNTY (Balance)	700	493	1,193

Table 8: Estimated Number of Women, Infants and Children by Agency

LOCAL AGENCY	CHILDREN UNDER 5 YEARS OLD	ESTIMATED ELIGIBLE CHILDREN	ESTIMATED ELIGIBLE INFANTS	TOTAL ESTIMATED ELIGIBLE CHILDREN	PREGNANT & POSTPARTUM WOMEN	ESTIMATED ELIGIBLE PREGNANT WOMEN	ESTIMATED ELIGIBLE POSTPARTUM WOMEN	ESTIMATED ELIGIBLE WOMEN	ESTIMATED ELIGIBLE WOMEN & CHILDREN
ATLANTIC CITY	16,894	5,214	1,311	6,525	4,346	990	668	1,658	8,184
BURLINGTON	24,055	3,514	857	4,371	6,022	646	433	1,079	5,450
TRI-COUNTY	53,145	16,432	4,296	20,729	13,875	3,250	2,102	5,352	26,081
EAST ORANGE	14,950	5,470	1,354	6,824	3,780	1,023	696	1,719	8,542
GLOUCESTER	15,154	2,874	736	3,610	3,933	554	375	929	4,539
JERSEY CITY	19,857	7,716	1,925	9,641	5,089	1,449	984	2,432	12,074
VNACJ	90,728	17,008	4,153	21,162	22,631	3,126	2,118	5,245	26,406
NEWARK	30,733	11,091	2,747	13,838	7,774	2,075	1,411	3,486	17,324
NORTH HUDSON	24,915	8,505	2,115	10,620	6,330	1,591	1,079	2,670	13,289
NORWESCAP	34,404	4,345	1,003	5,349	8,328	754	531	1,285	6,634
PLAINFIELD	14,508	3,242	814	4,056	3,650	613	409	1,022	5,078
ST. JOSEPH'S	92,219	17,903	4,372	22,275	22,633	3,291	2,181	5,472	27,747
EWING	22,313	5,469	1,417	6,886	5,726	1,073	706	1,779	8,665
UMDNJ	13,359	4,888	1,210	6,097	3,378	914	622	1,536	7,633
OCEAN	37,489	10,194	2,784	12,978	9,734	2,095	1,312	3,407	16,385
PASSAIC	15,434	4,798	1,211	6,008	3,890	912	593	1,505	7,513
TRINITAS	25,181	6,456	1,630	8,086	6,391	1,229	820	2,049	10,135
TOTAL	545,338	135,120	33,934	169,054	137,510	25,586	17,040	42,626	211,680

4.3 Disclaimers and Notes for FFY 2013 WIC Affirmative Action Plan

The Data Source for the 2013 WIC Affirmative Action Plan was the New Jersey Department of Health & Senior Services Birth and Death Certificate files. This data is provisional and should be used for planning purposes only.

The data is based on the recording of the residence of the mother at the time of birth as understood and reported by the mother or other informant. Sometimes the coding of the residence information is limited by confusion between a temporary mailing address used around the time of birth and the permanent residence of the mother or informant. More seriously in New Jersey, the municipalities where people live may differ from the cities listed as their mailing address. Births are for New Jersey residents only.

A fetal death is defined as a death occurring before the complete expulsion or extraction from its mother. Fetal deaths occurring after the completion of 20 or more weeks of gestation are included in the fetal death count. Induced abortions are not included in the fetal death count. Deaths are to New Jersey residents only and population is by 2000 census. It should be noted that Pemberton Township's population dropped below 30,000 in the 2000 census.

4.4 Pregnancy Nutrition Surveillance System*

The Pregnancy Nutrition Surveillance System (PNSS) is a public health nutrition program-based surveillance system used to monitor the prevalence of nutrition problems, selected health/behavioral risk factors associated with birth outcomes among low-income women. The PNSS women participate in federally funded public health/nutrition programs in United States, U.S. territories and Indian Tribal Organizations (ITOs). In New Jersey, the PNSS data were collected exclusively from women who participate in the Supplemental Nutrition Program for Women, Infants and Children up to age five years old (WIC) during certification and subsequent certification into the Program.

In New Jersey, PNSS data is used to examine the prevalence rates of maternal behavioral factors; health indicators and pregnancy/birth outcomes. Variations in maternal behavioral factors; health indicators and pregnancy/birth outcomes are examined using selected maternal demographic characteristics. The PNSS data over years provides information to monitor trends in maternal health, behavior and birth outcomes and in examining how health/behavior indicators and health problems are spread based on maternal demographics.

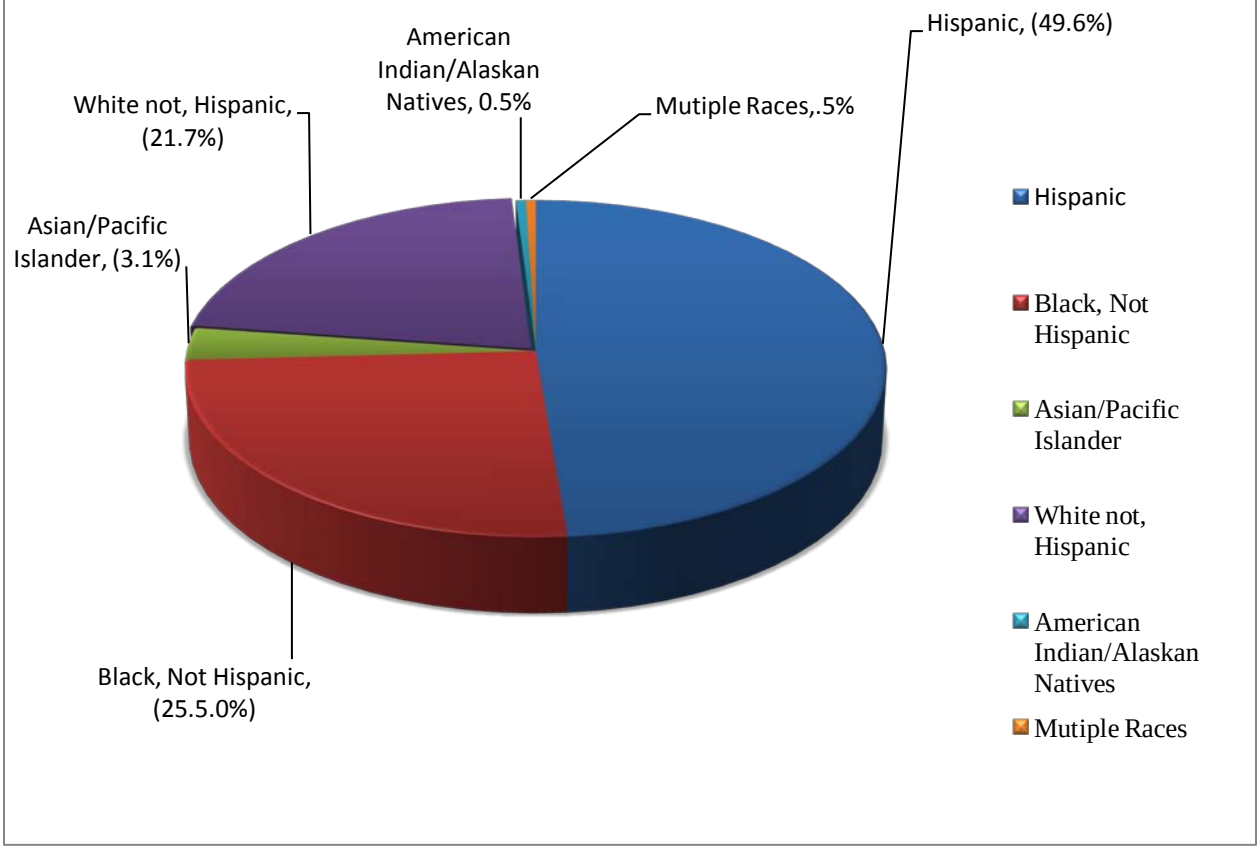
Demographic Characteristics

Race and Ethnicity

Race/Ethnicity data were analyzed to check for disparity in WIC service utilization, maternal behaviors and birth outcomes. In 2010, the New Jersey PNSS had 43,973 women. Of the 43,973 PNSS women, 48.7% were Hispanic, 25.5.0% were Black, not-Hispanic, 21.7% were White, not-Hispanic, 3.1% were Asian/Pacific Islanders, 0.5% was American Indian/Native Alaskan, and 0.5% was of Multiple Races. In the 2010 PNSS, a higher proportion of the women were Hispanic (48.7%) in New Jersey, while the highest proportion (41.6%) were White not Hispanic in the national 2010 PNSS. The proportion of PNSS women of Hispanic ethnicity was 1.8 times higher in New Jersey than in the national 2010 Hispanic PNSS women. The percentage of White, not Hispanic PNSS women in national PNSS was 41.6% more than double (21.7%) compared to New Jersey PNSS women. Figure 1 shows the distribution of the New Jersey PNSS women by race and ethnicity.

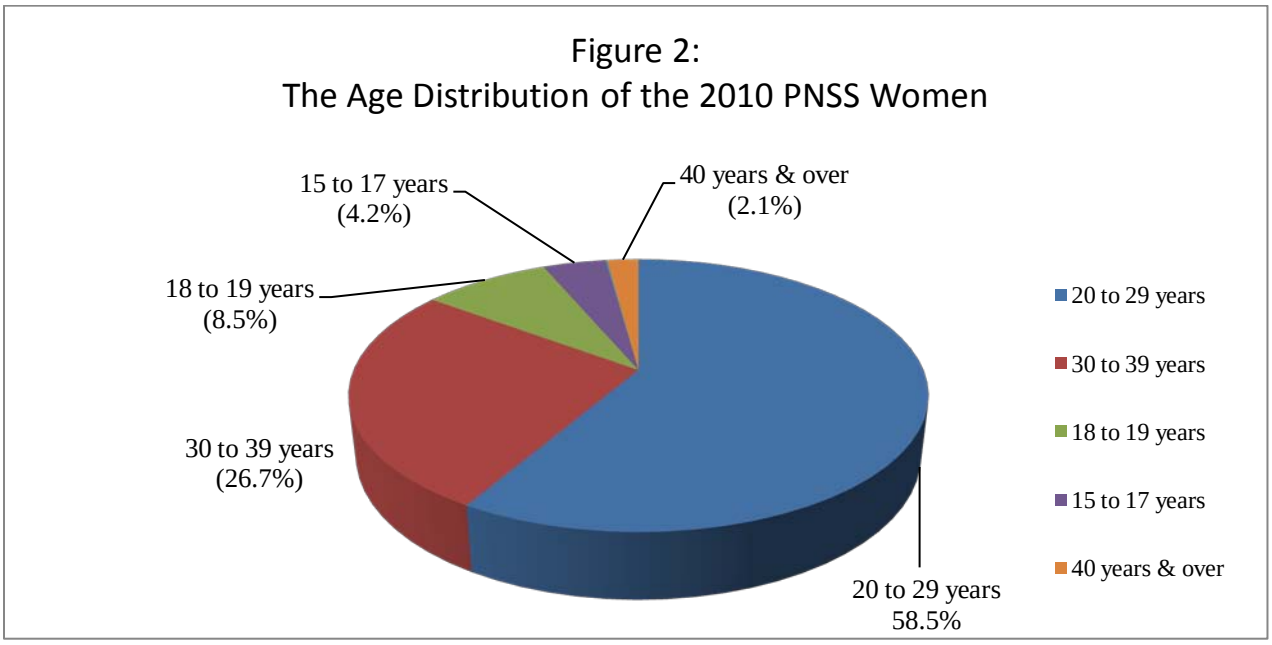
* Available at http://www.cdc.gov/pednss/

Figure 1:
Racial and ethnic distribution of New Jersey 2010 PNSS Women



Age Distribution

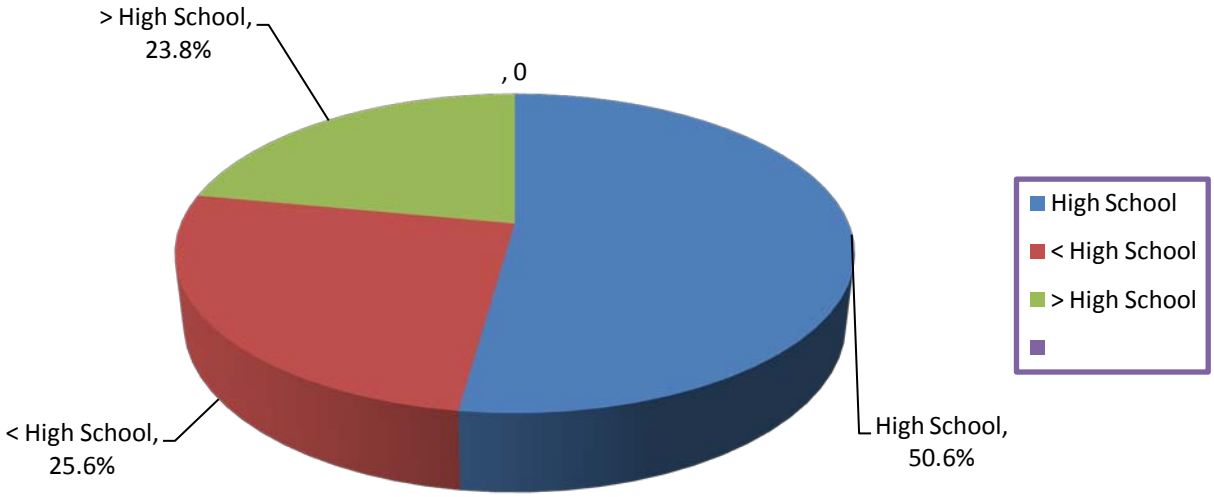
Maternal age can be considered a risk factor because the prevalence of some indicators varies with age. Forty-three thousand seven hundred and fifty-seven (43,757) women provided information about age in the New Jersey 2010 PNSS. Of the 43,757, 58.0% were 20 to 29 years old, 25.4% were 30 to 39 years old, 9.4% were 18-19 years old, 4.2% were 15 to 17 years old and 0.1% was less than15 years old. Figure 2 shows the age distribution of the New Jersey 2010 PNSS women. Compared to the previous year data on age distribution of the New Jersey PNSS women, there was a decrease of about 1.2% among those less than twenty years old.



The Educational Level

Educational level can be used as an indirect measure of socioeconomic status and to examine variations in maternal health behaviors that contribute to pregnancy and birth outcomes. Information about educational level was provided for forty-five thousand five-hundred forty-three (45,543) women. Of the 45,543 of New Jersey 2010 PNSS women, 25.6% had not completed high school, 50.6 % had a high school education, and 23.8% had more than a high school education.

Figure 3:
Educational Attainment of New Jersey 2010 PNSS Women

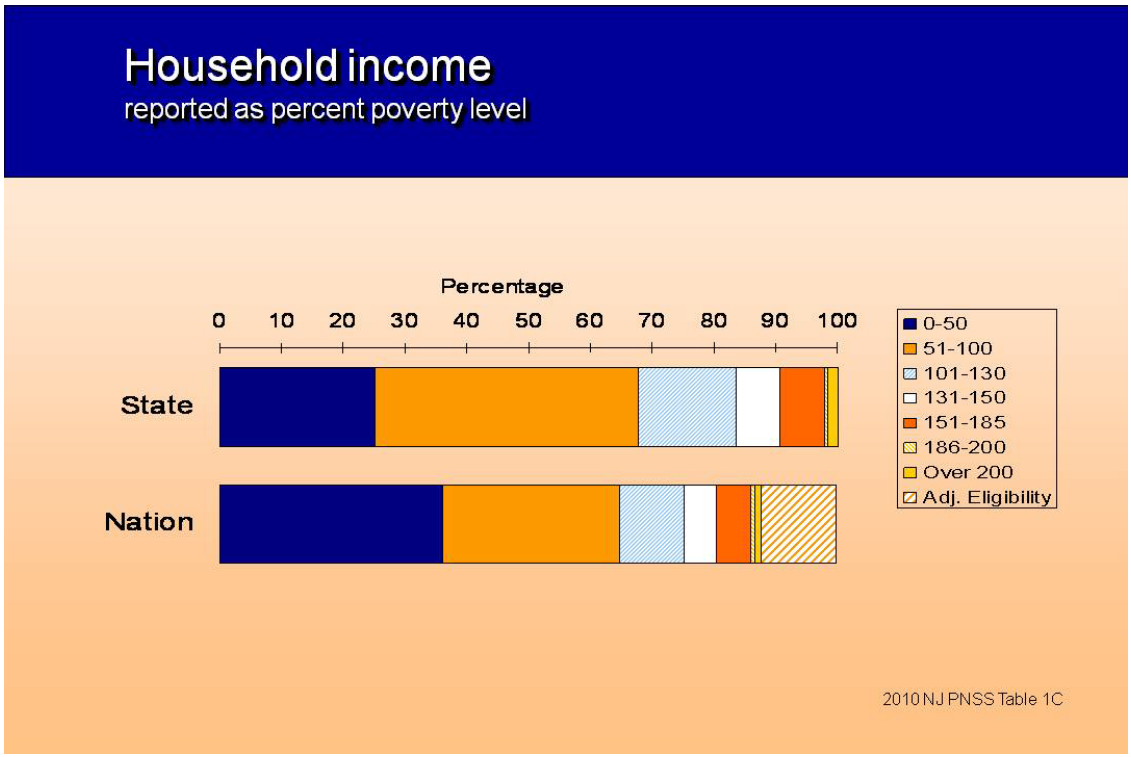


Household Income

Income is one of the eligibility criteria for WIC participation. To qualify for WIC participation based on income criterion, an applicant must have a household gross income at or below 185% of the Federal Poverty Level. Also, applicants who are participating in programs such as Supplemental Nutrition Assistance Program (SNAP), Transitional Assistance to Needy Families (TANF)), or Medicaid are automatically/adjunctively determined to be income-eligible.

The 2010 New Jersey PNSS had thirty-five thousand four-hundred sixty-one (35,461) women who participated in WIC. Thirty-five thousand one hundred and ninety (35,190) also participated in SNAP or Medicaid. Thirty-five thousand one hundred and eighty three (35,183) of New Jersey 2010 PNSS women, 25.2% reported income that was at or below 50% of the federal poverty level (FPL). Majority of the women in New Jersey 2010 PNSS (42.5%) had a household income between 51% and 100% of the FPL and 23.0% at 101% to 150% FPL. Over seven percent (7.2%) of New Jersey 2010 PNSS women reported income within the151% to 185% of the FPL. Figure 4 shows the household income reported as percent of federal poverty level.

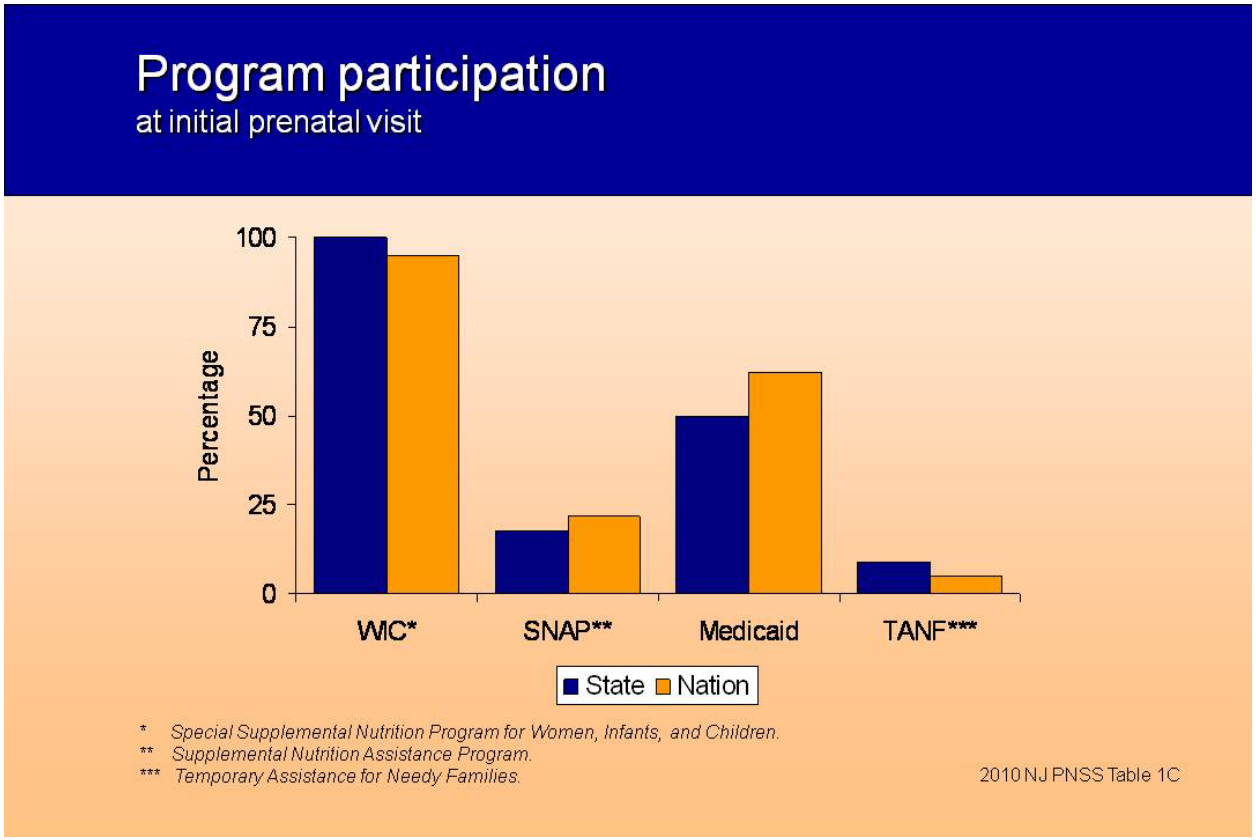
Figure 4



Participation in Other Federal Assistance Programs

In 2010 New Jersey PNSS, all the women (100.0%) were enrolled in the WIC Program and many also participated in other federal assistance programs. More than forty-nine percent (49.9%) participated in the Medicaid program, 17.8 % in the SNAP (a 2.9% increase from 2009 at 14.9%), and 9.1% received TANF. Figure 5 shows the rates for participation in other federal assistance programs among New Jersey and National women.

Figure 5



MATERNAL BEHAVIORAL INDICATORS

Enrollment into Medical Care

Enrollment into Medical care indicates the month in which medical care began for the current pregnancy among the PNSS women. Early enrollment into prenatal care contributes to better pregnancy and birth outcomes. Enrollment into medical care data were collected at the prenatal and postpartum visits to the WIC clinics. A WIC participant may have only postpartum enrollment into medical care data if enrolled in the WIC program after delivery of the baby. Women who begin medical care after the first trimester are at a higher risk for poor pregnancy outcomes with infants being born prematurely, with low birth weight, or growth retardation. One of the Healthy People 2010 Objectives is to increase the percentage of women who begin receiving medical care in the first trimester of pregnancy to 90%.

The prevalence rate of New Jersey 2010 PNSS women that enrolled into medical care during the first trimester of pregnancy was 48.8%. The prevalence rate for enrollment into medical care in the first trimester slightly changed from 48.0% in 2009 to 48.8% among New Jersey 2010 PNSS women but

significantly lower than the 82.2% for the National 2010 PNSS women. The prevalence rate of New Jersey 2010 PNSS is below the target for the Healthy People 2010.

The prevalence rate for women not receiving medical care during the first trimester of pregnancy among New Jersey 2010 PNSS women was 43.0% which is about 14 times higher compared to the National 2010 PNSS women rate (3.1%).

Comparisons by race/ethnicity showed that Hispanic women had the highest prevalence rate (52.9%) followed by American Indians/Alaska Natives (49.5%), White, not-Hispanic (48.7%) and Asian Pacific Islanders (45.5%). Multiple Races had the lowest prevalence rate (42.2%) followed by Black, not-Hispanic (43.2%) among New Jersey 2010 PNSS women that received prenatal care during the first trimester of pregnancy.

New Jersey 2010 PNSS women in the age group 15 years to 17 years old and 18 years to 19 years old had the highest prevalence rates of receiving medical care during the first trimester of pregnancy 52.2% and 50.8% respectively. The prevalence rates of receiving medical care during the first trimester of pregnancy were almost the same for 20 to 29 years olds (48.6%) and (48.0%) for 30 to 39 year olds. The prevalence rate (46.8%) of receiving medical care during the first trimester of pregnancy for New Jersey PNSS women 40 years and above was the lowest.

Enrollment into WIC Program

WIC enrollment is defined as the date a pregnant or postpartum woman is certified to participate in WIC Program. Enrollment into the WIC provides opportunity for PNSS women to receive nutrition assessment and education, nutritious foods at no cost, and referral to health care and other social service programs. Studies have shown that early enrollment in WIC during pregnancy is associated with improved birth weights, a reduction in preterm deliveries, lower neonatal mortality. stillbirth deliveries and reduced Medicaid costs. Ahluwalia et.al. concluded that WIC participation during pregnancy resulted in fewer deliveries of infants who are small for gestational age, and healthier infants. Women who participate in WIC also showed better dietary intake and prenatal weight gain than those who did not.

The overall prevalence rate of women in New Jersey 2010 PNSS that enrolled in WIC Program was 23.7% during the first trimester, 42.0% in the second trimester, and 20.1% in third trimester, and

0.3% after delivery. A majority of New Jersey 2010 PNSS population (42.0%) enrolled in WIC during the second trimester compared to the 34.7% for National 2010 PNSS women. The change in the proportion of women who enrolled during their second trimester was 8.8% when comparing 2009 rate of (50.8%) to the 2010 rate of (42%).

