United States General Accounting Office

GAO

Report to the Chairman, Committee on the Budget, House of Representatives

October 1997

FOOD ASSISTANCE

Working Women's Access to WIC Benefits

GAO/RCED-98-19

United States
General Accounting Office
Washington, D.C. 20548

Resources, Community, and
Economic Development Division

B-277788

October 16, 1997

The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

Dear Mr. Chairman:

The U.S. Department of Agriculture's (USDA) Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is designed to improve the health of low-income pregnant, breast-feeding, and postpartum women; infants; and children up to age 5, who are at nutritional risk. The program provides annual cash grants to the states for food, nutrition education, health care referrals, and administrative expenses. Food benefits are generally provided to participants in the form of vouchers or checks that they can redeem for certain foods at approved stores. Within the states, local WIC agencies distribute food vouchers and provide nutrition education through the clinics they operate in their service areas. In fiscal year 1997, appropriations for WIC totaled $3.7 billion, and average monthly participation was 7.4 million through February 1997.

This report is the third in the series of reports responding to your request for information on certain aspects of WIC.[1] In this report, we provide information on the extent to which WIC program benefits are accessible to eligible working women. Specifically, we (1) identified the actions taken by local WIC agencies to increase access to WIC benefits for working women; (2) asked the directors of local WIC agencies to rate the accessibility of their clinics; and (3) identified factors that limit program participation.

This report is based on the results of our nationwide survey of randomly selected local WIC agencies. Officials at these agencies (referred to as directors throughout this report) provided us with information on their agencies' operating characteristics. The survey responses from our random sample are representative of the entire universe of local WIC agencies. (App. I contains a detailed discussion of our scope and methodology; app. II discusses the methodologies and analysis used in the mail survey; and app. III presents the aggregated responses of our mail survey.)

[1]The other two reports are entitled WIC: States Had a Variety of Reasons for Not Spending Program Funds (GAO/RCED 97-166, June 12, 1997); and Food Assistance: A Variety of Practices May Lower the Cost of WIC (GAO/RCED-97-225, Sept. 17, 1997).

Results in Brief

The directors of local WIC agencies have taken a variety of steps to improve access to WIC benefits for working women. The two most frequently cited strategies are (1) scheduling appointments instead of taking participants on a first-come, first-served basis and (2) allowing a person other than the participant to pick up the food vouchers or checks, as well as nutrition information, and to pass these benefits on to the participant. These strategies focus on reducing the amount of time at, or the number of visits to, the clinic. Although three-fourths of the local WIC agencies offer appointments during the lunch hour, only about one-tenth offer Saturday appointments, about one-fifth offer early morning appointments, and less than half offer evening appointments. Collectively, at least one-fourth of the participants do not have access to any clinic hours outside of the regular work day.

Seventy-six percent of the directors of local WIC agencies believed that their clinics are reasonably accessible for working women. In reaching this conclusion, the directors considered their hours of operation, the amount of time that participants wait for service, and the ease with which participants are able to get appointments at the desired time. Although most directors were generally satisfied with their clinics' accessibility and had made changes to improve access, 9 percent of the directors still rated accessibility as a problem. Fourteen percent of the directors rated accessibility as neither easy nor difficult, and 1 percent responded that they are uncertain.

The directors of local WIC agencies identified several factors that limit WIC participation by working women. The factors most frequently cited reflected the directors' perceptions of how women view the program. Specifically, the directors told us that women do not participate because they (1) lose interest in the program as their income increases, (2) perceive a stigma attached to receiving WIC benefits, or (3) see the program as limited to those who do not work. Directors less frequently identified other factors—such as the lack of adequate public transportation and long waits at clinics—as also limiting WIC participation by working women.

Background

USDA's Food and Consumer Service (FCS) administers WIC through federal grants to states for supplemental foods, health care referrals, and nutrition education. To qualify, WIC applicants must show evidence of health or nutritional risk that is medically verified by a health professional. In addition, participants must have incomes at or below 185 percent of the

poverty level. In 1997, for example, the WIC's annual limit on income for a family of four is $29,693 in the 48 contiguous states and the District of Columbia.[2]

WIC operates in the 50 states, at 33 Indian tribal organizations, and in the District of Columbia, Guam, the U.S. Virgin Islands, American Somoa, and the Commonwealth of Puerto Rico. These 88 government entities administer the program through more than 1,800 local WIC agencies. These agencies typically are a public or private nonprofit health or human services agency; they can be an Indian Health Service Unit, a tribe, or an intertribal council. Local WIC agencies serve participants through the clinics located in their service area.

Most WIC food benefits are provided to participants through vouchers or checks that can be issued every 1, 2, or 3 months. These vouchers allow participants to purchase a food package designed to supplement their diet. The foods they can purchase through WIC are high in protein, calcium, iron, and vitamins A and C; they include milk, juice, eggs, cereal, and, where appropriate, infant formula. The value of the food package varies by state and by the participants' nutritional needs. The average value of the monthly food package in 1996 for all participants nationwide, excluding infant formula, was $43.54. Families with infants using formula obtained a package valued at about $82.

WIC was established in 1972 by Public Law 92-433, which amended the Child Nutrition Act of 1966. In 1989, the act was amended to require that state agencies improve access to WIC for working women by making changes that minimize the time they must spend away from work when obtaining WIC benefits. The directors of local WIC agencies generally estimated that working women represented between one-tenth and one-half of all those served in their clinics, although few agencies collect data on the number of working women.