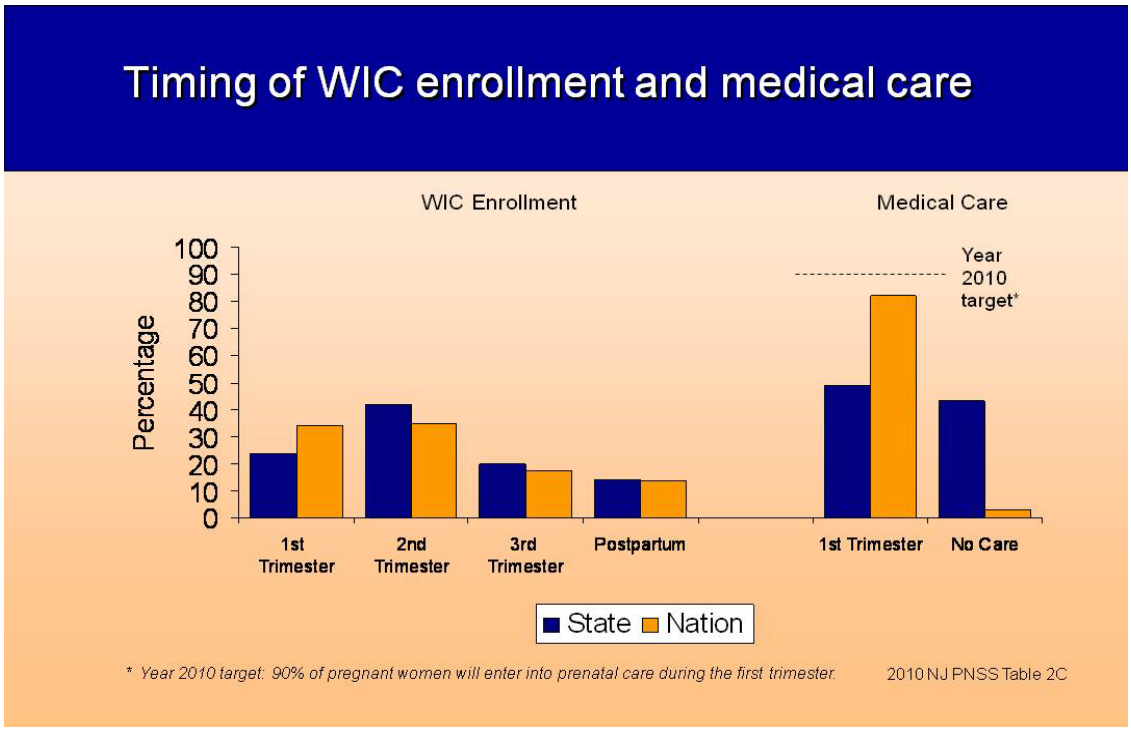
The prevalence rate for WIC Program enrollment during the first trimester of pregnancy among National PNSS 2010 PNSS women was 34.1%, higher than the rate for New Jersey 2010 PNSS. The prevalence rate of WIC enrollment during the first trimester of pregnancy for women in New Jersey 2010 PNSS (23.7%) decreased slightly from the 2009 rate of 25.2%.

The prevalence rates for WIC Program enrollment during the second trimester of pregnancy among New Jersey 2010 PNSS women was (42.0%) and is higher than enrollment in the first (23.7%) and third (20.1%) trimesters. More than 14.3% of 2010 New Jersey PNSS women enrolled in WIC Program during the postpartum period.

Race/ethnicity comparisons showed that Hispanic women had the highest prevalence rates (26.3%) and Black, not-Hispanic had the lowest prevalence rate at 18.0% for women enrolled in WIC Program during the first trimester of pregnancy. The prevalence rates for New Jersey 2010 PNSS women enrolled in WIC Program during the first trimester of pregnancy for American Indians/Alaska Natives was 21.0%, for White, not-Hispanic and Multiple Races, both had a rate of 24.2.0%.

The age comparison showed little variance with the highest prevalence rate (25.4%) reported for greater than 40 years old women and the lowest rate (20.6%) for 15 years to 17 years old for enrollment into the WIC Program during the first trimester of pregnancy among New Jersey 2010 PNSS women. The prevalence rate for enrollment into New Jersey WIC Program during the first trimester of pregnancy for the 20 years to 39 years old was 23.8% and for 18 to 19 years olds 23.2%. Figure 6 shows the prevalence rate of enrollment into WIC and medical care during the first, second and third trimester of pregnancy by New Jersey and National 2010 PNSS women.

Figure 6



Maternal Smoking

Smoking during pregnancy is associated with an increased risk of premature rupture or separation of uterine membranes, placenta previa, congenital heart defects, low birth weight and small for the gestational age babies.[i] It is widely known that women who smoke during pregnancy are more likely to have low birth weight infants. Also smoking during pregnancy contributes to Sudden Infant Death Syndrome (SIDS). The long term effects of smoking during pregnancy include stunted growth, developmental delay, behavioral disorders and cognitive disabilities.

The prevalence rate for New Jersey 2010 PNSS women that reported smoking during the three months preceding their pregnancy was 6.8% and 3.6% for women smoking during the last trimester of pregnancy. Comparatively, the prevalence rate of smoking during the three months preceding and three months after pregnancy for National PNSS women 22.9% and 13.0% respectively was three times and four times higher than the rate of 6.8% and 3.6% for New Jersey PNSS women. While the prevalence rate of smoking during the three months preceding pregnancy decreased by 0.7%, the decline in the prevalence rate of smoking during the last three months of pregnancy was very small.

In New Jersey 2010 PNSS women, the prevalence rate of smoking during the three months before pregnancy was highest among White, not-Hispanic women (15.1%), followed by Multiple Race with 13.5%. The prevalence rate of smoking during the three months preceding pregnancy among the American Indians/Alaska Natives and Asians/Pacific Islanders were the lowest at 1.5%. The prevalence rate of smoking during the three months preceding pregnancy for Black not-Hispanic women was 7.8% and 2.9% for Hispanic New Jersey 2010 PNSS women. The majority (63.6%) of New Jersey 2010 PNSS women that abstained from smoking by the first prenatal visit and remained non-smokers were Hispanic women followed by 49.8% for Black not-Hispanic women. Abstaining from smoking by the first prenatal visit and remaining non-smokers was more prevalent among New Jersey 2010 PNSS women who were 18 to 19 years compared to 20 to 29 years and 30 to 39 year old women.

Among New Jersey 2010 PNSS women smoking during the three months preceding pregnancy that provided data about educational attainment, the highest prevalence rate 6.9% for both those that completed and did not complete high school education. The lowest prevalence rate of smoking during the three months preceding pregnancy was among those that completed more than a High School education 6.8%.

The prevalence rates of smoking during the last trimester of pregnancy among New Jersey 2010 PNSS women varied from 9.2% for White not-Hispanic women to 0.3%. for Asian/Pacific Islanders. The prevalence rates of smoking during the last trimester of pregnancy among New Jersey 2010 PNSS women were 6,3% for Multiple Race (stayed the same), 4.2% for Black, not-Hispanic women, 1.1% (stayed the same) for Hispanic women and one percent for American Indians/Alaska Natives.

The highest prevalence rates (4.0%) of smoking during the last trimester of pregnancy among New Jersey 2010 PNSS was among those 18 to 29 year old women. The lowest prevalence rates of smoking during the last trimester of pregnancy among New Jersey 2010 PNSS women were 2.2% for 15 to 17 years followed by 3.1% for 30 to 39 years.

Smoking in Household

Smoking in the household is used to monitor the effect of passive smoking on pregnancy and birth outcomes and on the health of the infant. Research findings on the effect of passive smoking from people living in the same household on pregnancy and birth outcomes are mixed; however, the effect

of passive smoking on infants' and children health are better documented.[ii] Infants and children exposed to passive smoke have a higher incidence of Sudden Infant Death Syndrome (SIDS), respiratory infections, and chest illness.

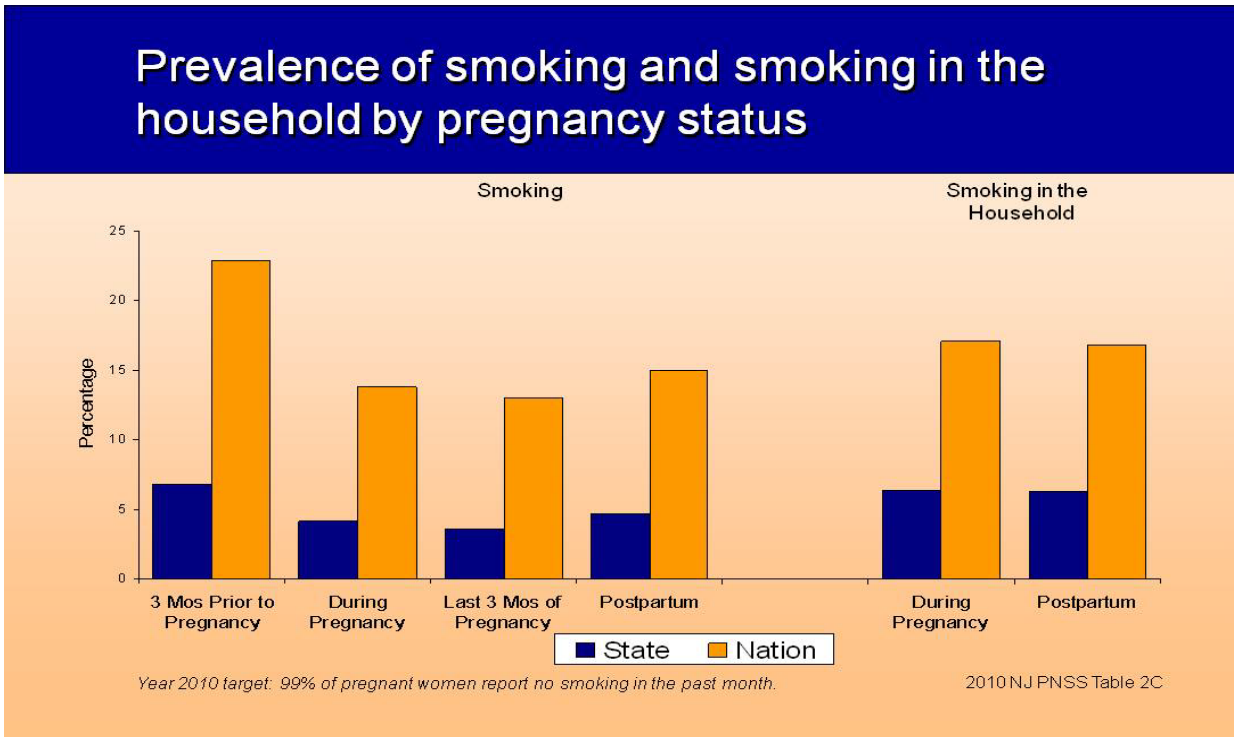
New Jersey 2010 PNSS showed that 7.2% women reported that household members were smokers during the prenatal and 6.4% in postnatal periods. The prevalence rates of household members smoking during prenatal and postnatal periods among the National PNSS were 17.1% and 16.8% respectively and both rates were considerably higher than the New Jersey prevalence rates.

In contrast with New Jersey 2008 PNSS data on the prevalence rates of household member smoking during prenatal (6.4%) and postnatal (6.3%) periods.

A higher prevalence rate of household member smoking during the prenatal period among New Jersey 2010 PNSS women was noted for White, Not-Hispanic (13.7%) and (12.7%) for Multiple Race. Black, Not-Hispanic women that reported they have household member smoking during prenatal period was (7.3%) compared to 4.5%, 3.5% and 3.0% for American Indians/Alaska Natives Asian/Pacific Islanders, and Hispanic women respectively. Comparatively, during the postpartum period, a lower prevalence rate of Hispanic (3.0%), Asian/Pacific Islander (3.9%) and American Indian/Alaska Native (5.2%) women lived with a household member who smoked. The highest prevalence rates for postpartum women living with a household member that smoked were for White Not-Hispanic (13.1%) and the Multiple Race (11.2%) women.

The prevalence rate based on educational level of New Jersey 2010 PNSS women living with a household member that smoked during both prenatal and postpartum periods became lower as reported educational level increased. The prevalence rate for New Jersey 2010 PNSS women living with a household member that smoked during prenatal period and with less than high school was the highest at 7.2% compared 6.2% for those that completed or have more than high school education. For New Jersey 2010 PNSS women living with a household member that smoked during postpartum period, the prevalence rate for those with less than high school education higher at 7.2% compared to 5.9% for those with higher than high school education and the 6.1% for the high school education. Figure 7 shows the prevalence rate of smoking and smoking in the household by pregnancy status.

Figure 7



Maternal Health Indicators

Pre-pregnancy Weight Status

In the PNSS women, pre-pregnancy weight is an indicator of the nutritional status of a woman before pregnancy. Pre-pregnancy weight status affects maternal health and is a determinant of infant birth-weight. Some studies have shown association between being underweight before pregnancy and premature birth, low birth weight and full term low birth weight infant.[iii] Risks such as preeclampsia, gestational diabetes, cesarean delivery, and failure to initiate breastfeeding are associated with being overweight before pregnancy. The highest risk of stillbirth is associated with women who are overweight compared to normal weight women who have the lowest risk.

Pre-pregnancy body weight status is reported as body mass index (BMI) and calculated for each woman in the 2010 PNSS based on self-reported weight and height before pregnancy. The self-reported height and weight are converted to a ratio known as Body Mass Index and is calculated as weight (kg) divided by height (m^2). The Institute of Medicine (IOM) in 2009 provided BMI ranges that serves as a standard in classifying women either as underweight, normal weight, overweight, and

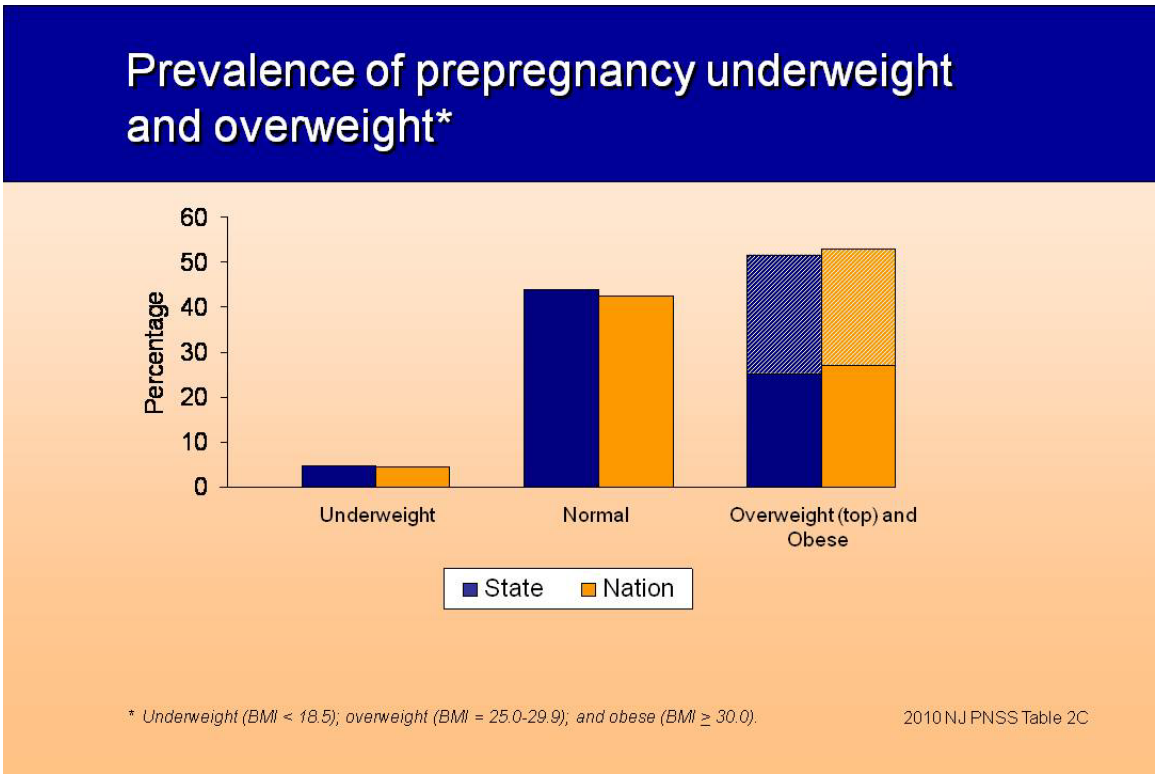
obese prior to pregnancy. Table 1 shows the classification of Pre-pregnancy weight based on IOM definition.

Table 1
Classification of Pre-pregnancy Weight and IOM Definition with BMI

Pre-pregnancy Weight Classification	Body Mass Index
Underweight	<18.5
Normal weight	18.5– 24.9
Overweight	>25.0 – 29.9
Obese	≥30

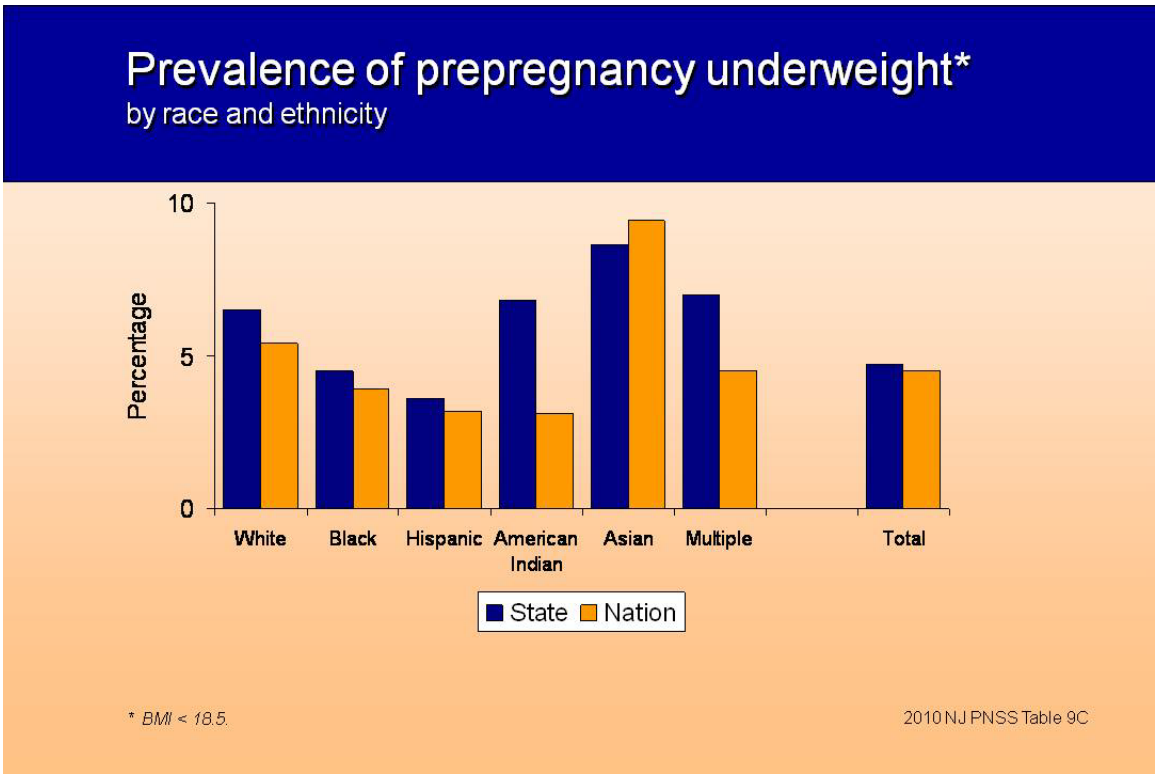
Based on IOM standard for classifying pre-pregnancy weight status, 4.7% of 2010 New Jersey PNSS women were designated as underweight and 51.6% as overweight Comparably, the prevalence rates of pre-pregnancy underweight among the 2010 New Jersey PNSS women (4.7%) was higher than the 4.5% for National PNSS women that met the criteria for pre-pregnancy underweight. The prevalence rate of pre-pregnancy overweight was slightly lower among New Jersey PNSS women (51.6%) compared to the National PNSS women with the rate of 52.9%. For the 2010 New Jersey PNSS women in the pre-pregnancy underweight, the prevalence rate (4.7%) was higher than rate (3.9%). in 2009. Figure 8 shows the prevalence rate of pre-pregnancy weight status based on IOM classification.

Figure 8



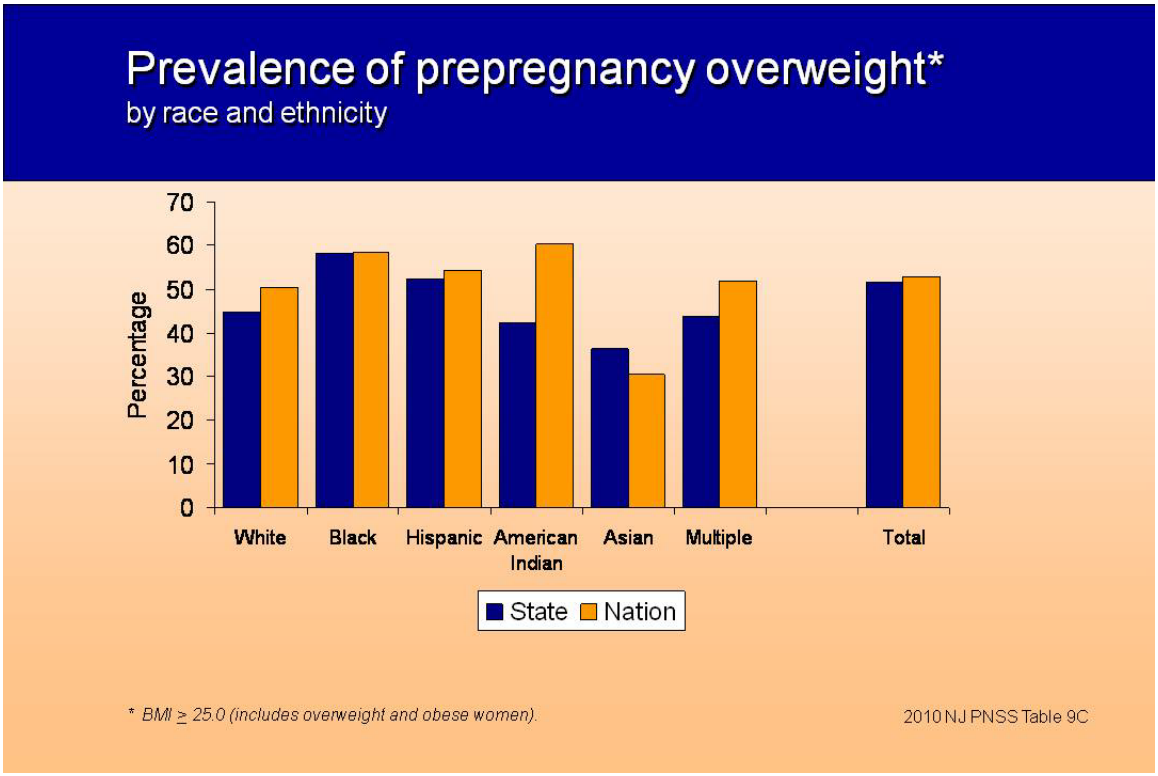
The prevalence rate of pre-pregnancy underweight among 2010 New Jersey PNSS women varied by race/ethnicity. By race/ethnicity**,** Asian/Pacific Islander had the highest prevalence rate (8.6%) of pre-pregnancy underweight followed by Multiple Races group (7.0%), American Indian/Alaskan Native (6.8%), White, not Hispanic (6.5%) among the 2010 New Jersey PNSS women. Hispanic (3.6%) and Black, not-Hispanic (4.5%) New Jersey PNSS women had lowest prevalence rates of pre-pregnancy underweight in 2010. Figure 9 shows the prevalence rate of pre- pregnancy underweight by race and ethnicity among 2010New Jersey and National PNSS women.

Figure 9



The prevalence rate for pre-pregnancy overweight among 2010 New Jersey PNSS women was highest among Black, not-Hispanic (58.1%) followed by Hispanic (52.3%), and White, not Hispanic (44.9%), American Indian/Alaskan Native (42.3%). Asian/Pacific Islander at 36.3 % and Multiple Races at 43.9% had the lowest prevalence rates of pre-pregnancy overweight. Figure 10 shows the prevalence rate of pre- pregnancy overweight by race and ethnicity among 2010 New Jersey and National PNSS women.

Figure 10



Maternal Weight Gain

Maternal Weight Gain or gestational weight gain refers to the amount of weight gained during pregnancy. Weight gain during pregnancy is used to assess and estimate fetal growth and estimate birth weight. The IOM established guidelines for gestation weight gain in reference to pre-pregnancy BMI/weight status (underweight, normal weight, overweight and obese). In 2009 the IOM recommended a pregnancy weight gain of 28–40 pounds for pre-pregnant underweight women, between 25–35 pounds for pre-pregnant women in the normal weight range, 15 to 25 pounds for both pre-pregnant overweight and 11 to 20 pounds for obese women (IOM 2009). The IOM recommended gestational weight gain is a strong predictor of birth weight. Infant birth weight contributes to infant morbidity and mortality. Women who gain more than the recommended weight are at increased risk of delivering infants that are large for gestational age (LGA) which may lead to a difficult and cesarean delivery. Also, women who gain excessive weight during pregnancy may have more difficulty returning to their pre-pregnancy weight.[iv] Women with less than the IOM recommended pregnancy weight gain are at increased risk of delivering

infants with low birth weight (LBW). Adequate weight gain during pregnancy is associated with better pregnancy and birth outcomes.

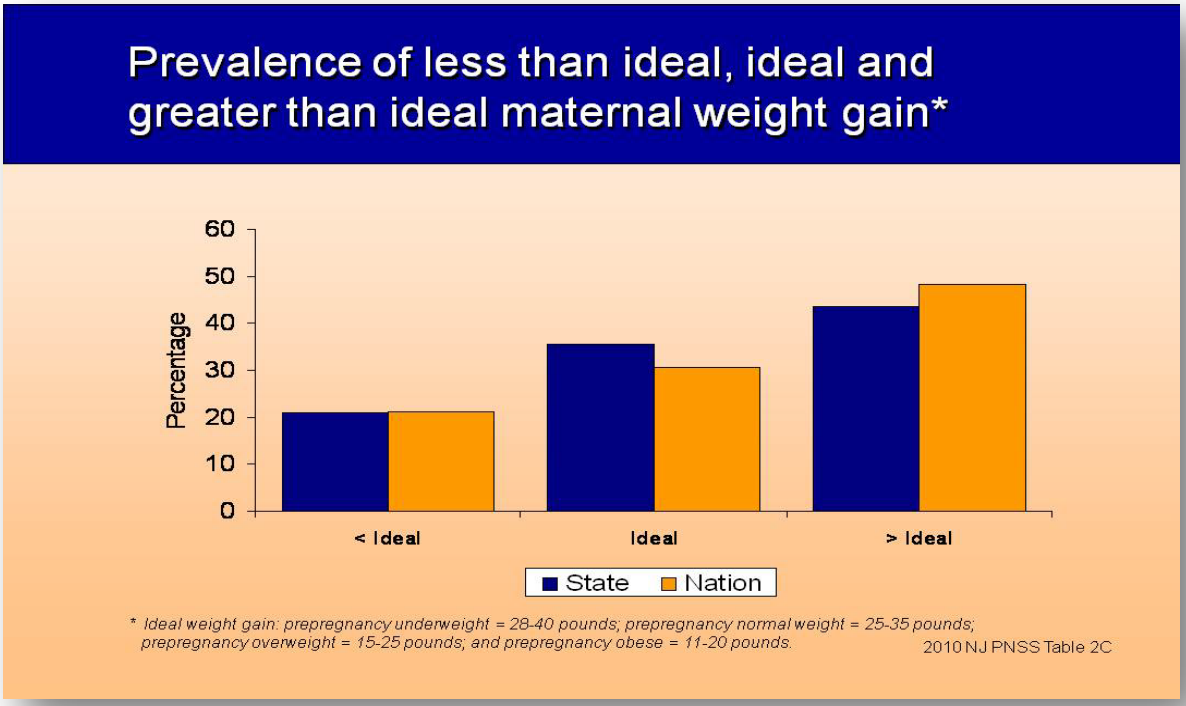
Table 2 shows the recommended gestational weight gain for women based on the pre-pregnancy BMI status (underweight, normal weight, overweight, and obese)

Table 2
IOM categories of Weight Status, Pre-pregnancy BMI and Ideal Total Gestational Weight Gain

Weight Classification	Pre-pregnancy BMI	Recommended Ideal Total Gestational Weight Gain (lbs)
Underweight	<18.5	28–40
Normal weight	18.5– 24.9	25–35
Overweight	>25.0 – 29.9	15–25
Obese	≥30	11- 20

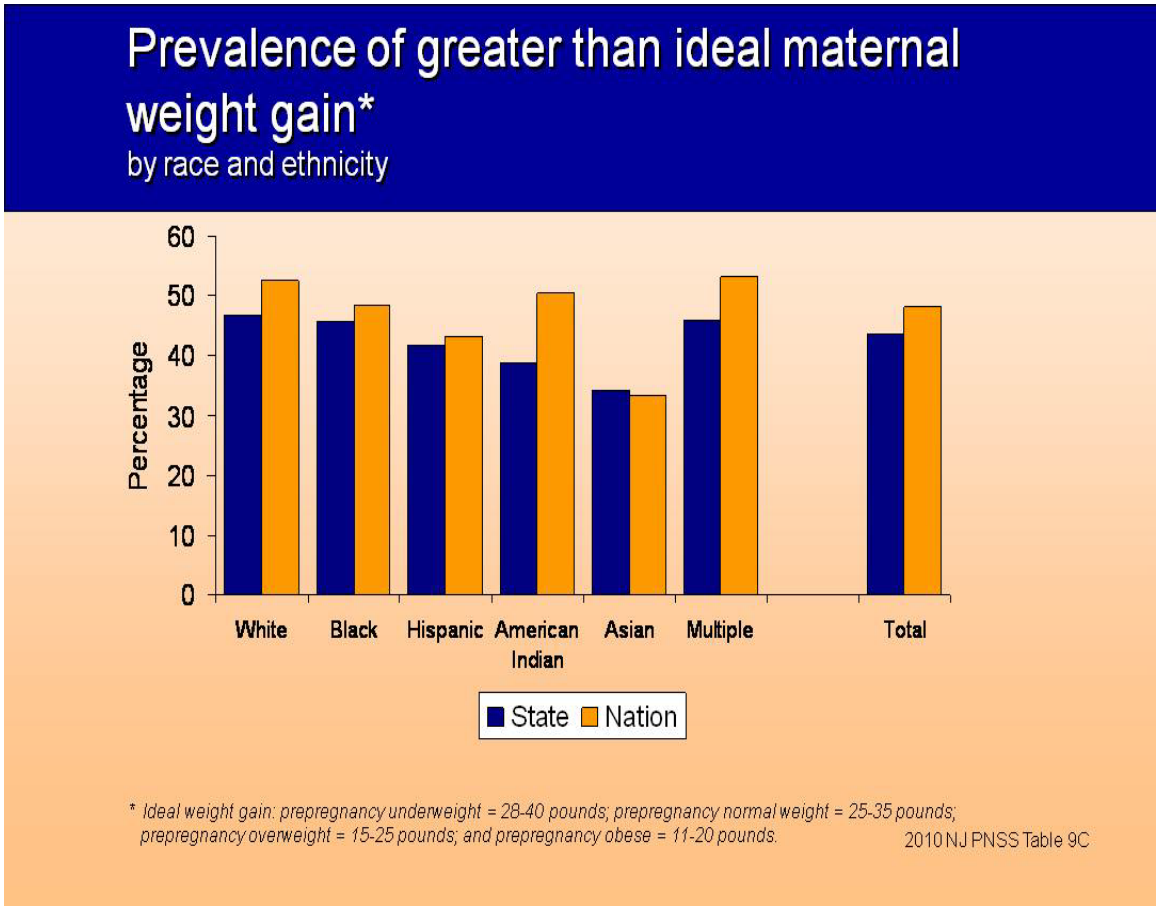
In the 2010 New Jersey PNSS the majority of women (43.6%) gained greater than the recommended ideal weight during pregnancy, compared to 20.9% who gained less than ideal weight. The prevalence rate (48.2%) for national 2010 PNSS women that gained greater than the recommended ideal weight during pregnancy was higher than the rate for New Jersey PNSS women. Also more than twenty one percent (21.2%) of national 2010 PNSS women gained less than the recommended ideal weight during pregnancy compare to (20.9%) for New Jersey 2010 PNSS women. Figure 9 shows the prevalence rate of pre- pregnancy underweight by race and ethnicity among 2010 New Jersey and National PNSS women. Figure 11 shows the prevalence rate of less than ideal, ideal and greater than ideal weight gain during pregnancy among 2010 New Jersey and National PNSS women.

Figure 11



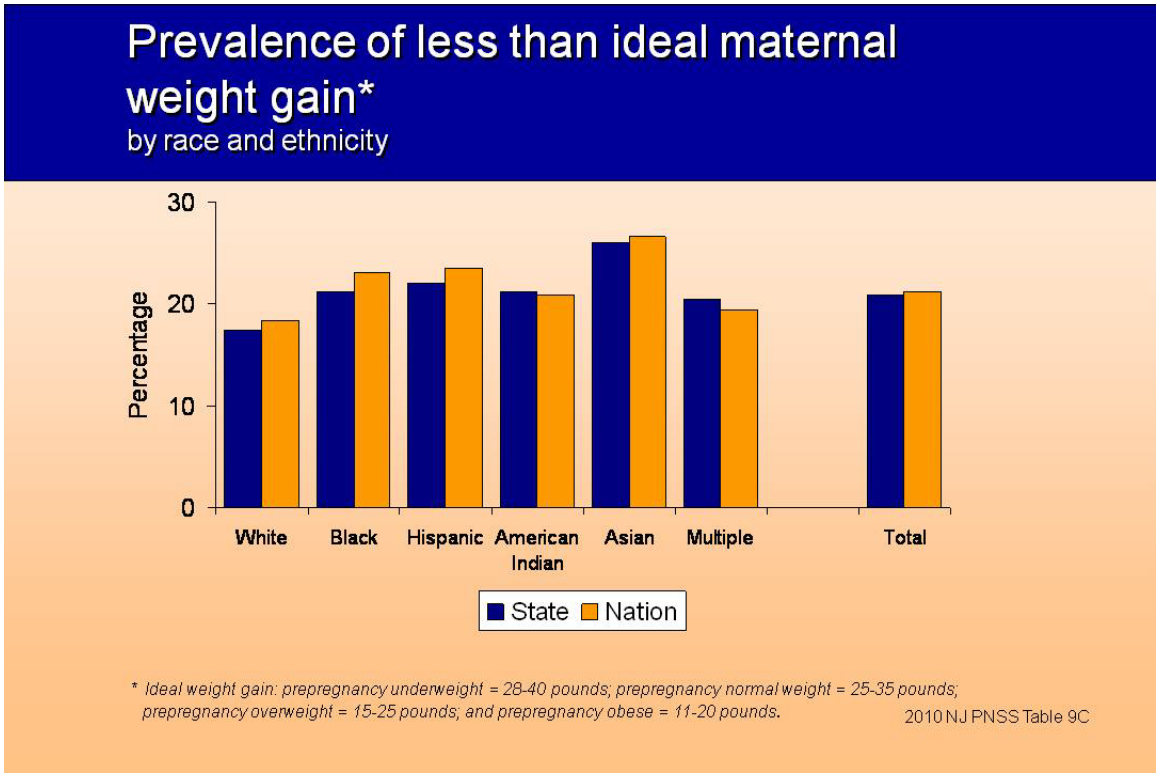
New Jersey 2010 PNSS women with greater than ideal gestational weight gain with the highest rates were the White Not-Hispanic (46.7%), Multiple Race (45.9%) and Black Not-Hispanic (45.7%). The Asian/Pacific Islander (34.2%), American Indian/Alaskan Native (38.9%) and Hispanic (41.8%) PNSS women had the lowest prevalence rates. Figure 12 shows the prevalence rate of greater than ideal maternal weight gain during pregnancy among 2010 New Jersey and National PNSS women.

Figure 12



The prevalence rate for New Jersey 2010 PNSS women that gained less than ideal weight during pregnancy by race/ethnicity was highest among Asian/Pacific Islander at (25.9%), followed by Hispanic at (22%) and American Indian/Alaskan Native, and Black Not-Hispanic both at (21.2%). The White Not-Hispanic (17.2%) had the lowest prevalence rates (20.5%) for women with less than ideal weight gain during pregnancy followed by Multiple Races among the New Jersey 2010 PNSS women. Figure 13 shows the prevalence rate of less than ideal maternal weight gain during pregnancy by race and ethnicity among 2010 New Jersey and National PNSS women.

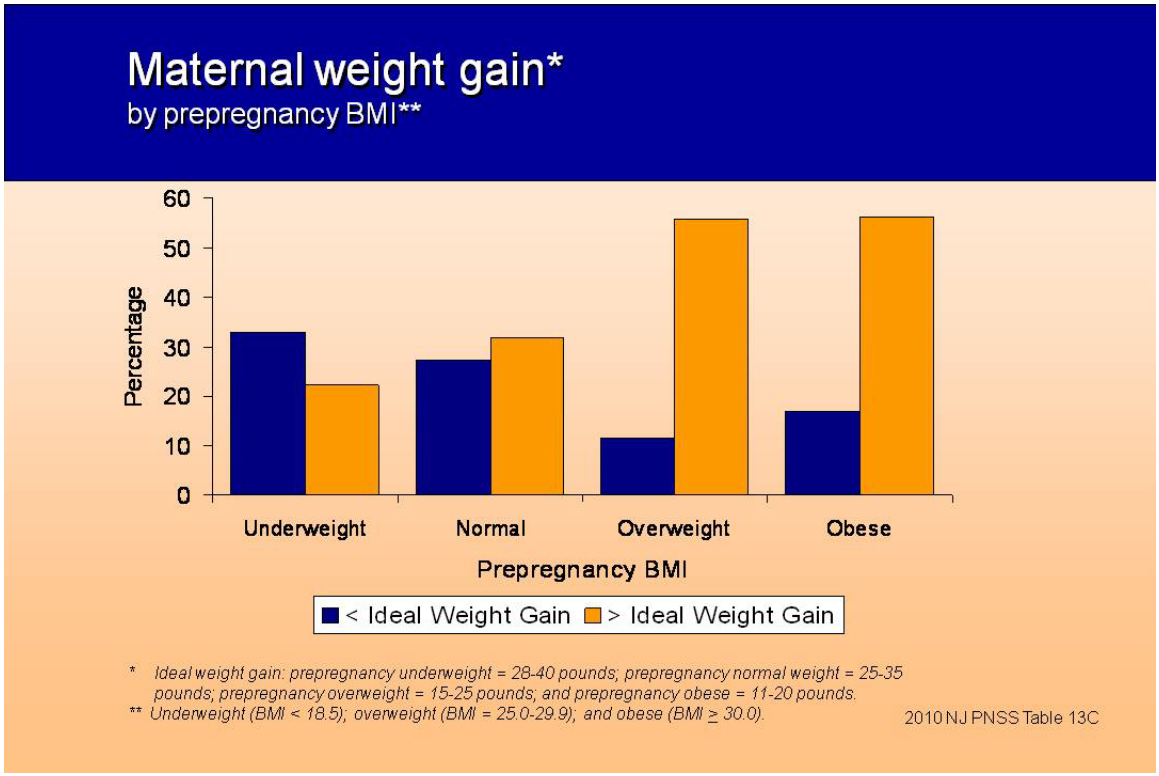
Figure 13



The age group comparisons for New Jersey 2010 PNSS women who gained less than the ideal weight during pregnancy, the prevalence rate (25.0%) was the highest and among women who were 40 years or older followed by 24.3% for those 15 years to 17 years of age and 21.2% for 18 years to 19 years old and 30-39 year olds. The New Jersey PNSS women in 20 to 29 years age group had the lowest prevalence rates at 20.3% among those that that gained less than ideal weight during pregnancy. For the New Jersey PNSS women that gained greater than ideal weight during pregnancy, the highest prevalence rates were 45.7% for 18 years to 19 years old, 44.4% for 20 to 29 years age group and 42.1% for 30 to 39 year olds. The lowest prevalence rates for those that gained greater than ideal weight during pregnancy was 38.8% and among the New Jersey PNSS women 40 years and older followed by the rate 39.9% for 15 to 17 year olds.

Figure 14 shows the prevalence rate of maternal weight gain by pre-pregnancy weight status (BMI) among 2010 New Jersey and National PNSS women.

Figure 14



Anemia

The most common nutritional deficiency during pregnancy is iron deficiency. Because pregnant women require higher amounts of iron, iron supplementation during pregnancy is often recommended. Pregnant women may not receive an adequate amount of iron if they do not take iron supplements during pregnancy or fail to take iron supplements during the first trimester of pregnancy. Iron-deficiency anemia during the first two trimesters of pregnancy has been associated with a two-fold risk for premature births, and a three-fold risk of giving birth to an infant with low birth weight and inadequate gestational weight gain. Longitudinal studies have shown that iron-deficiency anemia is more prevalent during the third trimester of pregnancy, reflects inadequate iron intake and can affect the woman's health postpartum. A goal in the Healthy People 2010 Objectives was to reduce the prevalence of iron deficiency anemia during the third trimester of pregnancy and 20% in the prevalence of iron deficiency anemia in the third trimester among low-income women by 2010.

The Centers for Disease Control and Prevention recommended cut-off values for hemoglobin and hematocrit values that are specific to the trimester of pregnancy in monitoring the prevalence of anemia among the PNSS population. Cut-off values for hemoglobin and hematocrit for postpartum women are based on age and on Trimester of pregnancy. Table 3 shows the cut off values for hemoglobin and hematocrit by trimester of pregnancy and post partum age.

Table 3

Cut Off Values for Hemoglobin and Hematocrit

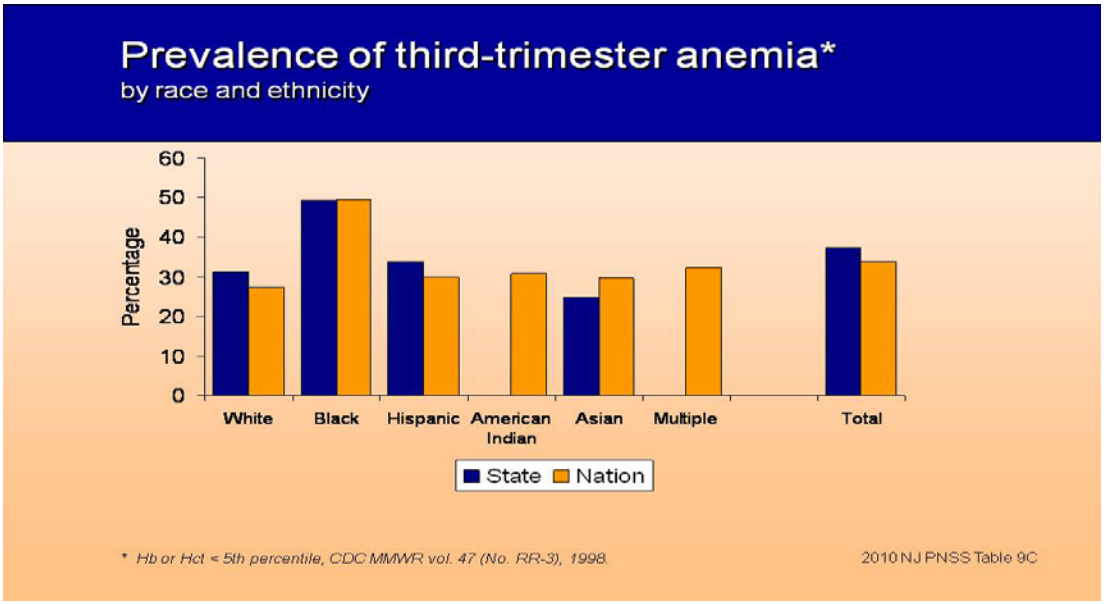
Trimester of Pregnancy/ Post Partum Age	Hemoglobin	Hematocrit
First	11.0	33.0
Second	10.5	32.0
Third	11.0	33.0
Postpartum Age	**Hemoglobin**	**Hematocrit**
12 - < 15 yrs	11.8	35.7
15 - < 18 yrs	12.0	35.9
≥ 18 yrs	12.0	35.7

The prevalence rate of anemia among New Jersey 2010 PNSS women was 10.8%, 12.1% and 37.4% respectively for the first, second and the third trimester of pregnancy. Among the post partum women, the prevalence rate of anemia was 47.6%. The prevalence rate of anemia for postpartum women in the 2010 New Jersey 2010 PNSS remained nearly the same. Also, the prevalence rate of anemia in the third trimester of pregnancy among New Jersey 2010 PNSS women was higher than the rates (33.9) for the National 2010 PNSS women.

New Jersey 2010 PNSS showed that the prevalence of anemia in the third trimester of pregnancy was highest for Black, not-Hispanic (49.2%) and Hispanic (33.9%). The prevalence rate of anemia in the third trimester of pregnancy was 31.2% for White not-Hispanic, and 24.7% for Asian/Pacific Islanders women in New Jersey 2010 PNSS. The prevalence of anemia in all the race/ethnicity represented in the New Jersey PNSS women exceeded the 20% target in the 2010 Healthy Objectives. It should be noted that prevalence rates are not calculated when records are less than 100. Therefore, the prevalence rate of anemia in the third trimester of pregnancy for American

Indian/Alaskan Native and the Multiple Races are not included in this report. Figure 15 shows the prevalence rates of anemia in the third trimester of pregnancy by race and ethnicity.

Figure 15



The prevalence of anemia in the third trimester of pregnancy among the New Jersey 2010 PNSS women also varied between age groups. The highest prevalence rate of anemia in the third trimester of pregnancy among the New Jersey 2010 PNSS women was in women 18-19 years old with a rate of (43.3%) and for postpartum period the 15 -17 year old women had the highest rate of (65.4%). During the third trimester of pregnancy, the prevalence of anemia decreased with increasing age. A similar trend found in women during the postpartum period with the exception of the 40 years and older group (28.9%), whose prevalence was less than that of the 20-29 year olds (36.2%) and 30-29 year olds (36.9%).

Birth Outcomes

Low Birth Weight

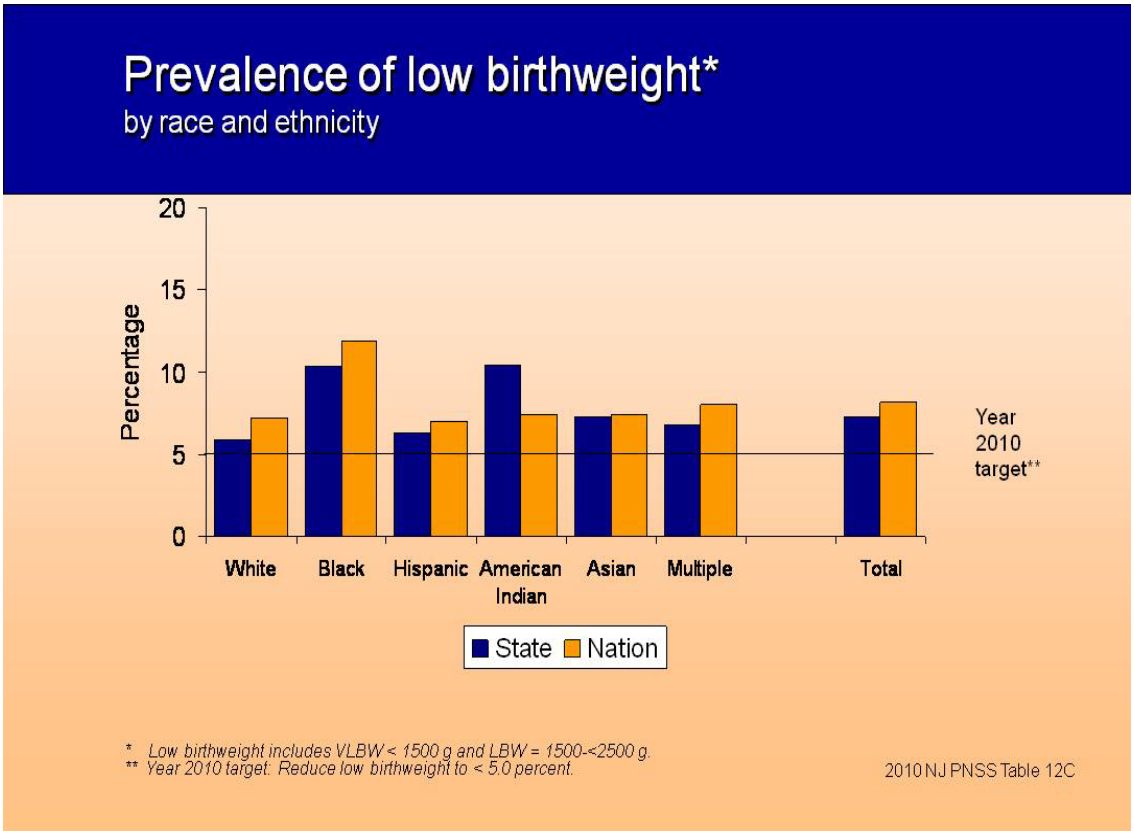
Low birth weight (LBW) is defined as birth weight of less than 2,500 grams or 5.5 pounds. Low birth weight is a contributory factor of neonatal mortality and post-neonatal mortality. Infants with low birth weight who survive are at increased risk for health problems that range from neurologic developmental disorders/disabilities to conditions of the lower respiratory tract.

Factors that contribute to low birth weight include cigarette smoking, poor nutrition and pre-pregnancy weight status. Variations in the occurrence of low birth weight are found by maternal age and socioeconomic factors. The Healthy People 2010 Objective is to reduce the prevalence of low birth weight to less than 5%.

The overall prevalence rate of low birth weight among New Jersey 2010 PNSS women was 7.3% and lower than the rate (8.2%) for the National 2010 PNSS women. Compared to the New Jersey 200 PNSS women rate (6.4%), the prevalence rate of low birth weight increased slightly among New Jersey 2010 PNSS women and also remained higher than the Healthy People 2010.

By race/ethnicity, American Indian/Alaska Native and Black, Not-Hispanic had the highest prevalence rate of low birth weight (10.4% and 10.3% respectively) than rates for Multiple Race (6.8%) and Asian/Pacific Islander (7.3%). White, Non-Hispanic women had the lowest the lowest prevalence rate (5.9%) of low birth weight among New Jersey 2010 PNSS. The prevalence rates of low birth weight for all the race/ethnicity in New Jersey 2010 PNSS were higher than the Healthy People 2010 Objective of 5%. However, the prevalence rate of low birth weight in New Jersey PNSS Hispanic women (6.3%) is closer to Healthy People 2010 target. Figure 16 shows the prevalence rates of low birth weight by race and ethnicity.

Figure 16

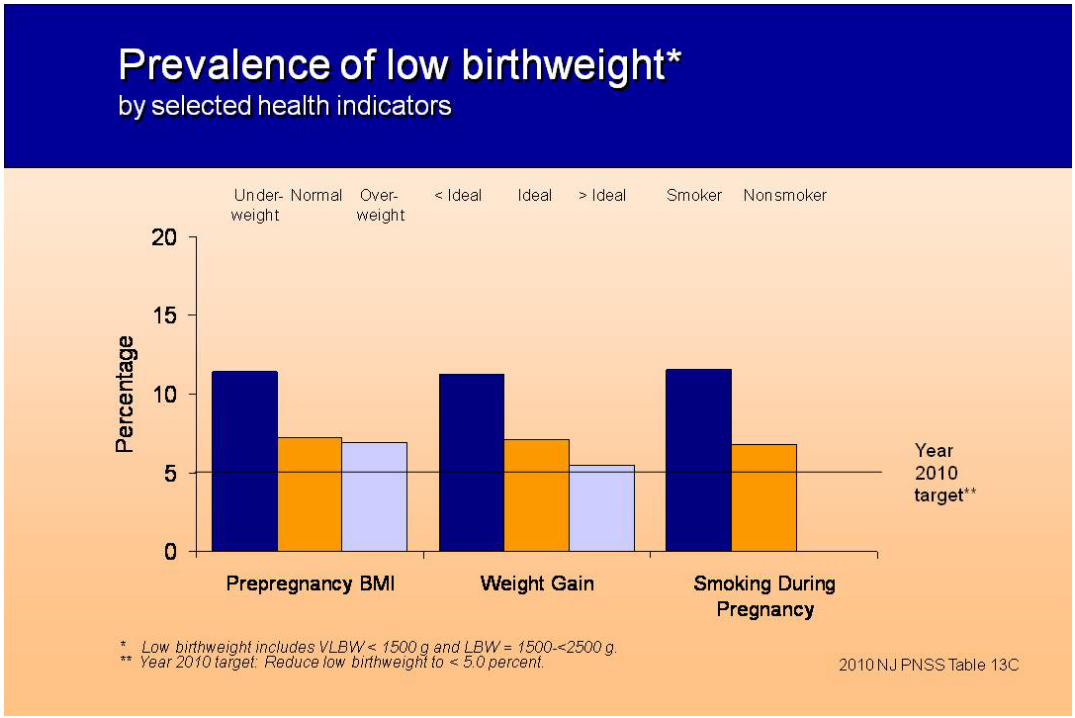


By age, the highest prevalence rate of low birth weight was (8.2%) for women aged 40 years and above and (7.9%). 15-17 years old. The prevalence of low birth weight was lowest for 20 to 29 years old (6.1%) followed by 6.6% for 30-39 years old and 6.7% for 18 to 19 years age group.