Local WIC Agencies Have Taken Steps to Increase Clinic Accessibility

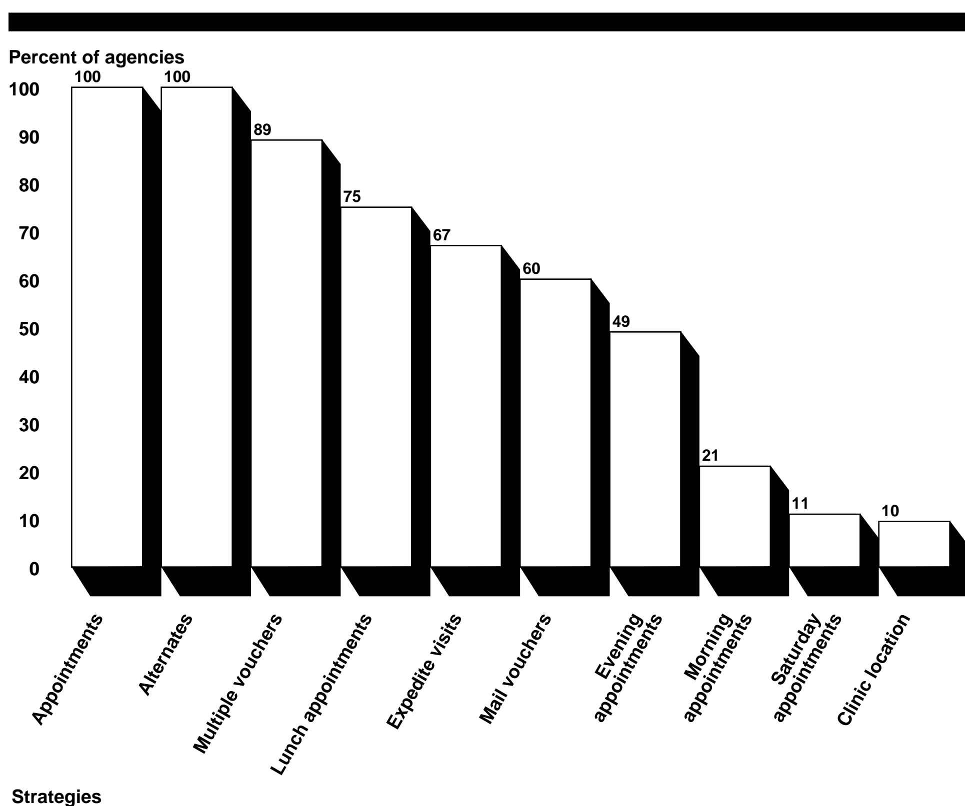
Nationwide, virtually all local WIC agencies have implemented strategies to increase the accessibility of their clinics for working women.[3] The most frequently cited strategies—used by every agency—are scheduling appointments instead of taking participants on a first-come, first-served basis and allowing a person other than the participant (an alternate) to

[2]Poverty guidelines are established separately for Alaska and Hawaii.

[3]While we found that 100 percent of the local WIC agencies we surveyed have implemented one or more strategies, our results are based on a sample, not the entire universe. Thus, we would estimate that at the 95-percent confidence level our finding applies to at least 99 percent of the entire universe.

pick up the food vouchers. Other, less frequently cited strategies, which are still used by more than half of the agencies, are issuing vouchers for more than 1 month at a time, offering appointments during the lunch hour, expediting clinic visits, and mailing vouchers to participants. Fewer directors use strategies that extend clinic hours beyond the typical workday—Saturday, early morning, or evening hours—or located clinics at participants' work or day care sites. Figure 1 illustrates the frequency of use for 10 strategies.

Figure 1: Strategies Used by Local WIC Agencies to Increase Accessibility for Working Women



As shown in figure 1, each of the six strategies—scheduling appointments, using alternates, issuing multiple vouchers, offering lunch hour appointments, expediting clinic visits, and mailing vouchers to participants, are used by more than half of the local WIC agencies. More specifically:

- Scheduling appointments. All local WIC agencies offer participants the convenience of scheduling their appointments. Scheduling appointments reduces a participant's waiting time at the clinic. Furthermore, Kansas state officials told us that they recommend that local WIC agencies schedule appointments for participants in order to make more efficient use of the agency staff's time.
- Using alternates. All local WIC agencies allow a person designated as an alternate to pick up food vouchers and nutrition information for the participant, thus reducing the number of visits to the clinic by working women. California state officials told us that they allow the use of alternates statewide and that many participants designate a relative or baby-sitter as an alternate. At one local WIC agency we visited in Pennsylvania, officials told us that alternates, such as grandmothers who provide care during the day, can benefit from the nutrition education because they may be more familiar with the children's eating habits than the parents.
- Issuing vouchers for multiple months. Almost 90 percent of local WIC agencies issue food vouchers for 2 or 3 months. California state officials said that issuing vouchers every 2 months to participants who are not at medical risk reduces the number of visits to the clinic.
- Offering lunch hour appointments. Three-fourths of local WIC agencies had some provision for lunch hour appointments. All of the local agencies we visited in California operate at least one clinic in their service area during the lunch hour, which allows some working women to take care of their WIC visit during their lunch break.
- Expediting clinic visits. Two-thirds of local WIC agencies took some action to expedite clinic visits for working women to minimize the time they must spend away from work. For example, a local agency official in New York State stated that the agency allows women who must return to work to go ahead of others in the clinic. The director of a local agency in Pennsylvania told us the agency allows working women to send in required paperwork before they visit, thereby reducing the time spent at the clinic. The Kansas state WIC agency generally requires women to participate in the program in the county where they live, but it will allow working women to participate in the county where they work when it is more convenient for them. Finally, one local agency in Texas remodeled its facilities to include play areas where children could be entertained during appointments. Not having to spend time minding their children decreases the amount of time that women need for visits.
- Mailing vouchers. About 60 percent of the local WIC agencies, under special circumstances, mail food vouchers to participants. Mailing vouchers eliminates the need for a visit to the clinic. Officials at all of the state