Examination of New Jersey 2010 PNSS data showed that the prevalence rate of low birth weight for women who were pre-pregnancy underweight (11.4%) was the highest compared to the rate for normal weight (7.2%), overweight (6.8%) or obese (7.1%) before pregnancy. Likewise, the prevalence rate of low birth weight was lower for those who gained more than the ideal weight (5.5%) than those that gained ideal weight (7.1%) or less than the ideal weight (11.2%). Low Birth Weight was more prevalent among New Jersey 2010 PNSS women who smoked during pregnancy (11.5%) than the non-smokers (6.8%).

Variations in the prevalence of low birth weight exist based on maternal pre-pregnancy underweight status, less than ideal weight gain during pregnancy and maternal smoking behavior during pregnancy among New Jersey PNSS women. Figure 17 shows the prevalence rates of low birth weight by maternal selected health indicators (pre-pregnancy BMI, weight gain and smoking during pregnancy).

Figure 17



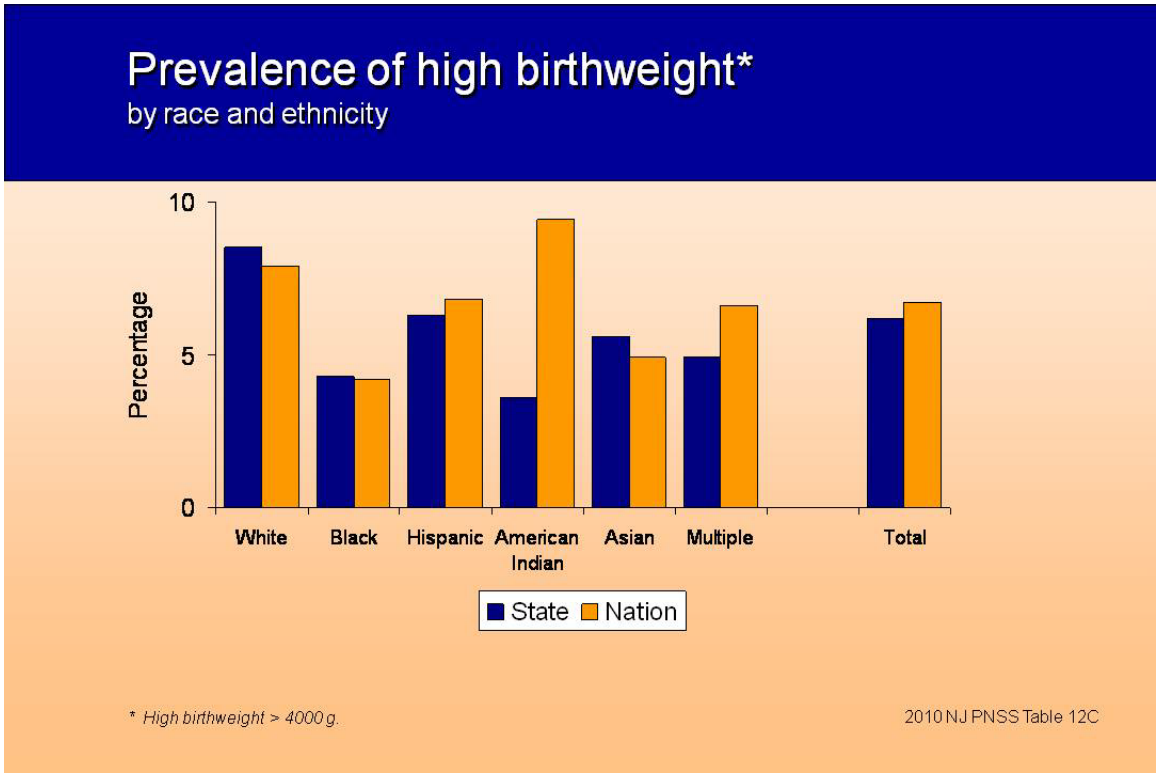
High Birth weight

High birthweight is defined as birth weight greater than 4,000 grams or 9 pounds. High birthweight (HBW) significantly increases the risk of injuries such as shoulder dystocia during vaginal delivery and nerve injury, fractures, asphyxia, death during infancy, childhood obesity and medical complications. High birthweight infants are also at increased risk for Type I and II diabetes, obesity, lower respiratory tract conditions, hypertension and future cardiovascular difficulties compared normal birth weight infants.

The prevalence rate of high birthweight varied by race/ethnicity in the New Jersey 2010 PNSS women. White not-Hispanic had the highest prevalence rate (8.5%), followed by Hispanic (6.3%) and women. American Indian/Alaska Native women had the lowest prevalence rate of 3.6%

followed by Black not-Hispanic 4.3% while rates for Multiple Race (4.9%) and for Asian/Pacific Islander and were (5.6%). Figure 18 shows the prevalence rates of high birthweight by race/ethnicity among 2010 New Jersey PNSS women.

Figure 18



The variation by age for high birth weight among New Jersey 2010 PNSS showed that women over 40 years had the highest prevalence rate (8.2%) followed by women aged 30 to 39 years (7.9%) for and 5.9% for 20 to 29 years old. The lowest prevalence rate for high birth weight was (2.8%) for 15-17 years and (4.5%) for women in the 18 to 19 years age groups.

New Jersey 2010 PNSS data showed that the highest prevalence rates of high birth weight (8.5%) and (7.3%) were among obese or overweight women (based on pre-pregnancy BMI). The lowest prevalence rates of high birth weight (2.8%) were among women who were underweight followed by those classified as normal weight before pregnancy. The prevalence rates of high birth weight among New Jersey 2010 PNSS women that gained more than the ideal was three times higher compared to those that gained less than the ideal weight and two times more than those that gained the ideal

weight. New Jersey 2010 PNSS women who were non-smokers during pregnancy had higher (6.4%) prevalence rate of high birth weight than those that smoked (2.8%) during pregnancy.

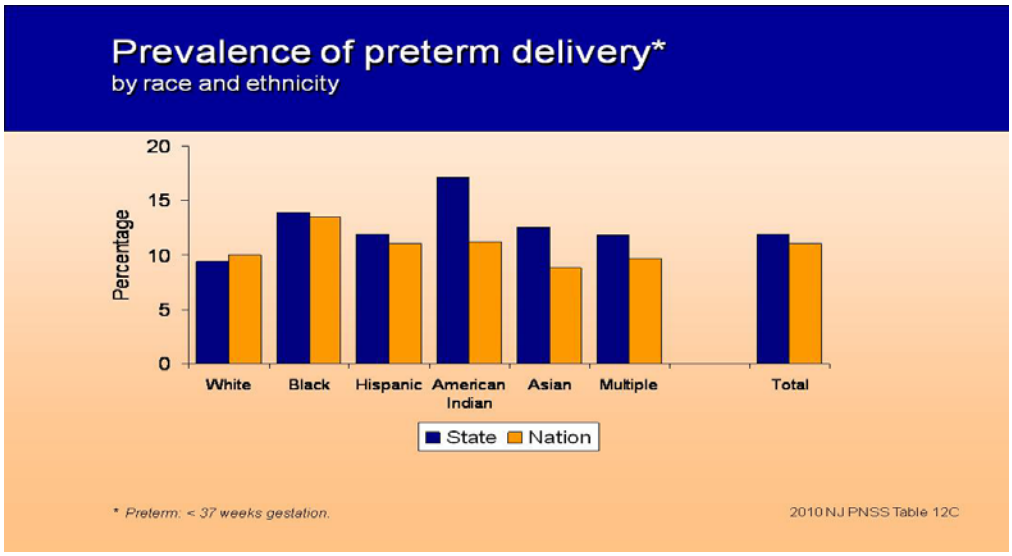
PREMATURITY:

Preterm birth refers to delivery before 37th weeks of gestation. Prematurity has been identified as a fundamental factor contributing to perinatal health problems in industrialized nations. An infant born prematurely has an increased risk of neurological and respiratory disorders, ocular diseases, and death. It is increasingly recognized that prevention of preterm births is crucial to improving pregnancy outcomes. An objective in Healthy People 2010 is to reduce preterm births to no more than 7.6%

The New Jersey 2010 PNSS women had a higher overall prevalence rate of premature birth (11.9%) than the similar National group with 11.1%. The prevalence rate (11.9%) of premature birth among New Jersey 2010 PNSS women was lower by more than 1.2 percent compared to the rate of the 2009 New Jersey PNSS women.

The prevalence rate of preterm birth in the 2010 New Jersey PNSS varied between racial and ethnic groups. American Indian/Alaska Native had the highest prevalence rate for preterm birth (17.1%) followed by Black, Not-Hispanic (13.9%) and Asian/Pacific Islander at 12.5% among New Jersey 2010 PNSS women. White, Not-Hispanic had the lowest prevalence rate for preterm birth at 9.4%. and Multiple Races had prevalence rate of preterm birth 11.8% and Hispanic had a rate of 11.9% among New Jersey 2010 PNSS women. Figure 19 shows the prevalence rates of premature births by race/ethnicity among 2010 New Jersey and National PNSS women.

Figure 19



Comparing the prevalence of preterm birth by women's age, New Jersey 2010 PNSS women 40 years old and above had the highest rate (16.0%). The prevalence rate (13.7%) for preterm birth was also high for New Jersey 2010 PNSS women who were in the 30 to 39 year age group. New Jersey 2010 PNSS women who were 15 to 17 years old had higher prevalence rate (13.1%) for preterm birth than the 10.8% for 18 to19 years old and (11.0%) for 20 to 29 years old.

The prevalence of preterm birth declined by almost 2% when the rates were compared across educational attainment of the New Jersey 2010 PNSS women. Specifically, New Jersey 2010 PNSS women with less than high school education had the highest prevalence rate for preterm birth (13.0%) compared to 11.4% for those that completed high school education and 11.8% for the group with above high school education.

Comparisons based on pre-pregnancy BMI, women with normal weight had the lowest prevalence rate of preterm birth (10.9%), but the rate (11.7%) for the overweight women was relatively similar. While the obese women showed the highest rates of preterm birth at 13.5%, the rate (13.1%) for the underweight women was also high among New Jersey 2010 PNSS women.

The prevalence rates of preterm birth among New Jersey 2010 PNSS women that gained more than the ideal weight was 10.2% which was the lowest rate for preterm births. New Jersey 2010 PNSS women that gained less than the ideal weight had worse prevalence rate 15.7% compared to 11.7%

for women that gained the ideal weight. New Jersey 2010 PNSS women that were non-smoking during pregnancy had lower (12.2%) prevalence rate of preterm birth compared to the smokers (14.3%).

Maternal Health Progress

Advances in several indicators were observed in the PNSS population from 1999 through 2010. The prevalence of initiation of breastfeeding increased from 53.6% in 1999 to 63.2% in 2010. In addition, since 1999, the proportion of women who enroll in the WIC program during their first trimester increased from 16.3% to 23.7% in 2010. The proportions of women who smoke before pregnancy or during the last trimester of pregnancy have declined since 1999, when 10.9% of women reported smoking before becoming pregnant, and 10.0% reported smoking during their last trimester. Now those rates are 6.8% and 3.6% respectively in 2010.

Overweight is a major public health problem that has steadily increased in New Jersey and the nation. From 1999 through 2010, the prevalence of women who were overweight or obese before pregnancy increased from 45.0% to 51.6%.

Pregnancy Nutrition Recommendations

The PNSS data indicate that national and state public health programs are needed to support the following activities:

- Implement innovative strategies to continue to reduce the prevalence of tobacco use among pregnant women and women of reproductive age.
- Promote and support breastfeeding through effective programs, medical care systems, work sites, and communities.
- Prevent preterm delivery and low birthweight by providing preconception nutrition, including iron supplementation. Conduct outreach activities to promote early identification of pregnancy and early entry into comprehensive prenatal care, including the WIC program.
- Provide information to prenatal participants, especially women who are overweight or obese before pregnancy, about the importance of appropriate weight gain during pregnancy and the health risks of excess weight gain and post partum weight gain retention. Continue to promote appropriate physical activity as well as healthy eating to help support appropriate weight gain.

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4.5 The New Jersey Pediatric Nutrition Surveillance System*

The Pediatric Nutrition Surveillance System (PedNSS) is a public health surveillance system used in monitoring the nutritional status of low-income children in federally funded maternal and child health programs. Data on birth weight, breastfeeding, anemia, short stature, underweight, and overweight are collected for children who visit public health clinics for routine care, nutrition education, and supplemental food. Data are collected at the clinic level then aggregated at the state level and submitted to the Centers for Disease Control and Prevention (CDC) for analysis.

Data for the New Jersey 2010 PedNSS were collected during certification or recertification in the WIC Program. The goal of PedNSS is to collect, analyze, and disseminate surveillance data to guide public health policies and actions. PedNSS information is used to set priorities and to plan, implement, and evaluate nutrition programs. This report summarizes 2010 New Jersey PedNSS data and compares New Jersey rates to the National PedNSS/ Healthy People 2010 objectives.

Demographic Characteristics

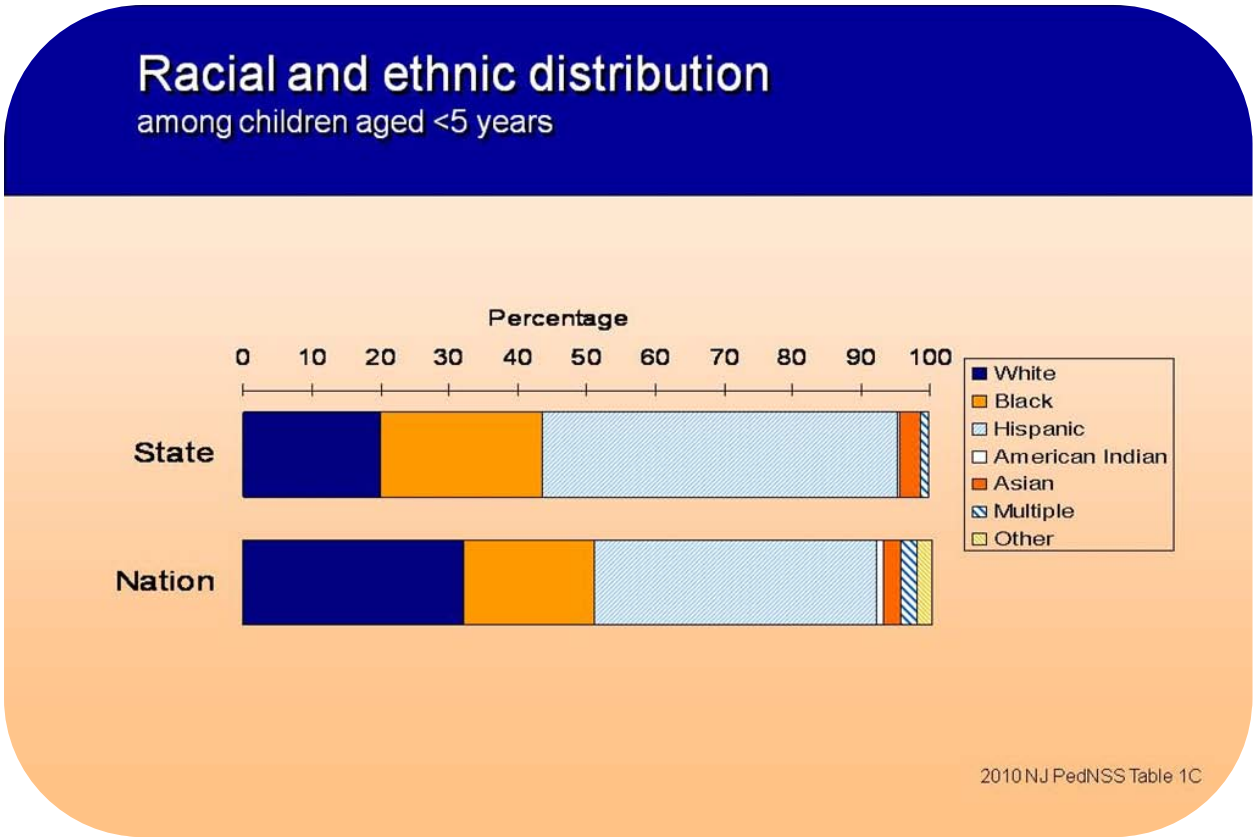
Age: New Jersey 2010 PedNSS database contained data for 180,750 infants and children. Of the 180,750, 35.4% were infants (0 to 11 months), 20.1% were (12 to 23 months) and 44.5% were children (24 months to 59 months). Figure 1 shows the age distribution of New Jersey 2010 PedNSS infants and children.

Figure 1

* Available at http://www.cdc.gov/pednss/

Race/Ethnicity: The race/ethnicity of New Jersey 2010 PedNSS varied, 51.6% Hispanic, 23.6% Black not-Hispanic, 19.9% White not Hispanic, 3.0% Asian/Pacific Islander, 0.5 % American Indian/Alaska Native, and 1.3% of Multiple Races. More than 50% of all New Jersey PedNSS population was Hispanic. Figure 2 shows the race/ethnic distribution of New Jersey 2010 PedNSS population.

Figure 2



Compared to 2009 New Jersey PedNSS, the percentage of Black not-Hispanic and American Indian/Alaska Native decreased; Asian/Pacific Islander and Multiple Races remained unchanged, Hispanic and White, not Hispanic increased. The Hispanic population was the largest in both New Jersey and National 2010 PedNSS, 51.6% and 40.6% respectively.

Pediatric Health Indicators

Low Birthweight

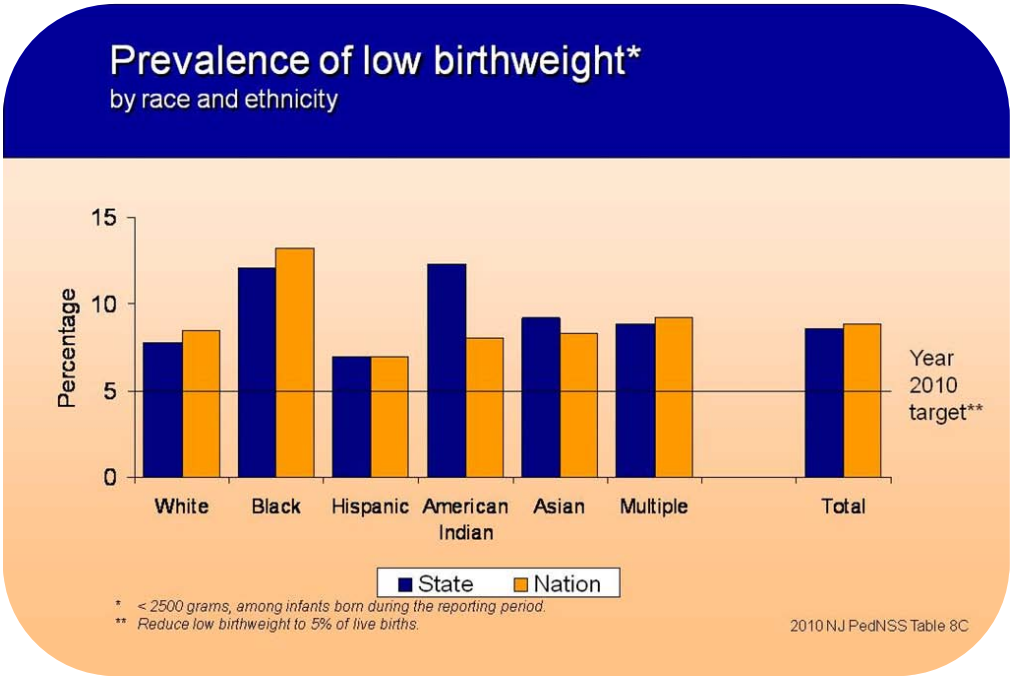
Birth weight, underweight, overweight, stunted growth and anemia were used in PedNSS as health status indicators among the population. In PedNSS, birth weight is grouped into two - low and high birth weights. Infant that weighed less than 2,500 grams or 5.5 pounds at birth are grouped as low birth weight infants. Low birth weight is a major determinant of neonatal and post-neonatal mortality. Infants with low birth weight are more likely to have developmental delays and disabilities than infants with normal birth weight. Poor maternal nutrition, pre-pregnancy weight status, gestational weight gain and behaviors such as smoking, alcohol consumption and illicit drug use during pregnancy contribute to the incidence of low birth weight. The Healthy People 2010 Objectives include reduction of low birth weight to 5% for all live births.[v]

The overall prevalence rate of low birth weight in New Jersey 2010 PedNSS was 8.6%, a decrease of 0.2 percent from the rate in 2009. The prevalence rate of low birth weight among the National 2010 PedNSS was 8.9% which is slightly higher than the New Jersey rate. Among New Jersey 2010 PedNSS, the prevalence rate of low birth weight is higher than the goal set in the Healthy People 2010.

Variations exist in the prevalence rate of low birth weight in New Jersey 2010 PedNSS population based on race/ethnicity. The highest prevalence rates of low birth weight among New Jersey infants in the 2010 PedNSS were 12.3% and 12.1% respectively for American Indian/Alaskan Native and Black, not Hispanic. The prevalence rates of low birth weight was 9.2% for Asian/Pacific Islander, 8.9% for Multiple Race, and 7.8% for White, not Hispanic were higher than the 2010 Healthy People objectives for the nation. The prevalence rate of low birth weight for Hispanic 7.0% was the lowest and closer reaching to the Healthy People 2010 national health objective for low birth weight.

Figure 3 shows the prevalence rates of low birth weight by race/ethnicity among New Jersey and national 2010 PedNSS population.

Figure 3



High Birthweight

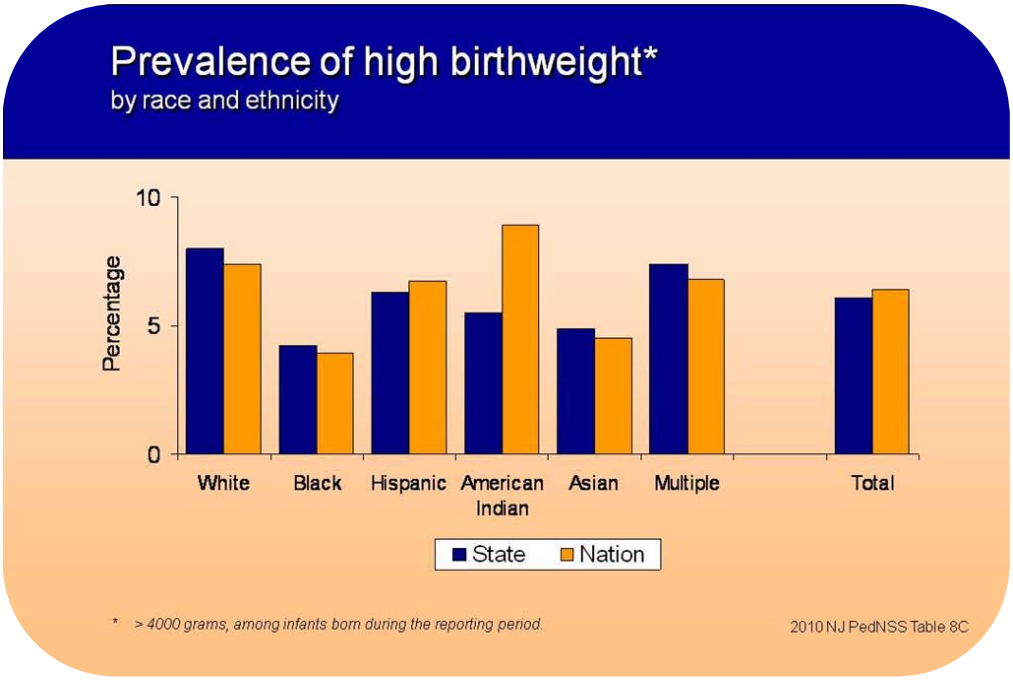
Infants that weighed more than 4,000 grams or 9 pounds at birth are grouped as high birth weight infants. High birthweight (HBW) puts infants at increased risk for death and birth injuries such as shoulder dystocia. Other risks associated with infants include nerve injury, fractures, asphyxia, childhood obesity and medical complications. High birthweight also predisposes infants to an increased risk for Type I and II diabetes, lower respiratory tract conditions, hypertension and future cardiovascular difficulties compared to normal birth weight infants.

In the New Jersey 2010 PedNSS, the prevalence rate of HBW was (6.1%). This 2010 NJ PedNSS HBW rate compared with the 2009 rate of (6.3%), slightly decreased. The overall prevalence rate of the national 2010 PedNSS population (6.4%) was slightly higher than the rate for New Jersey at the same period.

The prevalence varied by race/ethnicity among New Jersey 2010 PedNSS groups. The highest prevalence rate of (8.0%) was among White, not-Hispanic followed by 7.4% for the Multiple Races in New Jersey 2010 PedNSS. The lowest prevalence rates were (4.2%) among Asian/Pacific Islander and (4.9%) for Black, not Hispanic in New Jersey 2010 PedNSS population. The prevalence rate for

Hispanic was 6.3% and 5.5% for American Indian/Alaskan Native. Figure 4 shows the prevalence rates of high birth weight by race/ethnicity among New Jersey and national 2010 PedNSS population.

Figure 4



Comparison of 2009 and 2010 New Jersey PedNSS race/ethnicity data showed the prevalence rates among White, not-Hispanic remained the same, rates for Black, not Hispanic and Asian/Pacific Islander increased and American Indian/Alaskan Native and Multiple Races rates decreased. The changes in the prevalence rates within the race/ethnicities in New Jersey 2010 PedNSS were very small.