agencies we visited allow vouchers to be mailed but are generally very cautious in using this strategy. Both state and local agency directors told us that mailing vouchers eliminates the personal contact and nutrition information components of the program. One local agency director in Pennsylvania told us that she mailed vouchers to rural participants during a snowstorm when the agency van could not get to scheduled locations.

Three of the four less frequently used strategies shown in figure 1—Saturday, early morning, and evening hours—increase clinic hours beyond the regular workday. The fourth strategy—selecting clinic locations because they are at participants' work sites or day care providers—is the strategy least frequently cited. More specifically:

- Expanding clinic hours—Saturday, early morning, and evening hours. Offering extended hours of operation beyond the routine workday is an infrequently used strategy. About one-fifth of the local WIC agencies offer early morning hours—before 8 a.m.—at least once a week, and about one-tenth offer clinic hours on Saturdays at least once a month. Just under half of the agencies are open during evening hours—after 6 p.m.—once a week. At least one-fourth of the participants do not have access to any clinic hours outside the regular workday.

  The directors of local WIC agencies offered a variety of reasons for not offering extended hours of operation. For example, about 8 percent of these agencies had previously offered Saturday hours. Directors for several agencies said that they had discontinued this practice because participation was not high enough to warrant remaining open on Saturdays. Other reasons cited were an insufficient number of staff to allow for expanded clinic hours (79 percent), the staff's resistance to working hours other than the routine workday (67 percent), and a lack of security in the area after dark (42 percent). For example, at one agency we were told about two recent homicides after dark near one of the clinics. This clinic limits evening hours to one evening each month, and at closing time, the staff exit together to the parking lot across the street. In addition, in two states we visited, the clinic staff do not have access to their statewide computer system in the evenings or on Saturdays, which reduces efficiency in processing paperwork and discourages operating during extended hours.
- Clinic locations. About 5 percent of local WIC agencies selected a location for one or more of their clinics because it is at or near a work site. For example, one Texas agency operates a clinic twice a month at a poultry

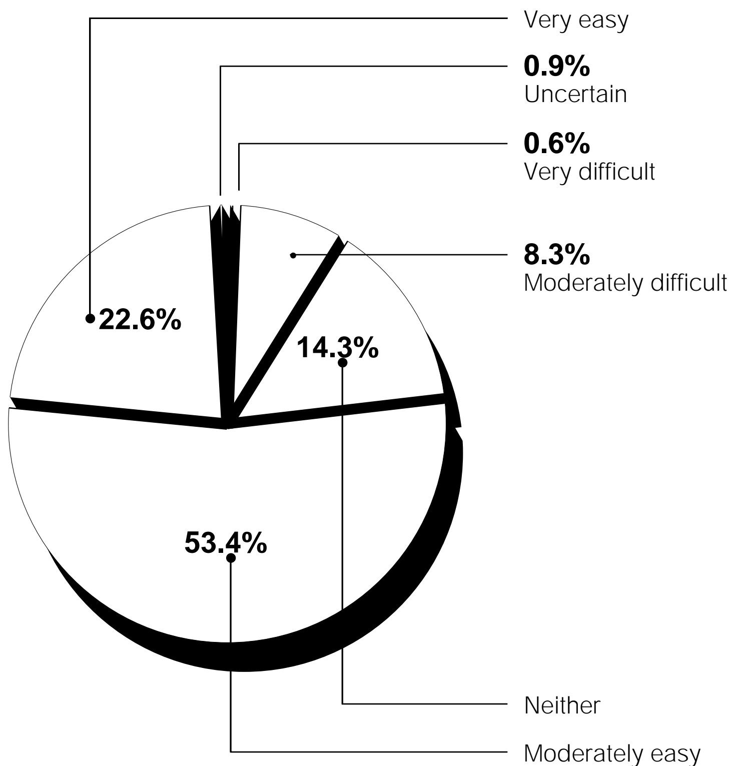
farm in an area where several such farms employ women who are WIC participants. In California, two local WIC agencies we visited have clinics at nearby military bases. One has a clinic at an Air Force base, and the other has six clinics at various installations—two at Marine bases and four at Navy locations.

Similarly, about 5 percent of local WIC agencies selected clinic locations because they are day care sites for participants. For example, according to a director of a local WIC agency in Texas, she operates a clinic once a month at a day care site used by 71 women who participate in WIC. Operating a clinic at this location is a convenience for the participants.

Directors Generally Believe Their Clinics Are Easily Accessible

About 76 percent of the directors of local WIC agencies believed that accessibility to their clinics is at least moderately easy for working women, as measured by such factors as convenient hours of operation and reasonable waiting time at the clinics. However, about 9 percent of the directors believed that accessibility is still a problem for working women. Figure 2 shows the directors' rating of their clinics for accessibility.

Figure 2: Directors' Views of Clinics' Accessibility



Despite the widespread use of strategies to increase accessibility, some directors reported that accessibility is still problematic for working women. In our discussions with these directors, the most frequently cited reason for rating accessibility as moderately difficult or very difficult is the inability to operate during the evening or on Saturday. As previously noted, directors provided several reasons for not offering extended hours, including the lack of staff, staff's resistance to working schedules beyond the routine workday, or the perceived lack of safety in the area around the clinic after dark.

While about 76 percent of the directors of local WIC agencies perceived that access to their clinics is easy at current participation levels, this situation could change with increases in WIC participation overall, as well

as with increases in participation by working women—a situation anticipated by many directors. About 58 percent of the directors indicated that they expect participation by working women to increase with the implementation of welfare reform. These expectations have already been realized in some states. Directors of local WIC agencies in Tennessee and Indiana reported that their states have already implemented some aspects of welfare reform and that the number of working women participating in WIC has increased.

Federal, state, and local WIC officials explained that overall participation in WIC is likely to grow with the implementation of welfare reform because the perceived value of WIC benefits will increase as benefits from other assistance programs are lost. Moreover, the percentage of working women in WIC is likely to increase because welfare initiatives place a premium on moving the beneficiaries of these programs into the workforce.

Increases in WIC participation could burden staff and space resources and hinder some agencies' ability to continue to provide easy access to their clinics. In fact, many directors who rated access to their clinics as generally difficult cited a current lack of resources—staff and space—as the primary reason.

Other local WIC agency directors reported similar staff and space constraints, noting that they were already working at full capacity and that one or more of their clinics had no room to accommodate more participants. For example, one director told us that his clinic was "already bulging at the seams" and that increases in participation would leave the clinic critically short of staff and space. Such shortages could limit working women's access to WIC clinics.

Directors View Women's Perceptions as a Major Factor Limiting Participation

Women's perceptions about WIC—such as the value of the program's benefits to them as their income rises or the perceived stigma attached to obtaining benefits—were the limitations to participation most frequently cited by the directors of local WIC agencies. Another major factor limiting participation is that women may not be aware of their continued eligibility for WIC if they begin working while participating or if they are working and have not participated in WIC. Less frequently cited factors limiting participation in WIC include difficulties in reaching the clinic and long waits at the clinic.

Frequently Cited Factors Limiting WIC Participation

The directors of the local WIC agencies indicated that working women's views of the WIC program may limit their participation, despite the agency's efforts to make the program more accessible to them. Sixty-five percent of the directors considered the fact that working women lose interest in WIC benefits as their income rises as a significant factor limiting participation. For example, one agency director reported that women gain a sense of pride when their income rises and they no longer want to participate in the program. While working women may choose not to participate in WIC as their income increases, one local agency director noted that the eligible working women and their families who drop out of the program lose the benefit of nutrition information.

The stigma some women associate with WIC—how they appear to their friends and co-workers as a recipient—is another significant factor limiting participation, according to about 57 percent of the local agency directors. One director said that when women go to work, they tend to change the way they view themselves—from thinking that they need assistance to thinking that they can support themselves. Another director told us that when her clinic was located in the county building, women were reluctant to come in because they were recognized as WIC recipients by county employees working elsewhere in the building.

Another aspect of the perceived stigma associated with participating in WIC is sometimes referred to as the "grocery store experience." The use of WIC vouchers to purchase food in grocery stores can cause confusion and delays for both the participant-shopper and the store clerk at the check-out counter and result in unwanted attention. For example, the directors of two local WIC agencies in Texas said that the state's policy requiring participants to buy the lowest-priced WIC-approved items in the store contributes to the stigma, which limits participation. In Texas, a participant must compare the cost of WIC-approved items, considering such things as weekly store specials and cost per ounce, in order to purchase the lowest-priced items. Texas state WIC officials told us that this policy maximizes the food dollar, thus allowing benefits for a greater number of participants.

Another director told us that a pilot project in which WIC-approved foods are purchased using a card that looks like a credit card could help reduce the stigma associated with shopping in the grocery store. The WIC card retains information on unused benefits and can be used at the check-out counter like an ordinary credit card.

More than half of the directors indicated that a major factor limiting participation is that working women are not aware that they are eligible to participate in WIC. Local agency officials we spoke to in both California and Texas confirmed that many working women do not realize that they can work and still receive WIC benefits. Furthermore, these officials said that WIC participants who were not working when they entered the program but who later go to work often assume that they are no longer eligible for WIC and drop out.

Other Factors Limiting Participation

Other factors limiting WIC participation were difficulty in reaching the clinic, long waits at the clinic, or the lack of service during the lunch hour. For example, 41 percent of the directors of local WIC agencies indicated that difficulty in reaching the clinic—the unavailability or inadequacy of public transportation—was a limiting factor. Eighteen percent of the directors reported long waits as a limiting factor. About 7 percent reported that clinics not being open during the lunch hour was a factor limiting participation—not surprising since more than three-fourths of all agencies offer lunch hour appointments in at least one of their clinics.