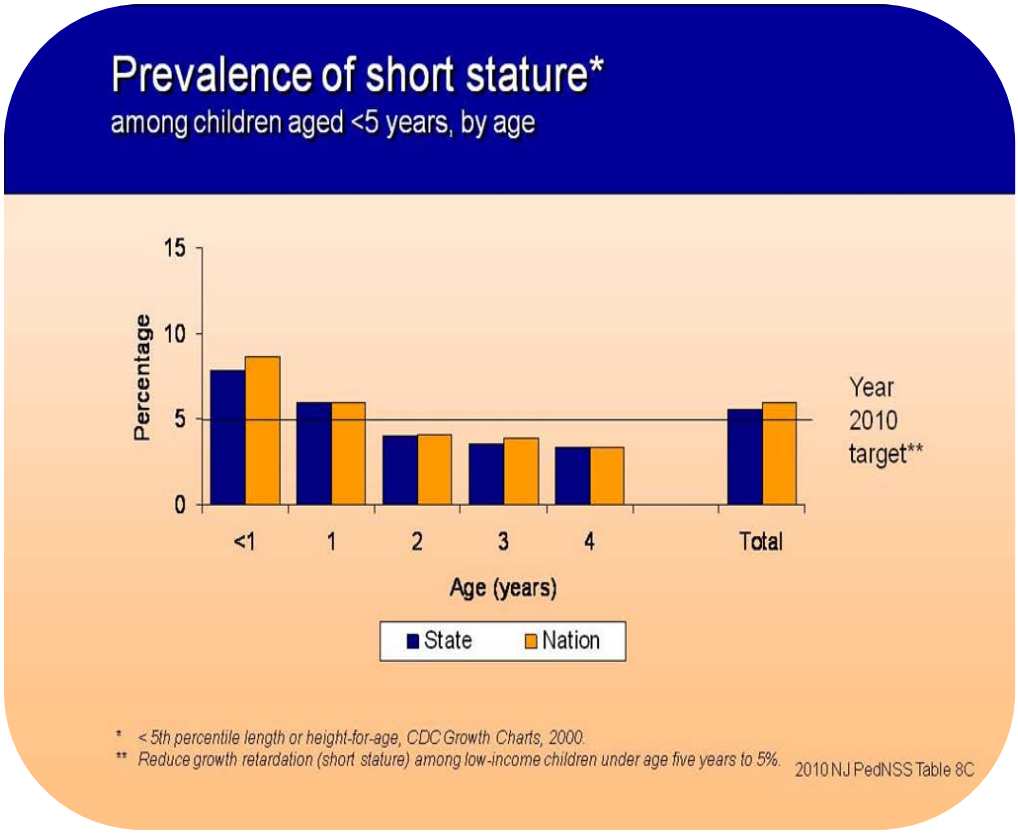
Short Stature

Short stature is low length/height-for-age. The causes or contributory factors to short stature are not well documented but some research has attributed short stature to long-term impact of recurrent illness and inadequate food intake. Short stature also is associated with parental stature or low birth weight. Healthy People 2010 objective (19-4) was to reduce growth retardation among low-income children less than 5 years of age to 5%.[i]

The general prevalence rate of short stature for New Jersey 2010 PedNSS group was 5.6% compared with 6.0% for the national group of the same age. The prevalence rate of short stature among New Jersey 2010 PedNSS was lower than the rate (6.1%) in 2009 and the national 2010 PedNSS rate. However, New Jersey 2010 PedNSS data showed that the prevalence rate of short stature has not reached the Healthy People 2010 objective target of five percent (5%).

By age, the highest prevalence rate of short stature was 7.9% for infants 0 to 11 months and the lowest rate was 3.4% for 3 to 5 years old among New Jersey 2010 PedNSS group. The prevalence rate of short stature for New Jersey 2010 PedNSS population decreased as the age increased. Figure 5 shows the prevalence rates of short stature by age among New Jersey and National 2010 PedNSS population.

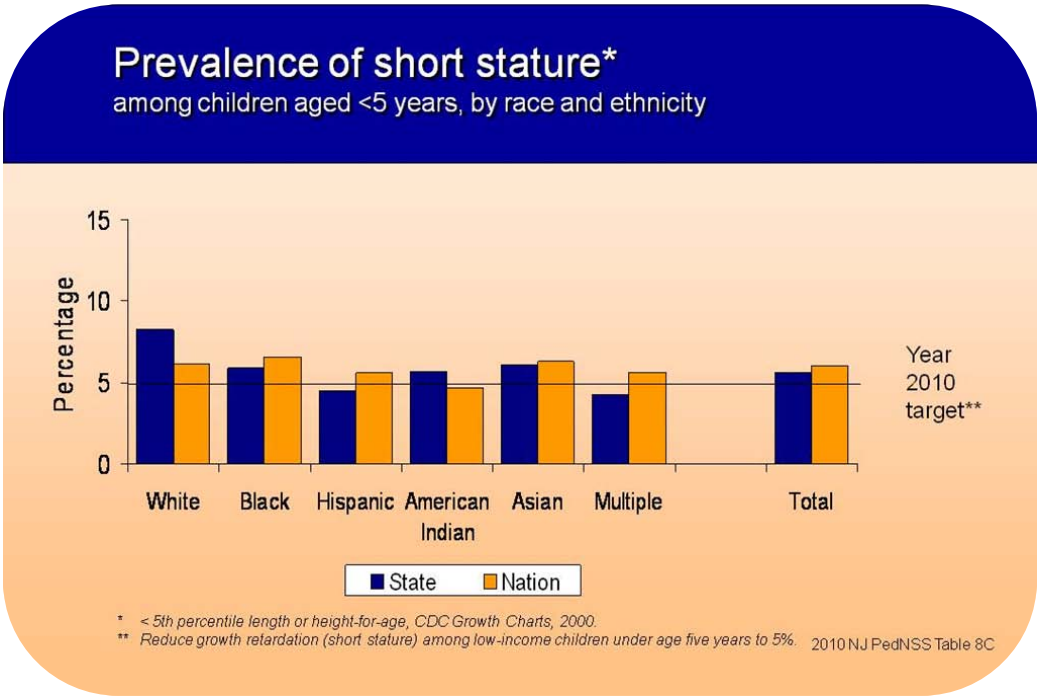
Figure 5



The prevalence of short stature varied by race/ethnicity among New Jersey 2010 PedNSS groups. New Jersey 2010 PedNSS data showed that White, not-Hispanic had the highest prevalence rate of short stature at 8.3% followed by 6.1% for Asian/Pacific Islander and 5.9% for Black, not Hispanic.

The prevalence of short stature for American Indian/Alaskan Native was 5.7%. The lowest rate (4.3%) for short stature was among Multiple Race in New Jersey 2010 PedNSS. Figure 6 shows the prevalence rates of short stature by race/ethnicity among New Jersey and National 2010 PedNSS population.

Figure 6



Only the Multiple Race prevalence rate of short stature has met and is below the Healthy People 2010 objective of five percent (5%) among New Jersey 2010 PedNSS. For all the race/ethnicity among New Jersey 2010 PedNSS population, the prevalence rates of short stature decreased from the 2009 rates with the largest decrease (1.0%) among American Indian/Alaskan Native.

Underweight

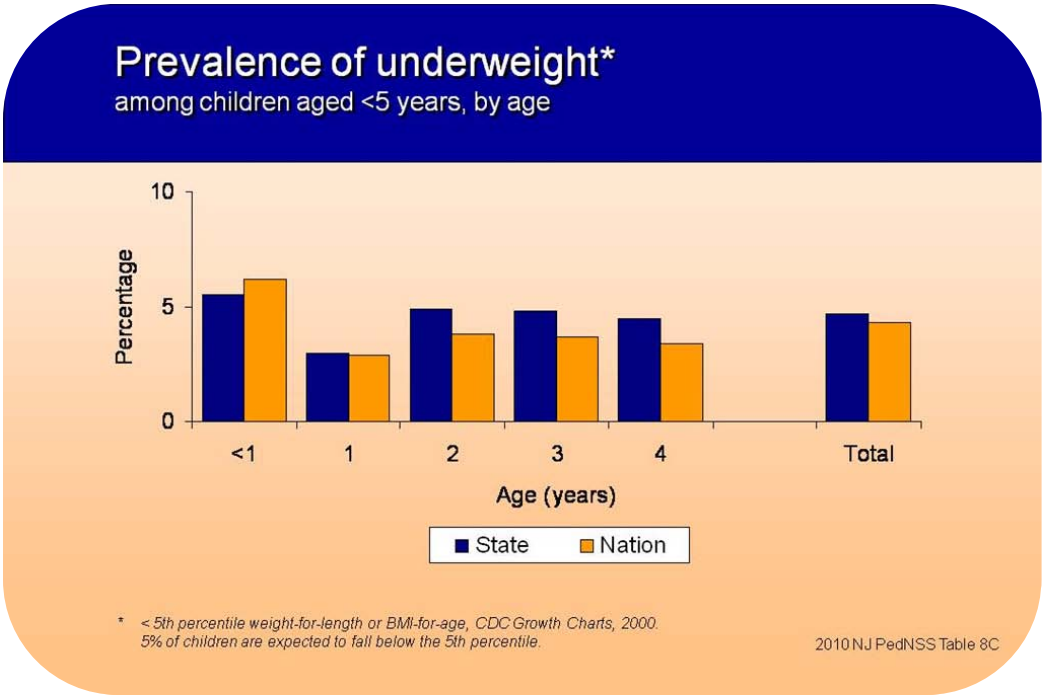
Underweight is determined by using the 2000 CDC gender-specific growth chart percentiles of less than the 5th percentile weight-for-length for children younger than 2 years of age and less than the 5th percentile BMI -for-age for children aged 2 years or older.

Data on underweight (low weight-for-length or low body mass index for age) in children from birth to age 5 years indicate the presence of acute malnutrition. Among New Jersey 2010 PedNSS, the overall prevalence rate of underweight was 4.7% which was less than the Healthy People 2010

objective target of five prevent (5.0%). The prevalence of underweight for the National 2010 PedNSS is 4.3% and less than the rate for the New Jersey 2010 PedNSS. The overall prevalence rate of underweight among New Jersey 2009 PedNSS increased from (3.9%) to 4.7% in 2010.

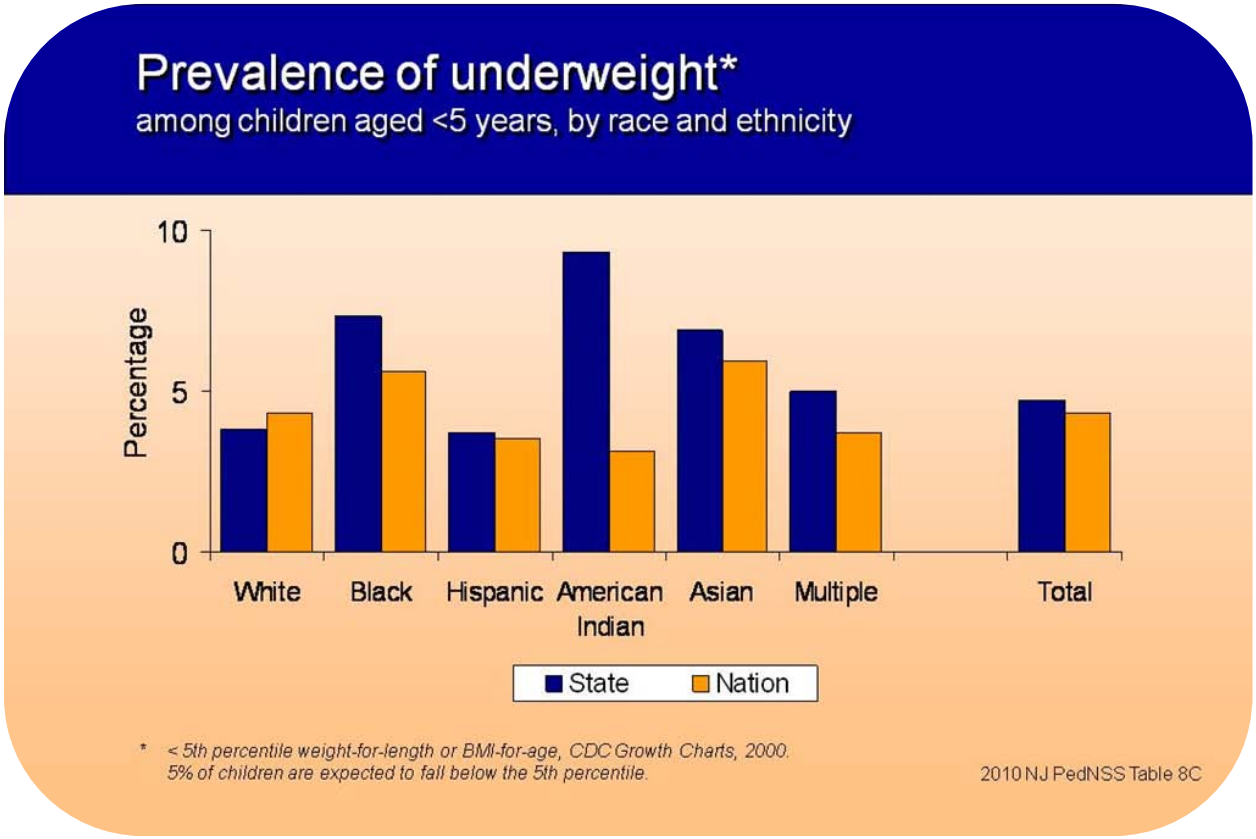
The highest prevalence rate of underweight by age was among infants less than one year old and the lowest rate among 12 months to 23 months old in New Jersey 2010 PedNSS. From the age group of 24 months to 35 months, as age increased among the New Jersey 2010 PedNSS, the rate of underweight decreased. The prevalence rates of underweight by age among New Jersey and national 2010 PedNSS population is shown in Figure 7.

Figure 7



Comparisons by race/ethnicity, showed the highest prevalence rates of underweight in New Jersey 2010 PedNSS was 9.3% among American Indian/Alaskan Native, followed by Black, Not Hispanic rate at 7.3% and Asian/Pacific Islander at 6.9%. Hispanic and White, not Hispanic had the lowest prevalence rate of underweight (3.7% and 3.8% respectively) among the New Jersey 2010 PedNSS group. Figure 8 shows the prevalence rates of underweight by race/ethnicity among New Jersey and National 2010 PedNSS population.

Figure 8



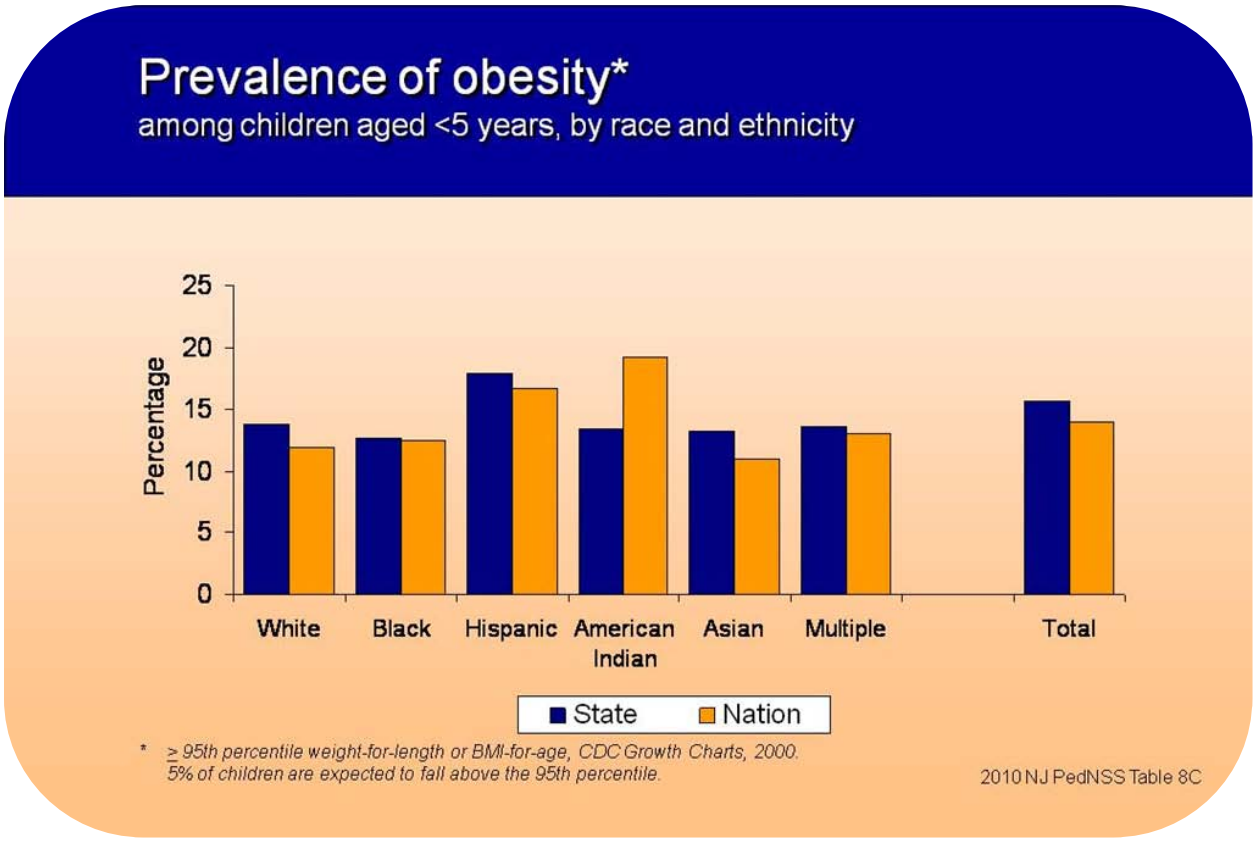
Overweight and Obesity

Childhood obesity continues to be a leading public health problem that disproportionately affects low-income and minority children. It is well documented that children who are obese in their preschool years are more likely to be obese in adolescence and adulthood and to develop serious health conditions such as diabetes, hypertension, hyperlipidemia, asthma, and sleep apnea. One of the *Healthy People 2010* objectives (19-3) is to reduce to 5% the proportion of children and adolescents who are obese.[i]

The Expert Committee on the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity recommends the use of two cutoff points to screen children for overweight and obesity in children aged 2 years or older. On the CDC Growth Chart for the United States (gender-specific percentiles), children with a BMI-for-age at or above the 95th percentile are considered obese, and those with a BMI-for-age between the 85th and 95th percentiles are considered overweight. In the New Jersey 2010 PedNSS, the prevalence rate of obesity among children aged 2–5 years was 17.3%, compared with 14.9% for National PedNSS of a similar age in the same period. In

the New Jersey 2010 PedNSS, the highest prevalence rates of obesity among children aged 2–5 years old were (20.9%) among Hispanic followed by (16.5%) for Asian/Pacific Islander, (14.8%) for American Indian/Alaska Native and (13.1%) for White not Hispanic. Black not Hispanic had the lowest prevalence rate of obesity among children aged 2–5 years (12.2%) and the Multiple Races (12.3%). Among all the race/ethnic groups in New Jersey 2010 PedNSS, except American Indian/Alaska Native, the prevalence rate of obesity among children aged 2–5 years declined compared to 2009 data. Figure 9 shows the prevalence rates of overweight by race/ethnicity among New Jersey and National 2010 PedNSS population.

Figure 9

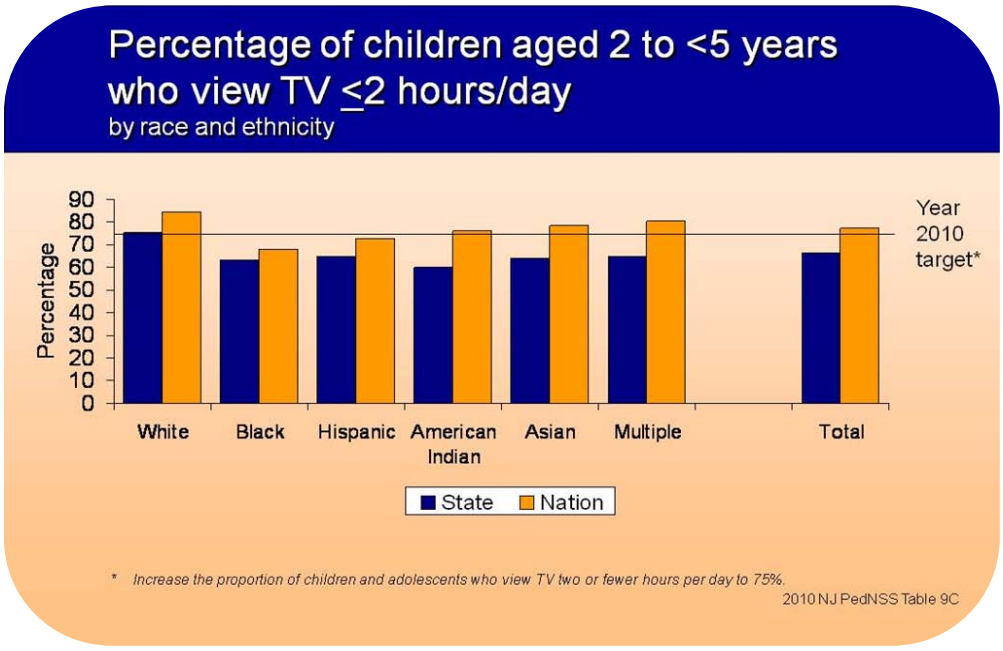


Watching television and/or engaging in playing electronic games are considered sedentary activities. Sedentary activities displace time for physical activity and potentially contribute to childhood overweight and obesity. The American Academy of Pediatrics recommends and data suggests children view less than two hours of television per day. Caregivers provided the estimated amount of time their children spent watching television or playing with other electronic game in a given day during certification or recertification into the WIC Program.

In reviewing the data, the prevalence rate of ≤ 2 hours of television viewing per day among New Jersey 2010 PedNSS population was 66.5%, compared to 77.3% for National PedNSS in the same period. New Jersey 2010 PedNSS data showed the prevalence rate of ≤ 2 hours of television viewing per day was lower than the target in the 2010 Healthy People objective.

In the New Jersey 2010 PedNSS, the highest prevalence rates of ≤ 2 hours of television viewing per day was among White not Hispanic at 75.1% followed by Hispanic at 65.0%, Multiple Race at 64.8% and by Asian/Pacific Islander with 64.2%. The lowest prevalence rate of ≤ 2 hours of television viewing per day was 60.2% for American Indian/Alaska Native and 63.4% for Black not Hispanic New Jersey 2010 PedNSS population. Figure 10 shows the prevalence rates of ≤ 2 hours of television viewing per day by race/ethnicity.

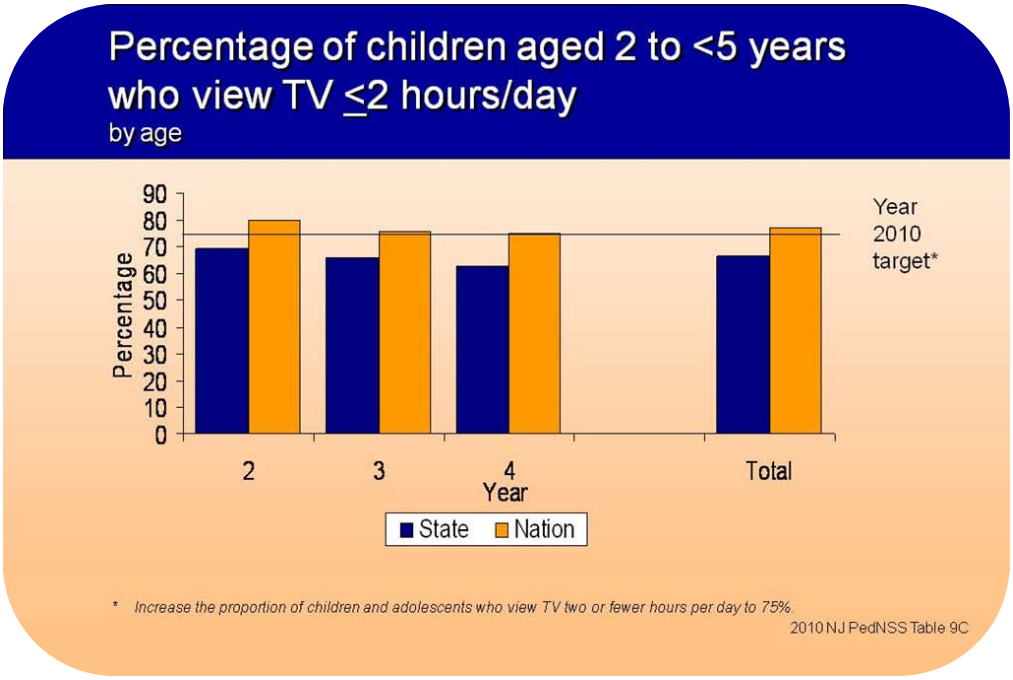
Figure 10



By age, the highest prevalence rate of ≤ 2 hours of television viewing per day was 69.2% among 12 to 23 months and the lowest prevalence rate 62.9% was for 48 to 60 month olds among New Jersey 2010 PedNSS group. The prevalence of ≤ 2 hours of television viewing per day for 36 to 47 months was 66.0%. As the age of the New Jersey 2010 PedNSS population increased the prevalence rate of

≤ 2 hours of television viewing per day decreased. Figure 11 shows the prevalence rates of ≤ 2 hours of television viewing per day by age.