Agency Comments

We provided a copy of a draft of this report to the USDA for review and comment. We met with Food and Consumer Service officials, including the Acting Director for the Supplemental Food Program Division, Special Nutrition Programs. The Service concurred with the accuracy of the report and provided several minor clarifications, which we incorporated as appropriate.

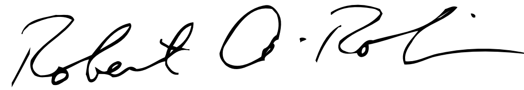
Scope and Methodology

To examine the accessibility of WIC for working women and the factors limiting their participation, we conducted a mail survey of 375 directors of local WIC agencies, visited 18 clinics in four states, and met with USDA headquarters officials and state agency officials responsible for WIC. We conducted our review from March through September 1997 in accordance with generally accepted government auditing standards.

We are sending copies of this report to the Chairman, Senate Committee on Agriculture, Nutrition, and Forestry; the Chairman, House Committee on Agriculture; and the Secretary of Agriculture. We will also make copies available to others upon request.

If you have any questions about this report, please contact me at (202) 512-5138. Major contributors to this report are listed in appendix IV.

Sincerely yours,



Robert A. Robinson
Director, Food and
Agriculture Issues

Contents

Letter 1

Appendix I
Objectives, Scope and Methodology 16

Appendix II
Methodology and Analysis Used in the Mail Survey 18

Appendix III
Aggregated Responses to the Mail Survey 20

Appendix IV
Major Contributors to This Report 29

Tables
Table I.1: Local WIC Agencies Visited 17
Table II.1: Sampling Errors for Selected Percentages 19

Figures
Figure 1: Strategies Used by Local WIC Agencies to Increase Accessibility for Working Women 4
Figure 2: Directors' Views of Clinics' Accessibility 8

Abbreviations

FCS	Food and Consumer Service
USDA	U.S. Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Objectives, Scope and Methodology

We conducted our review to obtain information on the extent to which the benefits of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are accessible for eligible working women and their children. Specifically, we (1) identified actions taken by local WIC agencies to increase access to WIC benefits for working women; (2) obtained agency directors' assessment of their clinics' accessibility; and (3) identified factors limiting participation in the program.

We conducted a mail survey of 375 randomly selected local WIC agencies from a nationwide list of 1,816 local agencies provided to us by the U.S. Department of Agriculture's (USDA) Food and Consumer Service (FCS). The survey asked the directors of the local agencies to provide information on (1) the strategies they have implemented to increase the accessibility of their clinics, (2) their views on the overall accessibility of their clinics for working women, and (3) factors that limit participation by working women. In addition, we asked directors to provide descriptive information on their agency, such as the number of clinics and participants. (See app. III for a complete list of questions.)

We used the survey responses to develop overall results that are representative of those that would be obtained from all local agencies nationwide. For an explanation of the survey results and how they can be used, see appendix II. Appendix III presents the aggregated responses to our survey.

To better understand the problems and limitations affecting working women's access to WIC benefits, we visited local WIC agencies and interviewed agency staff in several states. We judgmentally selected the sites visited to obtain states and agencies with high levels of participation and WIC funding and to provide geographic diversity. In addition, we discussed the selection of local WIC agencies with state agency officials, who identified unique agency features for consideration in selection, such as rapid growth in participation or migrant workers' participation. Table I.1 lists the local WIC agencies that we visited.

Table I.1: Local WIC Agencies Visited

Location	Local WIC agency
California	
Healdsburg	Alliance Medical Center
San Diego	American Red Cross
Stockton	Community Medical Centers, Inc.
San Diego	Mercy Healthcare
Santa Ana	Planned Parenthood, Orange & San Bernadino Counties
Irwindale	Public Health Foundation Enterprises, Inc.
Chula Vista	San Ysidro Health Center
Santa Barbara	Santa Barbara County Health Care Services
Kansas	
Newton	Harvey County Health Department
Olathe	Johnson County Health Department
Kansas City	Wyandotte County Health Department
Pennsylvania	
York	Community Progress Council, Inc.
Camp Hill	Family Health Council of Central Pennsylvania
Harrisburg	Hamilton Health Center
Gettysburg	WIC of Franklin and Adams Counties
Texas	
Austin	Austin Health and Human Services, Travis County Health Department
San Antonio	San Antonio Metropolitan Health Department
San Antonio	Santa Rosa Health Care Corporation

In addition, we interviewed state agency officials and FCS headquarters and regional officials to obtain information on overall program operations, policies, and guidance.

We provided a draft copy of this report to FCS for review and comment. We performed our work from March through September 1997 in accordance with generally accepted government auditing standards.

Methodology and Analysis Used in the Mail Survey

In developing the questionnaire for our mail survey, we conducted 12 pretests with directors of local WIC agencies in four states, the District of Columbia, and one Indian tribal organization. Each pretest consisted of a visit to a local WIC agency by two GAO staff, except for a pretest by telephone with one director. During these visits, we attempted to simulate the actual survey experience by asking the local agency director to fill out the survey. We interviewed the director to ensure that (1) the questions were readable and clear, (2) the terms were precise, (3) the survey did not place an undue burden on local agency directors, and (4) the survey appeared to be independent and unbiased in its point of view. We also obtained reviews of our survey from managers at FCS.