Figure 11



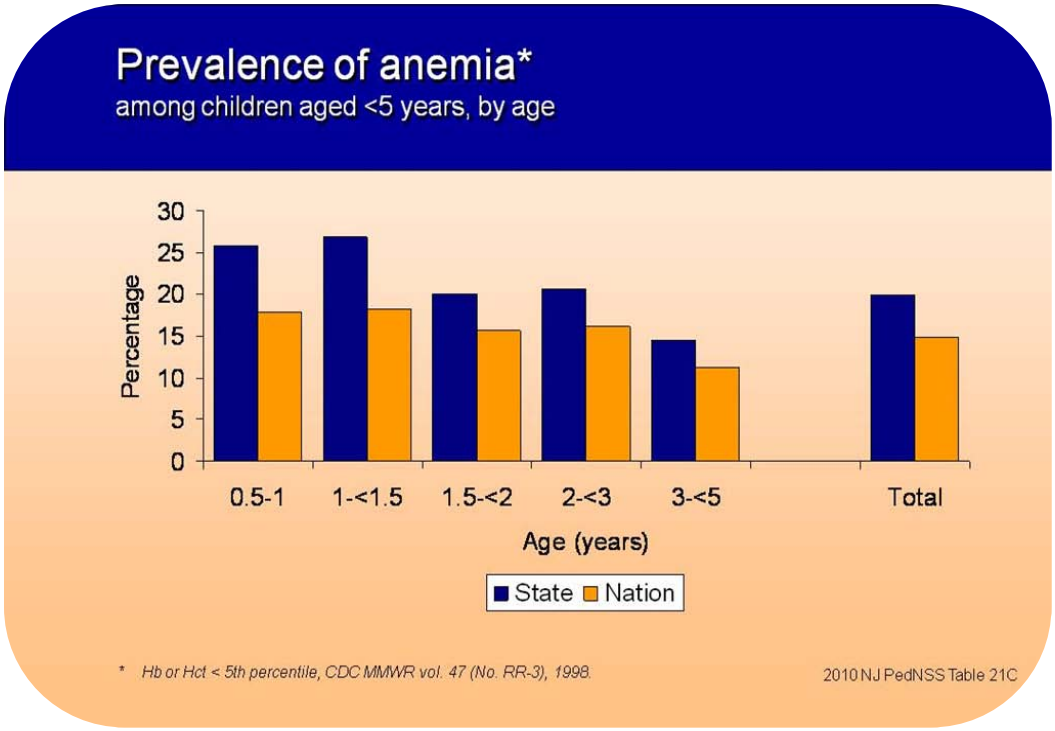
Anemia

Anemia (low hemoglobin or low hematocrit) is an indicator of iron deficiency, which is associated with developmental delays and behavioral problems in children. Children aged 6 months to 2 years are diagnosed with iron deficiency anemia if their hemoglobin (Hgb) concentration is less than 11.0 g/dL or if their hematocrit (Hct) level is less than 32.9%. Children aged 2–5 years are considered anemic if their Hgb concentration is less than 11.1 g/dL or if their Hct level is less than 33.0%.[vi] Values are adjusted for altitude. Hgb concentration and Hct level are not reported for children younger than 6 months.

In the New Jersey 2010 PedNSS, the prevalence rate of anemia was 19.9% compared to 14.9% for National 2010 PedNSS. The overall prevalence rate of anemia in New Jersey 2010 PedNSS slightly changed from 18.8% in 2009 to 19.9% in 2010 and also exceeded the National 2010 PedNSS rate in 2010. The prevalence of anemia in New Jersey 2010 PedNSS population is high and has not attained the Healthy People 2010 objective.

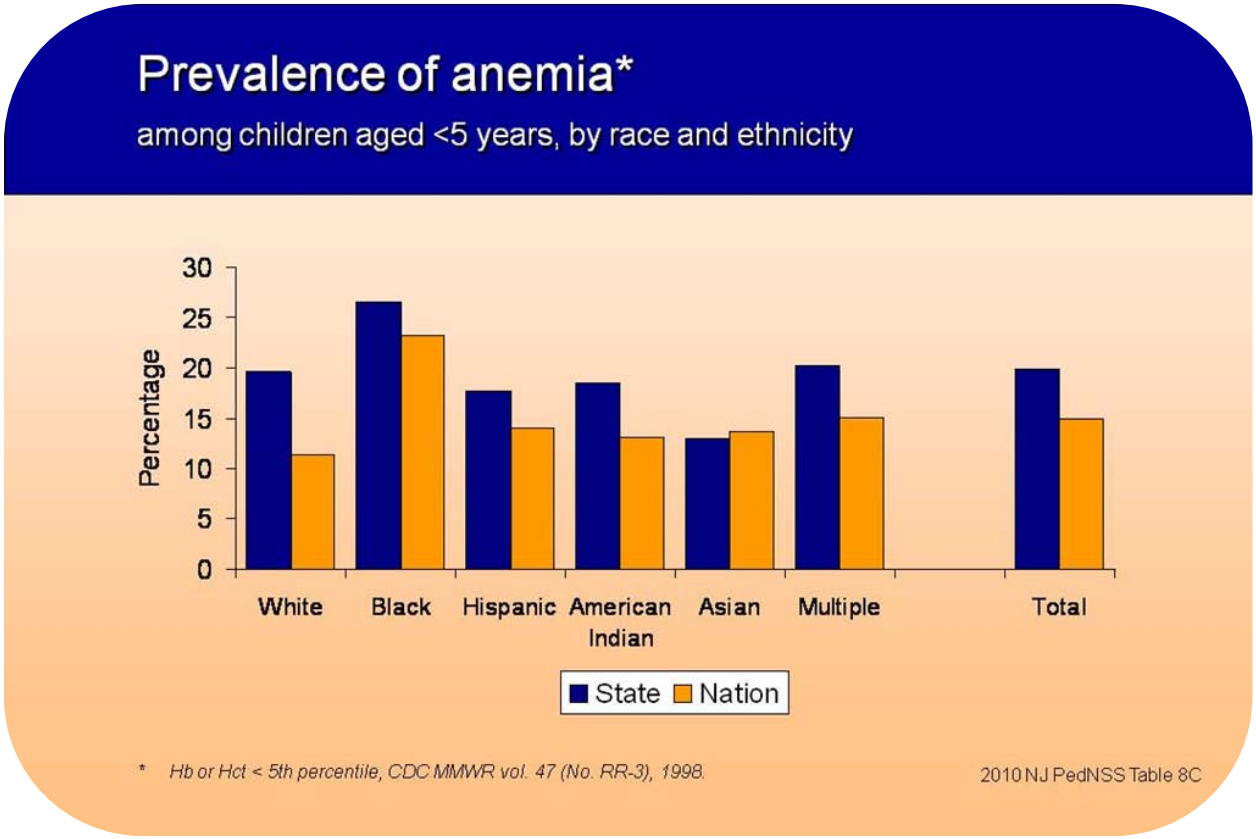
By the age categories, the highest prevalence rates of anemia in New Jersey 2010 PedNSS were among children aged 0–11 months (25.8%) and 12–23 months (23.9%). The lowest prevalence rate of anemia in New Jersey 2010 PedNSS was among 4–5 years (12.8%). The prevalence rates of anemia among New Jersey 2010 PedNSS consistently decreased as the age increased. Figure 12 shows the prevalence rates of anemia by age among New Jersey and national 2010 PedNSS population.

Figure 12



The prevalence rate of anemia varied by race/ethnicity in the New Jersey 2010 PedNSS. The highest prevalence rate of anemia (26.6%) was for Black not Hispanic and the lowest rate (13.0%) was among Asian/Pacific Islander in New Jersey 2010 PedNSS. Multiple Races, White not Hispanic, American Indian/Alaskan Natives, and Hispanic had prevalence rates of anemia 20.2%, 19.6%, 18.5% and 17.7% respectively. The various prevalence rates of anemia by race/ethnicity among New Jersey 2010 PedNSS increased from the 2009 rates. Figure 13 shows the prevalence rates of anemia by race/ethnicity among New Jersey and National 2010 PedNSS population.

Figure 13



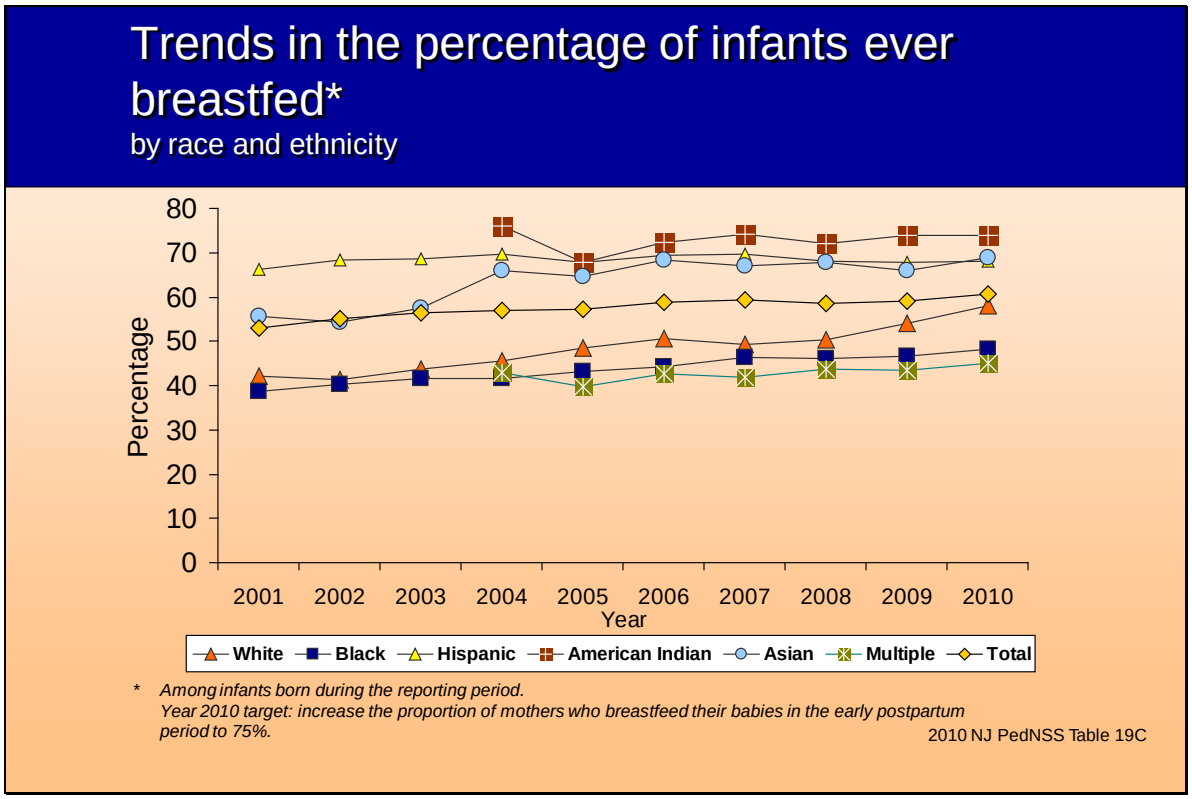
Breastfeeding

The nutritional, immunologic, allergenic, economic and psychologic importance of breast milk is well recognized.[vii] In the New Jersey 2010 PedNSS, 60.6% of infants were ever breastfed, 31.3% were breastfed for at least 6 months, and 23.6% were breastfed for at least 12 months; 8.0% of infants were exclusively breastfed for three months and 7.6% for six months. The *Healthy People 2020* objectives (MICH-21) are to increase the proportion of children ever breastfed to 81.9%, breastfed at 6 months to 60.6%, and breastfed at 1 year to 34.1%[i].

The prevalence of breastfeeding for children in PedNSS has increased more than 14% from the 2001 rate of 53.1% and these improved breastfeeding rates are evident among all racial and ethnic groups except American Indian/Alaskan Natives, which decreased from 76.0% in 2004 to 73.8% in 2010 (Figure 14). The lowest prevalence of breastfeeding (45.1%) is among infants of multiple races; this is a 4.9% increase from 2004, when multiple race data was first collected and the rate was 43.0%. Among black infants, the prevalence of breastfeeding in 2010 was 48.2%, an increase of more than 24% since 2001, when the rate was 38.8%. From 2001 to 2010 the prevalence among whites

increased from 42.0% to 58.0%; among Hispanics from 66.3% to 68.2%; among Asians or Pacific Islanders from 55.5% to 69.1%.

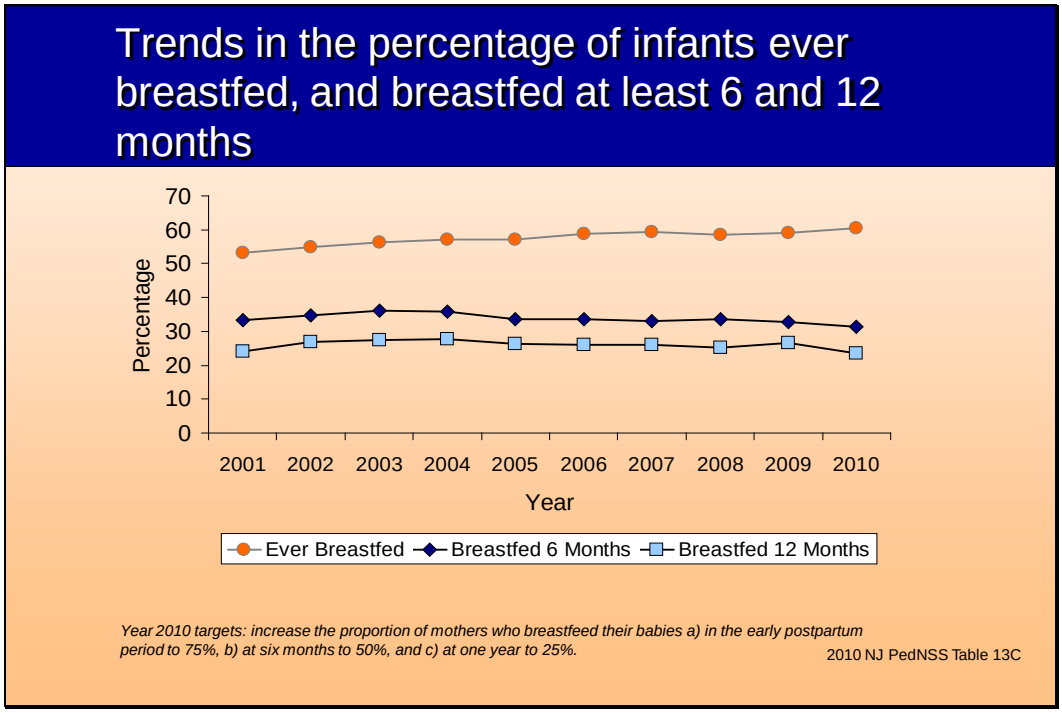
Figure 14



Nationally representative data from the National Immunization Survey (NIS) on 2008 births indicate that 74.6% of all U.S. infants were ever breastfed, 43.3% were breastfed for 6 months, and 23.8% were breastfed for 12 months.[viii]

The prevalence of breastfeeding at least six months among the New Jersey PedNSS population decreased from the 2001 rate of 33.2% to 31.3% in 2010. The prevalence of breastfeeding at least 12 months decreased from the 24.2% rate in 2001 to 23.6% in 2010 (Figure 15).

Figure 15



The PedNSS recently began monitoring *exclusive breastfeeding*, defined by WIC as a breastfeeding infant not receiving WIC formula. In 2010, 8.0% of New Jersey infants were exclusively breastfed for at least three months and 7.6% for at least six months, compared to 9.9% at three months and 5.3% at six months nationally. Exclusive breastfeeding has a strong protective effect against lower respiratory tract infections, middle ear infections, eczema, and childhood obesity.[ix]

Infant and Child Health Advances and Concerns

The prevalence of short stature in the New Jersey PedNSS population has not met the *Healthy People 2010* objective of 5% among low-income children younger than 5 years of age. Nutrition assessment at WIC clinics provides opportunity to assess whether food insecurity or parental knowledge/food skills are contributing to inadequate nutrition that is associated with stunted growth among infants and children and appropriate referral provided.

Overall New Jersey 2010 PedNSS data showed that the Healthy People objective for LBW, over/underweight and anemia and other health indicators are not yet met. Continued efforts on educating and counseling caregivers of PedNSS population at WIC clinics and collaboration with other agencies that provides services that address the above health problems should be intensified.

Disparity in health indicators exist based on race/ethnicity. Black, not Hispanic had worse outcomes on almost the health indicators. It is suggested that culturally competent approach be used in service provision and for studies conducted to untangle the factors that contribute to disparity in health outcomes.

Improvements have occurred in the prevalence of infants ever breastfed while the prevalence of infants breastfeeding for at least three and six months has decreased. Exclusive breastfeeding rates were below Healthy People 2010 and Healthy New Jersey targets.

Pediatric Nutrition Recommendations

The New Jersey PedNSS data indicate that national and state efforts are needed to:

- Lower low birth weight by educating/counseling child-bearing on maternal behaviors that contribute to the incidence of low birth weight.
- Increase the number of women for early enrolment in medical care and WIC Program. Early enrollment into medical care and WIC Program provide opportunities for early dictation of predisposing factors to negative birth outcomes.
- Promote and support breastfeeding initiatives in public health programs, medical care systems, work sites, and communities.
- Identify successful programs and policies to support exclusive breastfeeding, especially among populations with low prevalence.
- Promote adequate dietary iron intake and the screening of children at risk for iron deficiency.
- Implement promising approaches to preventing obesity and chronic diseases that have been recommended by CDC's Division of Nutrition, Physical Activity and Obesity. These approaches include 1) increasing breastfeeding initiation, duration and exclusivity; 2) increasing physical activity; 3) increasing the consumption of fruits and vegetables; 4) decreasing the consumption of sugar-sweetened beverages; 5) reducing the consumption of high energy dense foods (foods high in calories per gram weight); and 6) decreasing television viewing.

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[iv] Centers for Disease Control and Prevention. *Breastfeeding Report Card – United States, 2011*. Available at http://www.cdc.gov/breastfeeding/data/reportcard.htm.

[v] Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, et al. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. Evidence Report/Technology Assessment No. 153. Available at: http://www.ahrq.gov/clinic/tp/brfouttp.htm.

5.0 MILESTONES - SIGNIFICANT INITIATIVES FOR FFY 2012

5.1 Office of the Director

5.1.1 Partnership for Nutrition, Physical Activity and Obesity

WIC Services joined as one of over 100 partners in Shaping NJ, The State Partnership for Nutrition, Physical Activity and Obesity. This project was the result of recommendations of the Obesity Prevention Task Force, which was established by the legislature in 2003, and detailed in The New Jersey Obesity Prevention Action Plan in 2006. DHSS, Division of Family Health Services, was charged with the task of establishing an office to accomplish the recommendations of the Task Force, including identifying funding opportunities, needs, resources, and establishing collaboration among organizations and agencies. Family Health Services established the Office of Nutrition and Fitness, which received a 5 year grant from the CDC to address the issue of obesity in the State. The target areas under the grant are: increase breastfeeding initiation, duration and exclusivity, increase physical activity, increase the consumption of fruits and vegetables, decrease television viewing, decrease the consumption of sugar-sweetened beverages and decrease the consumption of energy-dense foods. In the third year of the CDC grant, workgroups for the target areas developed several strategies to implement during the last two years of the project according to settings in communities, childcare, worksites, healthcare, and schools.

The Partnership's strategies to encourage delivery facilities to adopt the Joint Commission's Perinatal Care Core Measure Set, which includes exclusive breast milk feeding, and to adopt the World Health Organization's Ten Steps for Successful Breastfeeding, and to increase the number of businesses that accommodate breastfeeding women in the workplace fit with WIC's efforts to encourage mothers to exclusively breastfeed for six months. Hospital practices that fail to help mothers establish successful exclusive breastfeeding undermine WIC's efforts to help mothers meet health objectives for exclusive breastfeeding for six months. Returning to work is a major barrier to breastfeeding for many WIC mothers. Progress in meeting the objectives of these strategies will benefit WIC mothers.

The Office of Nutrition and Fitness received a second grant from the CDC to support the breastfeeding strategies for healthcare. A forum was held for teams from the delivery hospitals to increase exclusive breastfeeding rates in New Jersey. The forum's objectives were to implement the Ten Steps to Successful Breastfeeding in the State's delivery hospitals and implement office-based trainings for pediatric, family, and obstetric providers and their staff about best breastfeeding

practices utilizing the *Educating Practices In Their Communities* (EPIC) model. Ten hospitals were awarded $10,000 mini-grants to assist their efforts to implement the Ten Steps.

5.1.2 Farmers' Market Collaboration Meetings

The NJ Farmers' Market Nutrition Program (FMNP) had three regional meetings with WIC and Senior Coordinators, staff from the Department of Agriculture, and certified farmers. At the meetings, many constructive suggestions were discussed, including ways to deliver bagged produce in $5.00 and $10.00 increments to the WIC offices. This would provide WIC participants the opportunity to purchase fresh fruits and vegetables and redeem their WIC FMNP and Cash-Value Voucher (CVV) immediately.

5.2 Health and Ancillary Services

Significant program initiatives for the Health and Ancillary Services Unit for FFY 2012 included continued follow-up training on Value Enhanced Nutrition Assessment (VENA) and completing the final phases of the *Using Loving Support to GROW and GLOW in WIC Breastfeeding Training for Local WIC Staff*; referrals to healthcare providers; conducting nutrition/breastfeeding services trainings, piloting a nutrition/breastfeeding discussion board; conducting a statewide movie screen outreach; breastfeeding services orientation, technical assistance training, and publishing four quarterly issues of the MARWIC Times.

5.2.1 Breastfeeding Peer Counseling

The new program guidance set forth in *Loving Support© Through Peer Counseling: A Journey Together For WIC Managers* was required online learning for WIC coordinators and local agency breastfeeding managers. Breastfeeding promotion and support services were provided according to this model. The new curriculum for training WIC Peer Counselors, "*Loving Support© Through Peer Counseling: A Journey Together*, was implemented. This curriculum resides on a highly interactive platform using the latest technology. The State put together a presentation kit consisting of the hardware and software necessary to conduct the trainings. The kit was loaned to local agencies for trainings through a reservation process, which allows the State to match agencies that plan trainings around the same time. This collaboration, when geographically possible, makes it more likely to attain an ideal class size of six to twelve women for the exchange of ideas and efficient use of trainers' time.

New Jersey's share of the FFY 2011 Breastfeeding Peer Counseling funds was placed in the FFY 2012 grants for the local agencies and MCH consortia. These funds, which are additional to the breastfeeding target funds, allowed agencies to increase staff hours and the number of breastfeeding staff. Agencies expanded breastfeeding services to WIC sites where there previously were no services, increased services at other sites, and began making visits to new WIC breastfeeding mothers in some hospitals. More women received breastfeeding services in Spanish, Arabic and other languages. The State Agency has prioritized making comprehensive breastfeeding promotion and support services fully integrated as a core service.

5.2.2 Nutrition and Breastfeeding Training, Technical Assistance, and Staff Development

State nutrition services staff continued to model VENA by utilizing facilitated group discussion during chief nutritionists' and breastfeeding managers' meetings. State and local agencies continued to use the revised monitoring tools finalized in April 2009, that include VENA evaluation questions (client-centered) related to clinic environment, customer service, counseling and nutrition education.

The State Office planned two Quarterly Nutrition Service (QNS) meetings; this year the State offered two locations and two dates for each training. The first QNS meeting was held in April 2012, the topics included: Pediatric Medical Disorders, NJ 2-1-1 resources for New Jersey residents, and the NJ WIC Participant Survey results. The second QNS meeting, also provided on two different dates and locations, was held in July 2012 on Facilitated Discussion, provided by Rayane AbuSabha. This training revisited VENA and its integration into breastfeeding and nutrition education by providing more practice using facilitated discussion techniques.

5.2.3 Using Loving Support to GROW and GLOW in WIC

Analysis of the GROW and GLOW training was conducted with impressive results. Although the attitude and behavior of staff was generally positive, pre- and post-training surveys of WIC staff showed overall improvement of 20 % toward breastfeeding. Staff's comfort level in talking to family members about breastfeeding increased from 9% to 82%. Staff support for covering for a coworker who is pumping her breastmilk increased from 7% to 86%. Staff perception of the feasibility of breastfeeding and working improved from 13% to 63%. The more negative the pre-training scores of the staff, the more improvement post–training. There was a 29% increase in WIC participants surveyed who stated WIC helps working mom's breastfeed. Analysis of the Grow and Glow training reveal improved overall staff perceptions and behaviors about breastfeeding. This improvement was also seen in the perceptions of participants receiving support at WIC.

5.2.4 Discussion Board

A discussion board for counseling staff utilizing the WIC Sharepoint website was piloted for three months by volunteers. A monthly topic on counseling skills and motiviational interviewing was introduced followed by an on-line discussion by the staff. Gary Rose, a trainer from Part IV of G&G, guided the training as a facilitator.

5.2.5 Web Based Nutrition Education for WIC Participants (NJWIConline.org)

In November 2009, the NJ WIC Program launched an interactive customized nutrition education website, NJWIConline.org. This website can be utilized by New Jersey WIC participants with internet access to satisfy their secondary nutrition education contact. The site offers participants informative nutrition and health lessons and fun and clever activities to reinforce the key points of the lessons. Topics include fruits and vegetables, calcium, cholesterol, oral health and iron. The website is offered in both English and Spanish. To promote NJWIConline.org, as well as, provide navigation instructions and useful website tips, a participant brochure was developed, printed and provided to the local agencies in both English and Spanish for distribution to their participants. This website offers an efficient and cost effective option to both the NJ WIC Program local agencies and participants to satisfy the secondary nutrition education USDA requirement. In January 2011, computer kiosks were placed in WIC local agency administrative sites to enable WIC participants to access *NJWIConline* on site. By using the touch screens on the kiosks, participants are able to receive nutrition education on topics of their choice while in the WIC clinic.

5.2.6 Bloodwork Training

The New Jersey State WIC Program provided a Blood-borne Pathogen Training of "Train the Trainer" to local agency staff in May 2010. The "Train the Trainer" program included the review and distribution of a power point presentation and reference materials on the blood borne pathogens standards. This training provided all the necessary information and resources for the local agencies to provide blood borne pathogen training. All local agencies "trainers" are responsible for returning to their agencies and ensuring that a federally mandated annual blood borne pathogen training is provided to all staff that conducts blood work screening. Local agencies must maintain their annual blood work training information in their training file which is reviewed by State staff during the agency's biennial on-site audit for compliance.

5.2.7 Outreach Initiative

In FY 2012, NJ WIC outreached to potential WIC eligible participants and their friends and relatives, on movie screens throughout New Jersey (from North Jersey to South Jersey). There was a video show lasting 15 seconds describing the benefits and services WIC offers: WIC is a supplemental nutrition program that provides free nutritious foods to low income women, infants and children, assistance with breastfeeding support and healthcare referral services. The WIC toll free phone number and website was shown as well. The WIC commercial was shown on 509 movie screens, reaching an average of 1,862,884 people for four weeks.

5.3 Food Delivery and Vendor Management

5.3.1 Vendor Cost Containment

New Jersey WIC Services has a Memorandum of Agreement between New Jersey Department of Health and Senior Services and the New Jersey Division of Taxation. The purpose of this Agreement is to share and verify tax information on vendors that may be above-50-percent vendors. The MOA has been a valid and valuable document in determining the status of vendors that are designated as above-50-percent vendors.

5.3.2 Banking Services Contract

New Jersey WIC Services has authorized approximately **850** vendors. All authorized vendors met the current vendor selection criteria and attended a vendor training session.

5.3.3 Vendor Application Process

New Jersey WIC Services - Food Deliver Services/ Vendor Management unit is responsible for activities that are associated with selecting, authorizing, training, monitoring and investigating the authorized WIC retail vendor population.

Federal Regulation mandates a limited number and appropriate distribution of WIC retail stores in order to ensure the lowest practicable food prices consistent with adequate participant access to supplemental foods and to ensure effective State agency management, oversight, and review of its authorized vendors. As required by Federal Regulations, New Jersey WIC Services has a vendor peer group system. The retail peer group types are chain, large independent, small, pharmacy, and commissary. The peer groups are assigned based on the amount of registers in the store.

There are 850 currently authorized retail food stores with a three year contract. The current agreement began October 1, 2009 and ends September 30, 2012. The effective date of the *new* contract period is October 1, 2012 through September 30, 2015. During the months of February and March, 2012 application packets for the new contract period are mailed to current authorized WIC vendors and vendors who have expressed in interest in becoming authorized WIC vendors.

Utilizing the Vendor Selection Criteria, current and new vendor applications will be carefully reviewed over the next four to six weeks. All retail stores who submitted applications and met the Vendor Selection Criteria shall be visited by State staff. The State WIC Agency staff will verify the

types and the amounts of WIC foods that are actually in the store and verify prices. Retail food stores that fail to meet the Vendor Selection Criteria are denied authorization. The applicant has the right to appeal the denied decision within 20 days of the receipt of the written notice.

5.4 WIC Information Technology Systems

5.4.1 Field Support Services

Local Agency hardware maintenance, repair and replacement, operating system, LAN administration and application troubleshooting support for all Local Agencies are handled by State office field support staff on an as required basis. All hardware and some software related calls reported through the contractor's help desk are forwarded to the State Field Support Service staff. The field support staff is responsible for the physical installation, maintenance, repair and administration of the PCs, printers and networks utilized with WIC ACCESS. Field support staff has responded to over 680 on site maintenance calls and provides daily telephone support as appropriate.

5.4.2 Ad-Hoc Reporting

Crystal Reports is an ad-hoc reporting tool that is being used to create management reports that had not been previously available or to address new requirements and temporary needs. State staff has been provided for development support for the generation of Crystal Reports upon request. That staff has responded to approximately 80 requests for data/reports.

5.4.3 WIC ACCESS Operating System

Computing hardware in local agencies has undergone a replacement project that includes new desktop and laptop workstations running Windows XP Professional and laptop and administrative servers running Windows Server 2003. All new product versions had undergone rigorous compatibility and regression testing to certify the WIC ACCESS application by the current contractor, CMA and by WIC's Quality Assurance Section. WIC ACCESS version 4.11 was implemented statewide and included a change in the end of day process implementing file transfer via FTP, replacing dial up connections.

5.4.4 WIC ACCESS Disaster Recovery Backup Site

New Jersey WIC has completed the creation of a stand-alone backup facility near the Central Processing Site (CPS) in Latham, NY. The hardware duplicates that in the CPS and in the case of an emergency can be loaded rapidly with the backups from the CPS to get the system operational in a matter of hours. The system has been rigorously tested and is on standby.

5.4.5 Data Warehousing

NJ WIC MIS is continuing the use of Data Warehousing which provides access to statewide participant data to State employees via the Internet.

5.4.6 Systems Lifecycle

WIC's Automated Client Centered Electronic Service System (ACCESS) is approaching the end of its useful product lifecycle. An RFP for a final contract for operations and maintenance of the system has been issued, and an RFP for a replacement system has been finalized and awaiting final USDA approval.

5.4.7 Electronic Benefit Transfer (EBT)

New Jersey WIC Services has engaged a planning contractor to develop planning documents for submission to the USDA to initiate a conversion to EBT by the mandated date of 2020. These documents include a feasibility study, cost benefit analysis, alternatives analysis, Implementation Advanced Planning Document (IAPD) and a Request for Proposal (RFP).

5.5 Monitoring and Evaluation

5.5.1 Infant Formula Rebate

The Infant Formula Rebate Contract with Ross Products Division, Abbotts Laboratories is providing $36M which will serve 553,080 WIC participants.

The Ross contract is effective until September 30, 2012.

5.5.2 WIC Administrative Funding Formula

The preliminary FFY 2013 funding was based on the guaranteed FFY 2012 base. Using USDA's funding formula which guarantees the annual base funding from one year to the next, the recommended FFY 2012 base with a ten percent inflation factor was the preliminary grant award to the grantees for FFY 2013. Adjustments will be made as more funds become available.

5.5.3 Infant Cereal and Juice Rebate

The Infant Cereal Rebate which New Jersey entered into a consortia of MARO states with Nestlé's went into effect May 1, 2007 for a period of three years. This rebate is estimated to provide $600,000 per year.

6.0 STRATEGIES

6.1 Client Services through Technology and Collaboration of Services

6.1.1 WIC ACCESS

The State of New Jersey has issued a Request for Proposal for an operation and maintenance contractor to maintain the current WIC ACCESS system at the local agencies.

6.1.2 Replacement system

The State of New Jersey has issued a Request for Proposal for a web based system to replace WIC ACCESS the local agencies and will be evaluating all proposals, selecting a system and Design and Development Contractor.

6.1.3 WHO Grids

A major enhancement to WIC ACCESS will be the implementation of World Health Organization Growth Grids as mandated by USDA.

6.1.4 EBT

New Jersey WIC Services will be finalizing the EBT planning documents for submission to the USDA.

The Monitoring and Evaluation Unit collaborates with new technology for gathering, processing, and disseminating data for the most effective ways of monitoring caseload and food funds.

6.2 Quality Nutrition Services

6.2.1 Value Enhanced Nutrition Assessment (VENA)/Grow and Glow Training for staff

USDA's Value Enhanced Nutrition Assessment guidance seeks to promote a participant-centered approach to dietary assessment and counseling. The State office is planning an October 2012 annual meeting to continue the incorporation of VENA /Grow and Glow concepts. The October meeting will be a continuation of team building, communication and customer service training. As mentioned in Section 5.0 Milestones, the State continues to model and provide VENA related trainings; the State provided Facilitated Discussion Training in the summer of 2012. State staff will continue ongoing evaluation of local agency VENA training needs through onsite reviews, quarterly nutrition services meetings, and chief nutritionists and breastfeeding managers meetings.

6.2.2 Breastfeeding Promotion and Support Services

WIC staff at all levels is expected to have a basic level of breastfeeding knowledge and to understand their role in supporting breastfeeding. This team approach has been the focus of the year-long GROW and GLOW training.

Local WIC agencies conduct their peer counseling programs according to *Loving Support(c) Through Peer Counseling: A Journey Together*. Breastfeeding services are a core service at all local agencies. Breastfeeding staff is present at all administrative sites and most satellite sites. They are part of the clinic flow, briefly meeting pregnant women during initial certification, and offering support and information during newborn certifications. Facilitated group or individual breastfeeding education is available so women can make informed infant feeding decisions. Support services are available for breastfeeding women to help them meet their breastfeeding goals. Peer counselors meet with new mothers at initial infant certification, check pick-up, and package change appointments. They telephone pregnant and breastfeeding mothers to offer support and information and are available outside normal hours to receive telephone calls from WIC mothers. They refer questions or problems beyond their expertise to International Board Certified Lactation Consultants. Breastfeeding literature and aids are available for pregnant and breastfeeding women. Peer counselors make contact with pregnant women monthly and every one to two weeks when women are in their ninth month of pregnancy, with new mothers every two to three days in the first week, once a week during the rest of the first month, once a month for the remainder of the first year, and

before she returns to work or school. Home visits are made when necessary and rounds are made at many hospitals. Breastfeeding staff coordinates with community groups and health care providers so that WIC women will receive consistent messages about breastfeeding. Breastfeeding managers and WIC coordinators collaborate with other organizations, such as hospitals, prenatal clinics and other community organizations to strengthen support for breastfeeding families.

Breastfeeding peer counselors are paraprofessionals who come from the communities and speak the same language as WIC participants. After satisfactorily completing the breastfeeding peer counselor training, they are mentored by experienced breastfeeding staff.

In FFY 2013, there will be continued emphasis on promoting exclusive breastfeeding in the first six months of life and continued breastfeeding for as long as mother and infant desire. WIC staff will target breastfeeding messages relevant to a woman's stage of change. Individual barriers to breastfeeding will be addressed using the 3-Step counseling method and VENA and GROW and GLOW techniques. WIC food packages and materials, staff attitudes and clinic environment reflect the importance of exclusive breastfeeding.

6.2.3 Nutrition Education Task Force

A task force is being formed by state and local agency staff to plan nutrition education initiatives in FY 2013. The task force will prioritize nutrition education needs, brainstorm ideas, and form action plans to address those needs with the goal of implementing the most feasible possibilities. Possible outcomes may be to apply for Operational Adjustment funding, expand the counseling discussion board, execute a state-wide public awareness breastfeeding campaign, explore the use of social media and offer additional breastfeeding training to counseling staff.

6.2.4 Promote Physical Activity in Conjunction with Nutrition Education

Local agencies will be encouraged to continue to promote the importance of physical activity by incorporating positive physical activity messages into all nutrition counseling. Recommended strategies will include providing educational materials that stress the importance of physical activity, having physical activity displays or posters visible, and arranging for physical activity experts to provide activities and demonstrations targeted for WIC participants. The local WIC staff will also focus on educational strategies that will assist WIC participants to increase the consumption of fruits and vegetables and making healthier food choices.

6.2.5 Web-Based Nutrition Education for WIC Participants (NJWIConline.org)

In Fiscal Year 2013 New Jersey WIC Services plans to increase the selection of lesson topics available on NJWIConline.org, the internet website. The expansion of topics will widen the appeal of, improve interest in, and increase revisit rates to the website. Since New Jersey launched this site in November 2009, several other State WIC Programs have adopted it for use as an option for secondary nutrition education. The Georgia WIC Program is developing a lesson on breastfeeding. After the breastfeeding lesson is completed, New Jersey WIC Services will review it, and if appropriate, transfer it to NJWIConline.org. Additionally, NJ WIC Services nutritionists have begun drafting content for a new lesson on physical activity.

6.3 Vendor Cost Containment

In FY 2013, retail vendors will be able to submit their Commodity Price List Survey's (CPL's) on line via a web-based application. This will reduce staff man hours needed for manual data entry and help the SA move toward a paperless system. Additionally it will allow the SA to more accurately evaluate the average prices across peer groups.

6.3.1 Vendor Selection

In FY 2013 SA staff will continue to review and process applications. for current and new vendors in preparation for the new contract period beginning October 1, 2012. The SA will also explore the use of electronic technology solutions to reduce and/or eliminate the manual collection and data entry of price data for all WIC authorized food items. Implementation of this type of system will also assist the SA with EBT readiness.

6.4 Program Integrity

6.4.1 Management Information Systems

To improve and maintain program integrity from an MIS overview, the selection of a replacement electronic data processing system for New Jersey WIC will encompass a conversion from a distributed client-server database environment to a centralized database environment. This will minimize any application and database anomalies that could affect database integrity that will enhance program integrity.

6.4.2 Compliance Buy Investigations

The Vendor Unit will be soliciting contractors to complete Compliance Buy investigations and/or Routine Monitoring.

6.4.3 Social Media – Program Integrity

Food Delivery Services The SA staff will conduct periodic reviews of EBay, Craigslist and other social media websites to help identify and resolve allegations of WIC participant and retail vendor fraud.

6.4.4 Management Information Systems

The State WIC Agency (SA) onsite team (Food Delivery, Nutrition Services, and MIS staff) conducts bi-annual monitoring and evaluations of 50 % of seventeen local WIC agencies per year. After the local agency review, the SA onsite team submits an onsite report that includes corrective action plans for the local agency to review and respond.

Planning for FY 2013 Bi-annual monitoring and evaluations of local WIC agencies will begin in August 2012. It is anticipated that the local WIC agencies who may be monitored in FY 2013 are North Hudson, Jersey City, Plainfield, Passaic, St. Joseph's, Ocean, VNA and CC of Ewing. Additionally, Food Delivery Services – Monitoring Unit in conjunction with Nutrition Services will review and revise Policies and Procedure as needed based on onsite review Corrective Action Plans.

7.0 APPENDICES

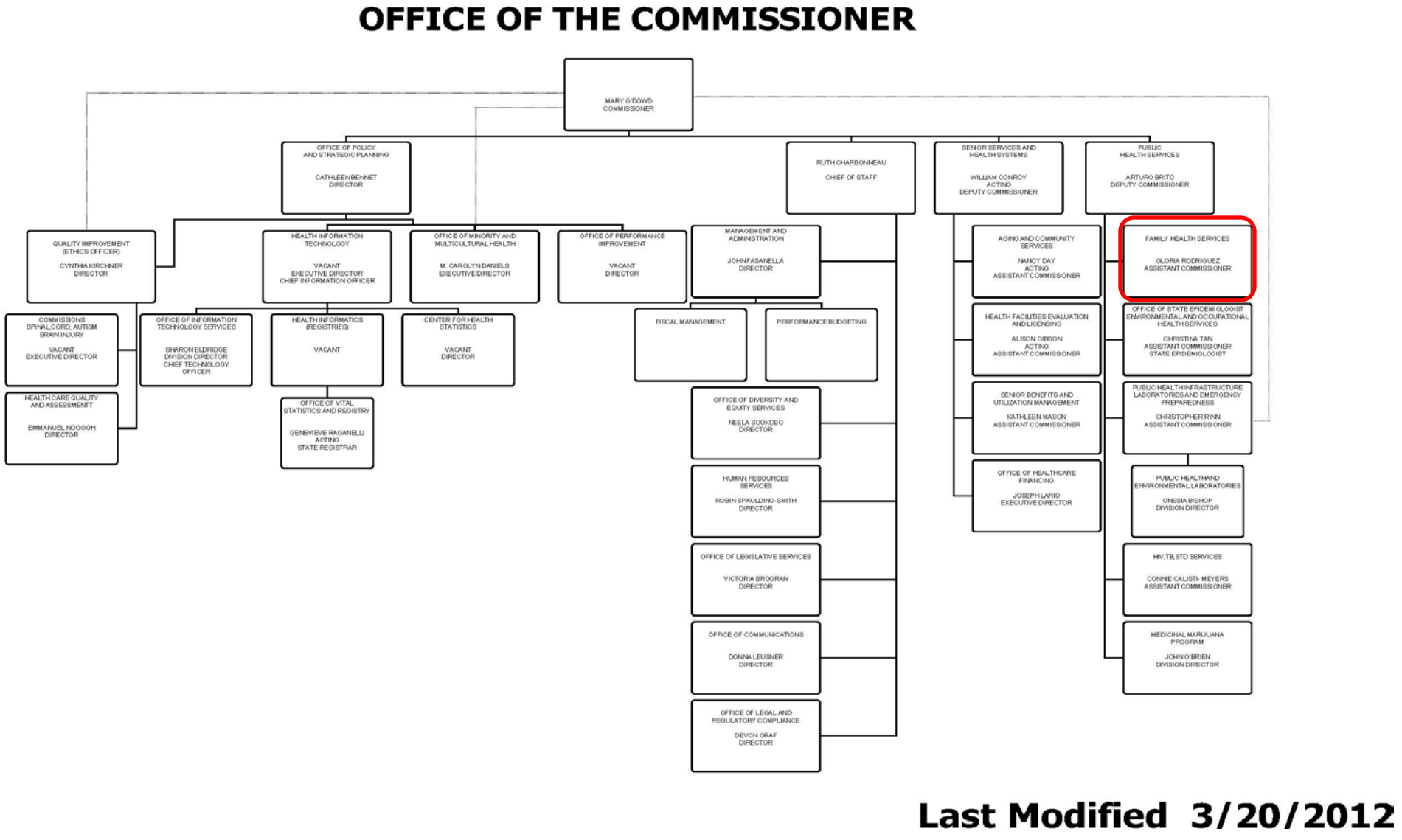
7.1 Organizational Charts

7.1.1 Department of Health and Senior Services

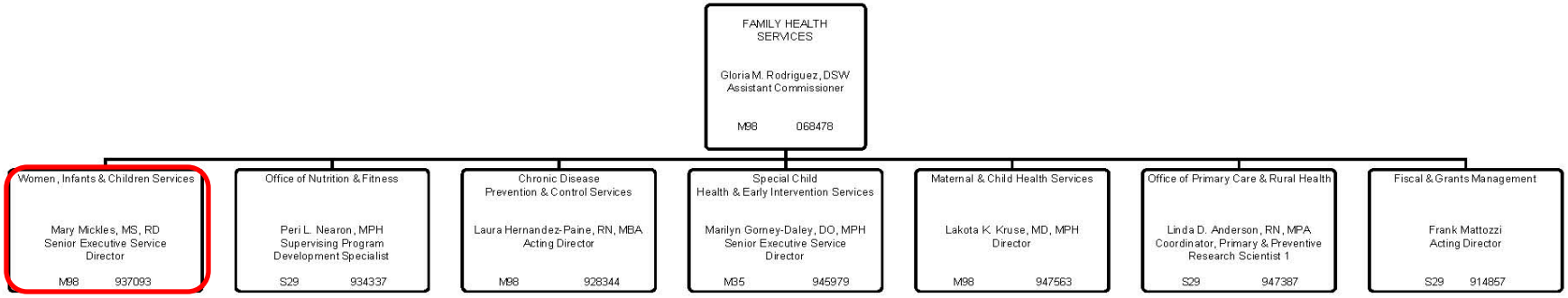
7.1.2 Division of Family Health Services

7.1.3 WIC Services

7.1.2 Department of Health and Senior Services



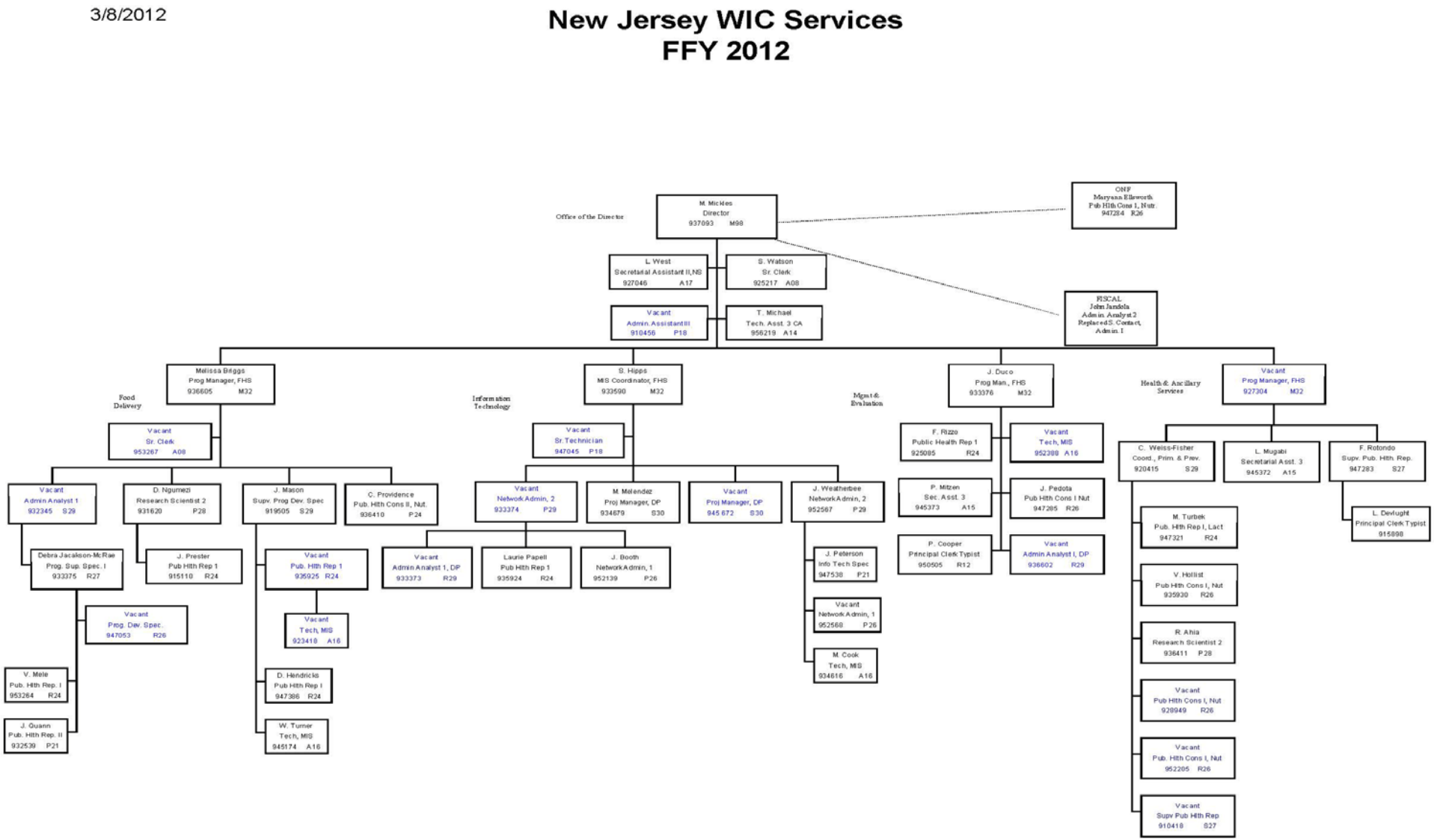
7.1.2 Division of Family Health Services



Last Modified 3/19/2012

7.1.3 WIC Services

3/8/2012



8.0 WIC Clinic Sites by County

Local WIC Agency Central Administrative, Administrative and Satellite Sites

01 ATLANTIC WIC PROGRAM
1301 BACHARACH BLVD
1ST FLOOR, CITY HALL
ATLANTIC CITY, NJ 08401
(609) 347-5656 **Coordinator: Kathleen Gesler**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Admin	Family Life Center 200 Phila Ave. Egg Harbor City, NJ 08215	CLOSED (9/2011)	Refer to Pleasantville or Atlantic City
04 Admin	One-Stop Career Center 2 South Main Street, second floor Pleasantville, NJ 08232	Monday – Thursday: 8:30 – 4:00	(609) 272-0854/9659 Fax: 609-347-5359
05 Main Admin	Atlantic City WIC Program 1301 Bacharach Blvd Atlantic City, NJ 08401	Monday & Friday: 7:30 – 4:00 Tuesday, Wednesday & Thursday: 8:30 – 4:00	Fax: 609-272-9051
03	(not in use		
09		Closed 12/08	
11	(not in use		
12	(not in use		
07	(not in use)		
08	(not in use		
10	(not in use		
44	(not in use		
06 Closed		Closed as of 2/2009	(609) 492-1212
			Total Caseload

03 BURLINGTON COUNTY WIC PROGRAM
15 PIONEER BLVD
WESTAMPTON, NJ 08060
(609) 267-7004 **Coordinator: Dr. Deepti Das**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	Burlington County Health Dept. 15 Pioneer Blvd., Westampton, NJ 08060	Monday – Friday: 8:00 – 5:00 1st & 3rd Tuesday: 8:00 – 8:00 2nd and 4th Monday: 8:00 – 8:00	(609) 267-4304 Fax: 609-518-7156
04	Browns Mills, Nesbitt Recreation Center Anderson Lane Pemberton, NJ 08068	1st & 3rd Monday: 9:00 – 4:00	
06	Central Baptist Church 5th & Maple Avenue Palmyra, NJ 08065	1st Thursday: 12:30 – 3:30	
08	1st United Methodist Church Camden & Pleasant Valley Moorestown, NJ 08057	2nd Thursday: 9:00 – 4:00	
09	Medford Farms Firehouse Rt. 206 Tabernacle, NJ 08088	2nd Wednesday: 12:30 – 3:30	
10	Shiloh Baptist Church 104 ½ Elizabeth Street Bordentown, NJ 08505	4th Wednesday: 9:00 – 12:30	
13	JFK Center 429 JFK Way Willingboro, NJ 08046	3rd Wednesday: 9:00 – 4:00	
14	American Legion 212 American Legion Drive Riverside, NJ 08075	1st Thursday: 9:00 – 4:00	
16	Heureka Center 11 Dunbar Homes at Belmont Street Burlington, NJ 08016	2nd Tuesday: 9:00 – 12:30	
19	McGuire AFB Chapel 2 Annex, Bldg. #3827 Falcons Ct. North MAFB, NJ 08641	1st Wednesday: 9:00 – 12:30 3rd Thursday: 9:00 – 4:00 (5905 Recreation Center, Newport & Doughboy Loop, Ft. Dix)	
20	Beverly Housing Authority 100 Magnolia Street Beverly, NJ 08010	Fourth Thursday: (January, April, July, October) 9:00 – 4:00PM	
03	(combined with site 09)		
12	(not in use)		
22	(not in use)		
70	(not in use)		
			Total Caseload

05 TRI-COUNTY WIC PROGRAM (Gateway Community Action Corporation)
10 WASHINGTON STREET
BRIDGETON, NJ 08302
(856) 451-5600 (office)
(856 453-9478 (fax)