In order to maximize the response to our survey, we mailed a pre-notification letter to respondents 1 week before we mailed the survey. We also sent (1) a reminder postcard 1 week after the survey, (2) a reminder letter to nonrespondents 2 weeks after the survey, and (3) a replacement survey for those who had not responded 31 days after the survey. We received survey responses from 350 of the 375 local agencies in our sample. This gave us a response rate of 93 percent. After reviewing these survey responses, we contacted agencies by phone to clarify answers for selected questions.

Since we used a sample (called a probability sample) of 375 of the 1,816 local WIC agencies to develop our estimates, each estimate has a measurable precision, or sampling error, which may be expressed as a plus/minus figure. A sampling error indicates how closely we can reproduce from a sample the results that we would obtain if we were to take a complete count of the universe using the same measurement methods. By adding the sampling error to and subtracting it from the estimate, we can develop upper and lower bounds for each estimate. This range is called a confidence interval. Sampling errors and confidence intervals are stated at a certain confidence level—in this case, 95 percent. For example, a confidence interval, at the 95-percent confidence level, means that in 95 out of 100 instances, the sampling procedure we used would produce a confidence interval containing the universe value we are estimating. Table II.1 lists the sampling errors for selected percentages.

Table II.1: Sampling Errors for Selected Percentages

Percent	Sampling error (in percent)
5	±2
10	±3
20	±4
30	±5
40	±5
50	±5
60	±5
70	±5
80	±4
90	±3
95	±2

Note: Sampling errors are calculated for the 95-percent confidence level using the finite population correction factor and 297 cases, the smallest number of valid cases for questions with finite categories. Questions with more than 297 valid cases will have slightly smaller errors.

In addition to the sampling errors reported above, one of our analyses required a ratio estimate in order to calculate sampling errors. We report that 24 percent of participants nationwide are served by local agencies that have no regular hours beyond the hours of 8 a.m. to 6 p.m., that is, participants have no access to Saturday, evening, or early morning hours. The sampling error associated with this estimate is 8 percent. Therefore, our estimate of 24 percent ranges between 16 and 32 percent, using a 95-percent confidence level.

In estimating the number of participants without access to hours beyond the routine workday, we made conservative assumptions that lowered the estimate. For example, if an agency had five clinics and only one with extended hours, we assumed that all of the agency's participants had access to the extended hours, even though this clinic does not serve all of the participants. Since we did not collect data on the number of participants at each clinic, we cannot determine the extent to which our estimates might be affected by these conservative assumptions.

Aggregated Responses to the Mail Survey

U.S. General Accounting Office

GAO Survey of Local WIC Agencies

Introduction

The U.S. General Accounting Office (GAO) is an agency that examines issues for the U.S. Congress. We are conducting a review of ***access to WIC benefits by working women,*** for themselves or their children. As part of our review we are sending a questionnaire to a sample of local WIC agencies nationwide, and your agency has been selected to be a part of the sample. The information you provide will assist us in developing a nation-wide picture of accessibility.

In this survey, we are asking specifically about local agency efforts towards increasing access to benefits for working women. Please have the primary WIC contact and/or other staff most knowledgeable about these issues respond to this survey.

Your response within 14 days of receipt of the survey will help us avoid costly follow-ups. Please use the enclosed self-addressed business-reply envelope. If the envelope is missing or has been misplaced, please return the questionnaire to the following address:

U.S. General Accounting Office
Attn: Judy Hoovler
Suite 1200
301 Howard St.
San Francisco, CA 94105-2252

If you have any questions please call Judy Hoovler at (800) 965-7121.

Thank you for your assistance.

1. Please fill out the following information for the person responsible for completing this survey in case we need to contact you.

Name: ____________________

Title: ____________________

Phone: (_______) ______________

2. What was your WIC participation for the month of January, 1997? *(Enter number. If none, enter "0.")* **N350**

Median=1,597 Mean=4180 Range=30-64,880

__________ participants

3. How many clinics are there in your agency, as of January 1, 1997? *(Enter number. If none, enter "0.")*

> **Definition:** A ***clinic*** is any facility where you 1) certify WIC applicants, or 2) provide nutritional education and counseling. This includes permanent, full-time, temporary, part-time, or mobile clinics.

N350
Median=3.0 Mean=5.4 Range=1-46

__________ clinics as of Jan. 1, 1997

Notes: Percentages may not add to 100 due to rounding.
Numbers in this appendix include categories omitted from the report, such as, "don't know", which will change percentages somewhat.
N=the number of respondents for each question.

1

4. How many of these clinic locations (See Question 3.) were selected because they are ***work sites*** of WIC participants? *(Check one.)*
N=349

1. 94.8% None
2. 2.0% 1
3. 2.3% 2-4
4. .6% 5 or more
5. .3% *Cannot estimate*

5. How many of your clinic locations (See Question 3.) were selected because they are ***day care providers*** for WIC participants? *(Check one.)*
N=349

1. 94.8% None
2. 2.3% 1
3. 2.0% 2-4
4. .9% 5 or more

6. Does your agency collect information on the number of working women participating in WIC? *(Check one.)*
N=350

1. 12% Yes
2. 84.9% No
3. 3.1% *Don't know*

7. Using your best professional judgment and experience, please estimate the percent of the women currently served by your clinics who are working women. In estimating this number, it may help you to consider how often a woman provides a check stub from her own earnings as proof of income. *(Check one.) N=347*

Definition: ***Working women*** are those women who work for an employer and receive wages. Employment should be at least 20 hours per week to qualify as "working." Students are ***not*** classified as working women unless they are also employed and receiving wages.