Coordinator: Dr. Jaya Velpuri

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	Bridgeton WIC Office 10 Washington Street Bridgeton, NJ 08302	Monday – Friday: 8:30 – 4:30 1st & 3rd Wednesday: 8:00 – 7:00	(856) 451-5600 Ext. 6732
02	Teen Center Bridgeton High School 111 West Avenue Bridgeton, NJ 08302	1st Wednesday as needed: 9:30 – 11:00 October – May	(856) 455-8030
05* see detail at bottom	Millville WIC Moved 10/10 to **530 North High St** Millville, NJ 08332	Monday, Thursday, Friday: 8:30 – 4:30 1st Thursday 10:00 – 6:00	(856) 327-6868
08 van	Countryside Village Parsonage Road Seabrook, NJ 08302	3rd Tuesday: 9:00 – 3:00	(609) 501-8370
13 Admin	Vineland WIC Office 610 E. Montrose Street Vineland, NJ 08360	Monday – Friday: 8:30 – 4:30 1st Tuesday: 8:30 – 6:30	(856) 691-1155 (856) 691-2410 (fax)
43 Admin	Salem WIC Office 14 New Market Street Salem, NJ 08079	Monday – Thursday: 8:00 – 4:00 1st Monday: 9:00 – 5:00	FAX: 856-935-3804
40 van	Penns Grove IGA	2nd & 4th Friday 8:00 – 3:30	
41	Salem Hospital Health Start 310 Woodstown Rd. Salem, NJ 08079	1st Tuesday: 1:00 – 3:00	(856) 935-1000
61 Admin	Cape May WIC Crest Haven Complex 6 Moore Rd. Cape May Court House, NJ 08210	Monday – Thursday: 8:00 – 4:30	(609) 465-1224 Fax: 609-465-6836
62 van	Ocean City(Not going) Tabernacle Baptist Church	2nd Monday: 9:00 – 2:30	(609) 501-8370
63	Wildwood WIC(temporarily operating from site 61)Cape Human Resource Center 14104 New Jersey Avenue Wildwood, NJ 08260	1st, 2nd & 4th Friday: 7:30 – 3:30	(609) 522-0231
64	North Cape May Villa Lower Township Municipal Court North Cape May, NJ 08204	1st, 2nd & 3rd Thursday: 8:30 – 2:00	(609) 898-8899
17 Admin	Lakeland WIC Office Di Piero Center, Suite 501 512 Lakeland Road Blackwood, NJ 08012	Monday-Thursday: 8:00 – 4:00	(856) 374-6085 Fax: 856-374-6083
04 Admin	AFCD WIC Office County Administration Bldg., Basement 600 Market Street Camden, NJ 08102	Monday- Friday: 8:30 – 4:30	856) 225-5155 (Fax: 856-225-5129
30 Admin	Mt Emphraim WIC Office Mt. Ephraim Plaza, Suite 411	Monday, Tuesday, Thursday & Friday:	856-225-5050 856-225-5051

	2600 Mt. Ephraim Ave. Camden, NJ 08104	8:00 – 5:00 Wednesday: 7:30 – 7:00	Fax: 856-225-8405
			Total Caseload

*05 van sites: Oak View Apts., 1701 E. Broad Street, Millville
Delsea Garden Apts., 2213 S. 2nd Street, Millville
Millville Senior High School, 200 N. Wade Blvd., Millville

06 **EAST ORANGE WIC PROGRAM**
185 Central Avenue, Suites 505 & 507.*
EAST ORANGE, NJ 07018
(973) 395-8960 **Coordinator: Monica Blissett**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	ELEPHONE NUMBER
02 Main Admin	East Orange WIC 185 Central Avenue, Suites 505 & 507, East Orange, NJ 07018	Monday – Friday: 8:30 – 4:30 Monday & Wednesday: 8:30 – 7:00	(973) 395-8960 **Fax:** **973-676-1360**
16 Admin	Belleville WIC Office 152 Washington Avenue Belleville, NJ 07109	Tuesday, Wednesday & Thursday: 9:00 – 1:00	(973) 450-3395 Fax: 973-450-4550
11	Montclair WIC Clinic (within United Way) 60 S. Fullerton Avenue (as of 9/11/09) Montclair, NJ 07042	Monday & Friday: 8:30 – 4:30	(973) 509-6501 (973) 509-6502
06	(not in use)		
08	(not in use)		
09	(not in use)		
17	(not in use)		
29	(not in use)		
07 -			
70	(not in use)		
			Total Caseload

07 GLOUCESTER COUNTY WIC PROGRAM
204 EAST HOLLY AVE.
SEWELL, NJ 08080
(856) 218-4116 **Coordinator: Kathleen Mahmoud**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
04 Main Admin	Gloucester County WIC Gloucester Co. Dept of Health & Senior Services 204 East Holly Ave. Sewell, NJ 08080	Monday – Friday: 8:00 – 4:00 (office hours) Tuesday & and every other Thursday: 8:00 – 4:00 Certs only Extended hours every other Tuesday: until 6:00 PM Friday NE classes – 8-3	(856) 218-4116 Fax: **856-218-4117**
03	Williamstown-Monroe Township 125 Virginia Avenue Williamstown, NJ 08094	Monday: 8:00 – 4:00 NE (8 am and 1 PM)	(856) 728-9800
01	Paulsboro WIC Office Gloucester County Health Dept 1000 Delaware Street Paulsboro, NJ 08066	Monday- Friday 8:30 – 4:30 Extended hours every other Wednesday: until 6:00	(856) 423-5849
05	(not in use)		
			Total Caseload

09 JERSEY CITY WIC PROGRAM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
384 Martin Luther King (Temporary location)
JERSEY CITY, NJ 07305
(201) 547-5682 (see other phone numbers below)

Coordinator: Deborah M. Murray

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
13 Main Admin	Jersey City WIC Program Dept. of Health & Human Services 384 Martin Luther King Jersey City, NJ 07305	Monday – Friday: 7:00 – 4:30	201-547-4697 201-547-4587 Fax: **201-547-5971** (201) 547-5682
06	Horizon Health Center (Health Start) 706-714 Bergen Avenue Jersey City, NJ 07306	Wednesday: 8:30 – 11:00	(201) 451-6300
14	Metropolitan Family Health Network (Health Start) 935 Garfield Avenue Jersey City, NJ 07304	Monday: 8:30 – 11:00	(201) 946-6400
15	North Hudson Community Action Corp. of Jersey City (Health Start) 324 Palisades Avenue Jersey City, NJ 07307	Tuesday: 8:30 – 11:00	(201) 459-8888
16	Bayonne Hospital (Health Start) 29 East 29th Street Bayonne, NJ 07002	Wednesday and Thursday: 8:30 – 11:00	(201) 858-5000 Ext. 5356
			Total Caseload

10 VNA OF CENTRAL JERSEY WIC PROGRAM
888 MAIN STREET
BELFORD, NJ 07718
(732) 471-9301 **Coordinator: Robin McRoberts**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
02 Admin	How Lane Health Center 123 How Lane New Brunswick, NJ 08901	Mon – Fri: 8:30 – 4:30 2nd , 3rd & 4th Saturday: 8:30 – 4:30	(732) 249-3513 Staff: (732) 249-3768 Fax: 732-249-3793
05	First Presbyterian Church 177 Gatzmer Avenue Jamesburg, NJ 08831	4th Tuesday: 8:30 – 2:00	(908) 902-3611
07	Edison Township Health Dept. 80 Idlewild Rd Edison, NJ 08817	2nd Tuesday & 4th Thursday: 8:30 – 4:00	(732) 248-7285
09	Somerset Community Action Program 900 Hamilton (temp street change 1/2010) Somerset, NJ 08875	1st Monday: 8:30 – 12:30	(732) 8282956
03 Admin	Perth Amboy VNA Central Jersey Ambulatory Care Dept. (Health Start) 313 State Street, Suite 704 Perth Amboy, NJ 08861	Tuesday, Wednesday, Thursday & Friday: 8:30 – 4:30 1st Saturday of the month: 8:30 – 4:30	(732) 376-1138 (staff) (732) 376-1188 (staff) Fax: 732-371-1193
15	Iglesia Penticostal el Tabernaculo 104 Union Street Carteret, NJ 07708	1st & 3rd Thursday: 8:30 – 4:30	
16	St. Mary's Church/St. Pat's Hall Church & Stevens Street South Amboy, 08879	2nd Thursday: 8:30 – 4:30	
19	Woodbridge/St. James Food Pantry Hwy 35/Main Street Woodbridge, NJ 07095	2nd & 4th Friday: 8:30 – 4:30	
08 Main Admin	Hartshorne Health Center 888 Main Street Belford, NJ 07718	Monday – Friday (office) 2nd Monday: 8:30 – 6:30 4th Monday: 8:30 – 4:30	(732) 471-9301 (732) 471-9302 Fax: 732-471-9303
01	Trinity Church 503 Asbury Ave, A Asbury Park, NJ 07712	Monday & Tuesday: 8:30 – 4:30	
04	Keyport Health Center, Health Start 35 Broad Street Keyport, NJ 07735	1st & 2nd Monday: 8:30 – 4:30	(732) 888-4146
06	St. Rose of Lima Church 12 Throckmorton Street Freehold, NJ 07728	Wednesday: 8:30 – 4:30 1st Wed until 7:00 1st & 3rd Certs (NE in evening) 2nd & 4th NE/check pick-up 1st Thursday of month (6/1)	
10	Red Bank Health Center 176 Riverside Drive Red Bank, NJ 07701	Wednesday: 8:30 – 4:30 4th Wednesday until 7:00 1st & 3rd – NE/check pick-up 2nd & 4th – certs (NE in evening)	

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
12	Trinity AME Church 66 Liberty Street Long Branch, NJ 07740	2nd, 3rd & 4th Thursday & Friday: 8:30 – 4:30 Thursdays NE/check pick-up Fridays certs	(732) 222-8436
14	First Presbyterian Church 9th Avenue and E Street Belmar, NJ 07719	1st Friday: 8:30 – 4:30	(732) 681-3108
72	Keansburg Senior Center 100 Main Street Keansburg, NJ		
11	(not in use)		
17	(formerly Piscataway Fire Co.)		
18	(not in use)		
70	(not in use)		
71	(not in use)		
73	(not in use)		
74			
75	(not in use)		
76	(not in use)		
			Total Caseload

11 NEWARK WIC PROGRAM
DEPARTMENT OF Child and Family Well-Being
110 WILLIAM STREET
NEWARK, NJ 07102
(973) 733-7628 **Coordinator: Christine Reynolds**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
15 Main Admin	Newark WIC Department of Child and Family Well-Being 110 William Street Newark, NJ 07102	Monday, Tuesday & Wed Friday: 8:30 – 4:30 Thursday: 8:30 – 6:30 Saturday: 9:00 – 2:00 – 2nd and 4th Sat.	(973) 733-7628 Fax: 973-733-7629
01	Newark Preschool/Alberta Bay 300 Chancellor Avenue Newark, NJ 07112	No longer going	
29	NCHC Dayton Street Center (Health Start) 101 Ludlow Street Newark, NJ 07114	1st and 3rd Wednesday: 10:00 – 3:00	(973) 565-0355
31	NCHC (Health Start) 741 Broadway Newark, NJ 07104	2nd and 4th Wednesday: 10:00 – 3:00	(973) 483-1300
18 Admin	Newark Beth Israel Medical Center (Health Start) 166 Lyons Avenue Newark, NJ 07112	Monday – Friday: 8:30 – 4:30	(973) 733-5157 (973) 733-5158 Fax: 973-733-5157
20 Admin	Irvington Municipal Building 1 Civic Square Irvington, NJ 07111	Monday – Friday: 8:30 – 4:30	(973) 399-6732 Fax: 973-416-5676
26 Admin	Columbus Hospital Admin 495 North 13th Street Newark, NJ 07107	Monday-Friday 8:30AM-4:30PM	973) 973-497-5618 Fax: 973-497-5619 online 7/2009
03			
17	St. James Hospital Family Service Heath Start 155 Jefferson Street , 3rd Floor Newark, NJ 07102	Monday and Friday : 8:30 – 4:30	(973) 465-2828 Ext. 1704/1705 Fax: 973-344-0641
02	(not in use)		
06	Not in use	**Closed – May 8, 2008**	
07	(not in use)		
08	(not in use – formerly Club del Barrio)		
80	van sites?? Locations Closed	Closing 4/30/09	(201) 819-2538
09 closed	(not in use – formerly Irvington Ped.)		

12 NORTH HUDSON COMMUNITY ACTION CORPORATION (NHCAC) WIC PROGRAM
407 39th Street, Union City, NJ
Union City, NJ 07087
(201) 866-4700

Coordinator: Karen Lazarowitz

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	NHCAC WIC 407 39th Street, Union City, NJ 07087	Monday Wed, Thurs and Friday: 8:30 – 4:00 Tuesday: 8:30 – 6:45 PM	(201) 866-4700 Fax: 201-866-2495
06Closed	Meadowlands Hospital 55 Meadowlands Parkway Secaucus, NJ 07094	closed	
	Kearny Health Department 645 Kearny Avenue Kearny, NJ 07032	1st Tuesday and 2nd Monday and 4th Monday 9:30-3:00PM	(201) 997-0600
07 (mobile)	Kearny	3rd Monday and 3rd Friday 9:30- 3:00PM	
08	Harrison Health Department Annex 318 Harrison Avenue Harrison, NJ 07029	2nd & 3rd Thursday and 4th Wednesday 9:30 – 3:00	(973) 268-2464
09	NHCAC Community Health Center at Hoboken 124 Grand Street Hoboken, NJ 07030	Tuesday: 9:30 – 3:30 Thursday: 9:30 – 3:00	(201) 863-7180 (201) 795-9521
71	Palisades General Hospital Maternity Floor 7600 River Road North Bergen, NJ 07047	Monday, Wednesday & Friday: 9:30 – 2:00	
85 Mobile site	NHCAC at Mesivta Sanz School 3400 New York Avenue Union City, NJ 07087	2nd Wednesday, March, June, Sept, Dec 9:30-3:30	(201) 424-3240
79	NHCAC at Union City CLOSED	CLOSED	
73	(not in use)		
74	(not in use)		
75	(not in use)		
82	(not in use)		
83	(not in use)		
84	(not in use)		
86	(not in use)		
87	(not in use)		
88	(not in use)		
89	(not in use)		

13 NORWESCAP WIC PROGRAM
350 Marshall Street
Phillipsburg, NJ 08865
(908) 454-1210
(800) 527-0125 **Coordinator: Nancy Quinn**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
07 Admin	NORWESCAP WIC Program 10 Moran Street Newton, NJ 07860 (Sussex Co.) (– mailing use site 1320)	Mon and Wed. – 8:30- 4:30 Tuesday 9:00-3:30	(973) 579-5155 Fax: 973-579-5655
05		CLOSED	
20 Main Admin	NORWESCAP WIC Program 350 Marshall Street Phillipsburg, NJ 08865 (Warren Co.)	Monday – Friday: 8:30 – 4:30 2nd and 4th Thursday: 8:30 – 7:00	(908) 454-1210 Fax: 908-454-5731
08	Trinity Methodist Church 211 Main Street Hackettstown, NJ 07840 (Warren Co.)	1st, 3rd & 5th Wednesday: 9:30 – 3:30	(908) 852-3020 Ext. 237
10	Flemington United Methodist Church 116 Main Street Flemington, NJ 08822	2nd & 4th Wednesday: 9:30 – 3:30	(908) 782-1070
17	First Presbyterian Church 41 East Church Street Washington, NJ 07882 (Warren Co.)	1st & 3rd Friday: 9:15 – 3:30	(908) 689-2547
22 Admin	NORWESCAP WIC Program People Care Center 120 Finderne Avenue, Suite 230 Bridgewater, NJ 08807 (Somerset Co.)	Monday – Friday: 8:30 – 5:00 1st & 3rd Wednesday: 8:30 – 7:00	(908) 685-8282 Fax: 908-704-9382
26	Watchung Avenue Presbyterian Church 170 Watchung Avenue North Plainfield, NJ 07060 (Somerset Co.)	1st, 2nd , 3rd & 4th Tuesday: 9:30 – 3:00	(908) 755-2781
01	(not in use)		
02	(not in use)		
04	(not in use)		
06 Closed			
11 Closed			
24 closed		Closed 1/27/2009	

14 PLAINFIELD WIC PROGRAM
510 WATCHUNG AVENUE
PLAINFIELD, NJ 07060
(908) 753-3397 **Coordinator: Prema Achari**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	Plainfield WIC Program 510 Watchung Avenue Plainfield, NJ 07060	Monday – Friday: 9:00 – 5:00 Wednesday May – Sept: 9:00 – 7:00	(908) 753-3397 Fax: 908-753-3640
02	(not in use)		

15 ST. JOSEPH WIC PROGRAM
185 6th Avenue
PATERSON, NJ 07524
(973) 754-4575 **Coordinator: Dorothy Monica**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	St. Joseph WIC Program 185 6th Avenue Paterson, NJ **07524** (Passaic Co.)	Mon & Fri: 8:00 – 4:30 Tues, Wed & Thursday: 8:00 – 6:00	(973) 754-4575 Fax: 973-754-4542
07 Admin	Market Street Clinic 166 Market Street Paterson, NJ 07505 (Passaic Co.)	Monday – Friday: 8:30 – 4:30 Saturday: 9:00 – 3:00	(973) 754-4730 ext.4736
12	Hackensack Department of Health 215 State Street Hackensack, NJ 07601 (Bergen Co.)	1st & 3rd Monday & every Thursday: 9:00 – 3:00	(201) 646-3965
14	St. Mark's Episcopal Church 118 Chadwick Road Teaneck, NJ 07666 (Bergen Co.)	1st, 2nd, 3rd & 4th Monday: 9:00 – 2:30	
15	Center for Family Resources 12 Morris Rd. Ringwood, NJ 07456 (Passaic Co)	1st Thursday 9:00 - 3:30 As of June 1, 2008	(973) 962- 0055
16	Pompton Lakes Health Department 25 Lenox Avenue Pompton Lakes,NJ 07442(Passaic Co.)	4th Monday: 9:00 – 3:00	(973) 835-0143 Ext. 222
17	First Presbyterian Church 457 Division Avenue Carlstadt, NJ 07072 (Bergen Co.)	1st Wednesday: 9:00 – 3:00	(201) 438-5526
18	St. Paul's Episcopal Church 113 Engle Street Englewood, NJ 07632 (Bergen Co.)1/2012	2nd & 4th Tuesday, 2nd & 3rd Thursday: 9:00 – 3:00	(Call main number)
19	Cliffside Park Head Start 263 Lafayette Ave. Cliffside Park, NJ 1/2012	1st and 2nd Friday: 9:00 – 3:00	Call main number
20	Wayne Health Department 475 Valley Road Wayne, NJ 07470 (Passaic Co.)	3rd Tuesday: 9:00 – 3:00	(201) 387-4058
21	Bergenfield Department of Health 198 N. Washington Avenue Bergenfield, NJ 07621 (Bergen Co.)	2nd & 4th Monday: 9:00 – 3:30	(201) 387-4058
22	Red Cross 74 Godwin Avenue Ridgewood, NJ 07450 (Bergen Co.)	3rd & 4th Friday: 9:00 – 3:30	(201) 652-3210
23	St. Margaret Church 6 Sussex Ave. Morristown, NJ 07960 (Morris Co.)1/2012	1st, 2nd, 3rd & 4th Friday: 9:00 – 3:00	
27	Boonton United Methodist Church 626 Lathrop Avenue Boonton, NJ 07005 10/2011 (Morris Co.)	3rd Wednesday: 9:00 – 3:00	(201) 299-7745
29	Dover Head Start 18 Thompson Street Dover, NJ 07801 (Morris Co.)	Wednesdays: 9:00 – 3:30	(973) 989-9052

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
30	Clifton Health Department 900 Clifton Avenue Clifton, NJ 07012 (Passaic Co.)	3rd Tuesday: 9:00 – 3:30	(973) 470-5778
09	St. Paul's Community Dev. Corp 451 Van Houten Street, 2nd Floor Paterson, NJ 07503 (Passaic Co.)	1st, 2nd, 3rd & 4th Friday: 9:00 – 3:00 Closing March 31, 2011	(973) 278-7900
11	Garfield Head Start 535 Midland Avenue Garfield NJ	2nd Wed. 9-3 2nd Tuesday 9-3 4th Thursday 9-3	**Call main number for Appointment**

17 CONCERNED CITIZENS OF EWING WIC PROGRAM
80 West Upper Ferry Road
Fisk Professional Center, 2nd Floor
Ewing, New Jersey 08628
(609) 498-7755 **Coordinator: Kelly Ryan**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 (26) Main Admin	Concerned Citizens of Ewing WIC 80 West Upper Ferry Road Fisk Professional Center, 2nd Floor Ewing, NJ 08628	Clinic hours: Monday: 8:30-5:00 Tuesday: 8:30 – 5:00 Wednesday: 8:30-6:00 Thursday: 8:30-6:00 Office: Friday: 8:30 – 4:00	(609) 498-7755 Central Call number for all sites. Fax: 609-434-0040
04	Hamilton Health Department 2090 Greenwood Avenue Hamilton, NJ 08609	Most Fridays 1st, 3rd & 4th Friday: 9:00 – 3:30 by appointment	
22	Princeton Twp. Municipal Building WIC 400 Witherspoon Street Princeton, NJ 08542	3rd Friday: 9:00 – 3:30 By appointment	
25	Ewing Clinic Ewing Neighborhood Center 320 Hollowbrook Drive Ewing, NJ 08638 Closing	CLOSED	Client will be offered new site or other sites
11	El Centro of Catholic Charities 327 South Broad Street Trenton, NJ 08608	1St Friday 9AM to 3:30PM by appointment	Client will be offered new site or other sites 609) 498-7755
19	First United Methodist Church 187 Stockton St, PO 137 Hightstown, NJ 08520 New site location. 2011	2nd and 4th Friday of the month 9:00-3:30PM, by apppointment	Clients should call main site
02 (30)			

18 UMDNJ WIC PROGRAM
Stanley Bergen Building, RM GA-06
65 BERGEN STREET
NEWARK, NJ 07107
(973) 972-3416 **Coordinator: Valeria Jacob-Andrews**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
03 Main Admin	UMDNJ WIC Program Stanley Bergen Bldg, Room GA-06 65 Bergen Street Newark, NJ 07107-1709	Monday, Tuesday, Thursday & Friday: 8:30 – 4:30 Wed. 8:30 – 6:30PM 1st Wednesday: 3:30 – 6:30	(973) 972-3416 (973) 972-3417 Fax: 973-972-8977
05	Ivy Hill Apartments Senior Citizen Center 230 Mt. Vernon Place Newark, NJ 07106	Wednesdays: 7:15 AM – 2:15PM	(973) 416-8826
70	University Hospital Prenatal Clinic Ambulatory Care Center 140 Bergen Street, Newark, NJ 07101-1709	Monday: 9:45 – 2:15 Tuesday: 9:00 – 2:15	(973) 972-2726
71	University Hospital Maternity Unit F-Green 150 Bergen Street Newark, NJ 07101-1709	Monday and Tuesday: 9:45 am- 2:45 pm Friday: 9:30-2:30	(973) 972-5624
04	(not in use)		
06	(not in use)		
07	(not in use)		

19 OCEAN COUNTY WIC PROGRAM
OCEAN COUNTY DEPARTMENT OF HEALTH
175 SUNSET AVENUE, PO BOX 2191
TOMS RIVER, NJ 08755
(732) 341-9700 EXT. 7520 **Coordinator: Meg-Ann McCarthy-Klein**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
06 Main Admin	Ocean County WIC Program Ocean County Health Department 175 Sunset Avenue Toms River, NJ 08755	Monday – Friday: 8:00 – 5:00 1st, 2nd & 4th Monday: 8:00 – 8:30	(732) 341-9700 Ext. 7520 Fax: **732-286-3951**
07	Brick Presbyterian Church 111 Drum Point Road Brick, NJ 08723	Tuesday: 8:00-5:00PM NE/Checks 2:00 – 3:00	(732) 691-7307 staff cell phone
09	Berkeley Head Start 264 First Avenue South Toms River, NJ 08758	Wednesday: 9:00 – 4:00 (AM certs/PM NE/checks)	(732) 691-7307 staff cell phone
14	Southern Ocean Resource Center 333 Haywood Avenue Manahawkin, NJ 08050	Monday-Thursday: 8:00AM –5:00 NE/Checks Monday: 8:30AM &Tueday : 2:00PM	
15	Lighthouse Alliance Community Church	CLOSED July 2011	(732) 691-7307 staff cell phone
16	Ortley Beach First Aid Squad Rt. 35 at 6th Avenue Ortley Beach, NJ 08751	1st, 3rd & 5th Weds: 9:00 – 12:00 certs 2:00 NE/checks	(732) 691-7307 staff cell phone
72	Medical Center of Ocean County	Closed July 2011	
73	Southern Ocean County Hospital Health Start clinic Manahawkin, NJ 08050	Closed July 2011	
74	Community Medical Center (prenatal) 301 Lakehurst Road, 3rd Floor Toms River, NJ 08753	Tuesday & Thursday: 8:00 – 12:00	(732) 818-3388
12 Admin	Northern Ocean Co Board of Health 1771 Madison Ave Lakewood NJ 08701 **Meg located at this site**.	Monday –Friday 8:00 – 5:00 1st & 3rd Thursday: 5:00 – 7:00	(732) 370-0122 Fax: 732-886-0983
71	Ocean Health Initiatives (OHI) Federal Qualified Health Center 101 Second St. Lakewood NJ 08701	Monday to Fridays 9AM-4PM Thursdays 3 PM checks/NE	732-363-6655
17	Forked River Baptist Church	CLOSED March 2010	

20 PASSAIC WIC PROGRAM
333 Passaic STREET
PASSAIC, NJ 07055
(973) 365-5620 **Coordinator: Dana Hordyszynski**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	Passaic WIC Program 333 Passaic Street Passaic, NJ 07055	Monday – Friday: 8:30 – 4:00 Saturdays (3/month) 8:00AM-12:00PM	(973) 365-5620/5619 Fax: 973-365-5622
02	The Senior Center 330 Passaic Street Passaic, NJ 07055	Closed	
03	NHCAC 110 Main Avenue Passaic, NJ 07055	Tuesday inactive 1:00 – 4:00	(973) 777-0256
05 Not in use	St. Mary's Hospital – Health Start 211 Pennington Avenue Passaic, NJ 07055	(not active)	(973) 470-3019

22 TRINITAS WIC PROGRAM
40 Parker Road
ELIZABETH, NJ 07208
(908) 994-5141 **Coordinator: Anita Otokiti**

SITE CODE	NAME AND ADDRESS	DAYS/HOURS OF OPERATION	TELEPHONE NUMBER
01 Main Admin	Trinitas WIC Program 40 Parker Road Elizabeth, NJ 07208 As of March 1, 2012	Monday – Friday: 8:00 – 5:00 Door opens 8:30	(908) 994-5141 Fax: 908-994-5513
02	Hillside Health Department Municipal Building Liberty Avenue & Hillside Avenue Hillside, NJ 07205	1st & 3rd Friday*: 9:00 – 2:00 * subject to change	
04	Union Township CHC Vauxhall Fire House 2493 Vauxhall Road Union, NJ 07083	1st 2nd & 3rd Tuesday*: 9:00 – 2:00 * subject to change	
05	Summit Health Department City Hall 512 Springfield ? Summit, NJ 07901	1st 2nd & 3th Tuesday*: 9:00 – 2:00 *subject to change	
03	(not in use)		