1. 13.0% 10 percent or less
2. 26.2% 11 - 25 percent
3. 34.6% 26 - 50 percent
4. 13.5% 51 - 75 percent
5. 1.4% 76 - 90 percent
6. .3% 91 - 100 percent
7. 11.0% *Cannot estimate*

2

8. Below is a list of strategies tried by agencies to increase the accessibility of their services to working women. Please indicate the number of clinics where your agency is ***currently*** using each strategy. *(Enter number of clinics. If none, enter "0.")* **N=350**

Note: If you have tried a strategy, but do not currently use it in any clinics, please circle the letter of the strategy.

> **Definition (Same as question 3):** A ***clinic*** is any facility where you 1) certify WIC applicants, or 2) provide nutritional education and counseling. This includes permanent, full-time, temporary, part-time, or mobile clinics.

% circled N=349		Strategy		Percent with at least 1 clinic:
8.0%	a.	Open on Saturdays (at least monthly)	________ clinics	11.4%
3.4%	b.	Open for early morning hours (before 8 am at least one morning per week)	________ clinics	20.9%
3.4%	c.	Open during lunch hours (at least one day per week)	________ clinics	75.4%
3.7%	d.	Open for evening hours (at least one night per month after 6 pm)	________ clinics	48.9%
1.7%	e.	Offer scheduled appointments (either routinely or when requested by participants)	________ clinics	100.0%
1.7%	f.	Allow for alternative food instrument pick-up in person by someone other than the participant (such as proxy or designated alternate)	________ clinics	100.0%
3.2%	g.	Allow for alternative food instrument pick-up by mail (at least in special circumstances)	________ clinics	59.7%
1.7%	h.	Issue food instruments for more than one month at a time to eligible participants	________ clinics	88.6%
.6%	i.	Offer expedited processing for working women when needed	________ clinics	67.1%

j. Please list any other strategies you use to increase the accessibility of your clinics to working women. 25.9%

3

9. Still considering strategies from the previous question, how much additional need, if any, do you see for increasing ***access for working women*** in your area? *(Check one for each row.)*

Numbers expressed in percentages in columns 1 to 6.

	No additional need (1)	Some (2)	Moderate (3)	Great (4)	Very great (5)	*Don't know (6)*
a. Open on Saturdays **N=343**	41.4	34.4	11.1	3.8	.9	8.5
b. Open for early morning hours (before 8 am) **N=344**	50.0	36.3	7.8	2.0	.9	2.9
c. Open during lunch hours **N=341**	55.4	20.2	14.4	5.0	3.5	1.5
d. Open for evening hours (after 6 pm) **N=345**	32.8	35.7	15.9	8.7	4.1	2.9
e. Offer scheduled appointments **N=343**	76.4	2.9	3.2	8.2	8.5	.9
f. Allow alternative food instrument pick-up in-person by someone besides the woman (such as proxy or designated alternate) **N=344**	77.3	2.6	4.7	7.6	7.6	.3
g. Allow alternative food instrument pick-up by mail **N=344**	56.1	23.5	8.4	4.1	2.6	5.2
h. Issue food instruments for more than one month at a time to eligible participants **N=344**	71.2	6.1	3.8	4.7	13.1	1.2
i. Offer expedited processing for working women **N=340**	52.4	22.4	10.0	4.4	4.7	6.2

4

10. What is the earliest time that any of your clinics are open to see women on a regular basis (at least once a month)? *(Check one.)* **N=350**

1. .3% Before 7:00 am
2. 6.3% 7:00 to 7:29 am
3. 14.6% 7:30 to 7:59 am
4. 59.4% 8:00 to 8:29 am
5. 15.1% 8:30 to 8:59 am
6. 4.0% 9:00 to 9:29 am
7. .3% 9:30 am or later

11. What is the latest time that any of your clinics are open to see women on a regular basis (at least once a month)? *(Check one.)* **N=350**

1. 6.3% Before 4:00 pm
2. 8.0% 4:00 to 4:29 pm
3. 20.9% 4:30 to 4:59 pm
4. 9.7% 5:00 to 5:29 pm
5. 10.0% 5:30 to 5:59 pm
6. 26.6% 6:00 to 6:59 pm
7. 15.4% 7:00 to 7:59 pm
8. 3.1% 8:00 pm or later

12. Below is a list of reasons that can limit an agency's ability to expand clinic access for working women. Please indicate to what extent each reason keeps your agency from expanding clinic access. *(Check one for each row.)* **Numbers expressed in percentages in columns 1 to 4**

	Major reason (1)	Minor reason (2)	Not a reason (3)	*Uncertain (4)*
a. We would have to reduce operating hours elsewhere to avoid overtime or staff burnout. **N=341**	60.4	15.5	21.1	2.9
b. We would need additional staff to expand our hours or to add locations. **N=343**	64.4	14.6	19.2	1.7
c. Our staff are resistant to working evenings or Saturdays. **N=345**	32.5	34.2	29.0	4.3
d. Our staff are resistant to staggering lunch hours in order to keep clinic open during lunch. **N=346**	4.3	12.1	81.5	2.0
e. Union rules and concerns limit our flexibility in making changes to our clinic schedules (for example, evening, weekend, lunch, or early morning hours). **N=347**	5.8	6.1	85.0	3.2
f. Some working women prefer to drop in rather than scheduling appointments. **N=344**	5.8	22.1	61.0	11.0
g. Our area or building is unsafe after dark. **N=346**	19.4	22.5	56.9	1.2
h. Our area or building is unsafe on Saturday. **N=344**	4.9	14.5	79.7	.9
i. We have to meet certain conditions in order to use the building after regular business hours or on Saturdays. **N=346**	17.6	15.3	62.1	4.9
j. We are not allowed to use the building after regular business hours. **N=346**	13.3	11.3	71.4	4.0
k. We are not allowed to use the building on Saturdays. **N=346**	15.6	10.1	68.8	5.5
l. Cost would be prohibitive. **N=346**	32.1	23.4	36.1	8.4

6

13. Are there actions that your agency could take that you think would increase participation by ***working women*** in your agency's WIC program? *(Check one.)* **N=342**

1. 41.2% Yes →Please list such actions below and explain why you have not been able to implement this so far.

2. 58.8% No →***Go to next question.***

Action Reason not implemented **N=231** Comments 60.6%

14. Please rate the current accessibility of your clinics for working women. *(Check one.)* **N=350**

> **Definition:** ***Accessibility*** is being able to get all WIC services and program benefits quickly and efficiently. Clinic accessibility includes such things as convenient hours of operation, reasonable waiting time, ease in getting an appointment at the time desired, convenience of location, and adequacy of public transportation.

1. 22.6% Very easy
2. 53.4% Moderately easy
3. 14.3% Neither easy nor difficult
4. 8.3% Moderately difficult
5. .6% Very difficult
6. .9% Don't know

15. Please rate the accessibility of your agency's clinics ***today*** for working women compared to January 1995. *(Check one.)* **N=350**

1. 20.6% Much better today
2. 37.7% Better
3. 38.3% About the same
4. .3% Worse
5. .0% Much worse today
6. 1.1% *This agency less than 2 years old*
7. 2.0% Don't know

7

16. For each factor listed below, please indicate to what extent it currently limits WIC participation by ***working women*** in your area. *(Check one for each row.)* **Numbers expressed in percentages in columns 1-5**

	Major factor (1)	Moderate factor (2)	Minor factor (3)	Not a factor (4)	*Don't know (5)*
a. Working women in our area are not aware of the WIC program and its benefits. **N=348**	5.7	27.0	39.4	22.4	5.5
b. Working women in our area are not aware that they may be eligible for WIC benefits. **N=350**	14.9	35.4	34.9	10.6	4.3
c. Women think they are no longer eligible when they begin working. **N=349**	15.2	31.5	28.4	22.3	2.6
d. Working women lose interest in benefits as their income rises. **N=348**	27.6	37.6	23.0	7.2	4.6
e. Working women feel there is a stigma attached to receiving benefits. **N=350**	19.4	37.4	28.9	9.4	4.9
f. Waits at our clinic(s) are too long for working women. **N=349**	4.3	13.8	30.9	50.1	.9
g. Working women need Saturday hours. **N=349**	4.0	14.6	31.8	36.1	13.5
h. Working women need evening hours. **N=348**	8.3	19.3	33.6	31.3	7.5
i. Our clinics are not open during lunch hours. **N=348**	.3	6.3	17.8	74.1	1.4
j. Working women can't get appointments for their visits to our clinics. **N=349**	.6	3.2	8.9	85.1	2.3
k. Working women feel that their schedules conflict with our clinic hours. **N=350**	4.9	18.0	43.1	26.0	8.0
l. Public transportation to our clinics is unavailable or inadequate. **N=348**	23.0	18.4	25.3	31.6	1.7
m. Distance to our clinics is too far for working women. **N=348**	1.7	13.5	28.4	53.2	3.2

n. Please list any other factors that make access to WIC benefits difficult for working women in your area. **N=346** Comment 12.1 %

8

17. Does your agency have any written plan that details actions for increasing accessibility of WIC program benefits specifically for working women? *(Check one.)* **N=348**

1. 17.0% Yes → a. What is the month and year of your most recent plan?

2. 79.3% No

3. 3.7% *Don't know*

18. What changes, if any, does your agency expect in the number of ***working*** women seeking WIC benefits as Welfare Reform takes effect? *(Check one.)* **N=350**

1. 10.9% Much higher
2. 47.4% Higher
3. 22.9% About the same
4. 2.9% Lower
5. .9% Much lower
6. 15.1% *Uncertain*

19. What changes, if any, does your agency expect in the overall number of individuals seeking WIC benefits as a result of Welfare Reform? *(Check one.)* ***N=350***

1. 14.6% Much higher
2. 40.3% Higher
3. 25.7% About the same
4. 4.3% Lower
5. .9% Much lower
6. 14.3% *Uncertain*

20. Please add any additional comments below regarding the WIC program. **N=349**

Comment 35.5%

9

Major Contributors to This Report

Robert E. Robertson, Associate Director
Judy K. Hoovler, Evaluator-in-Charge
D. Patrick Dunphy
Fran A. Featherston
Renee McGhee-Lenart
Carol Herrnstadt Shulman
Sheldon H. Wood, Jr.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Correction Requested

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100