For the Children: Analysis and Policy Recommendations for WIC Program, Lincoln Community Health Center

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Introduction

The Women Infants and Children (WIC) Special Supplemental Nutrition Program began in 1972 as a two-year pilot program partially in response to the 1969 White House Conference on Food, Nutrition and Health. The conference report suggested that poor nutrition among low-income women and children would lead to future medical problems and high costs. They argued that the WIC program would improve nutrition and subsequently health and save money. When the two years were up in 1974, the program was renewed and established as a long-term federal program.\textsuperscript{i}

The key word in the name of the program is Supplemental. Unlike food stamps, WIC is a voucher based plan to provide nutritional supplements to women, infants and children. There are federal mandated eligibility requirements. Family income must be at or below 185\% of the federal poverty line. In addition, participants must be nutritionally at risk, based on a series of clinical guidelines. There are three parts to the WIC program: (1) vouchers to purchase specific high-nutrition foods to supplement diets, (2) nutritional and health counseling and (3) referrals to healthcare and social-service providers.\textsuperscript{ii} The idea behind WIC is not just to give people food, but also to educate them about healthy eating, the consequences of poor diet, and how to make healthy food choices for themselves and/or their children. By law, WIC agencies must spend at least one-sixth of their allocation on nutrition education.

The WIC frequently garners praise as a model of efficiency. There have been estimates that the savings in medical expenses from WIC equal a 3-1 cost benefit ratio. No doubt the WIC program has improved the lives and nutrition of countless American mothers and their children, but is there still room for improvement? Are there still areas
where the WIC program fails to reach its goals? The purpose of this research is to examine one WIC office in particular and determine the areas where improvement is needed and make specific policy recommendations.

The WIC program in Durham, North Carolina is housed at Lincoln Community Health Center. The city of Durham has a population of 187,035 (2000 Census) people, with 223,891 (2000 Census) in the entire county. The mean household personal income is $66,082. The per capita income for the county is $34,549 annually, compared with the $25,821 figure for the entire state. In terms of education, 78.5% of Durham residents have completed high school, with 35.4% having completed college. This compares with 70% and 17.4% respectively for the state of North Carolina as a whole.

Hidden within these numbers is a tale of inequality. Durham is the ‘City of Medicine’, a city that houses prestigious Duke University and part of Research Triangle Park. That means that the income figures are inflated by doctors, other medical professionals, professors, technology workers, etc. who live in the better neighborhoods of Durham. A large part of Durham is dilapidated and run down. Just past downtown you can find people living in government housing or structures resembling shacks. Much of the income disparity apparent in Durham falls along racial lines. Blacks and the growing Latino population account for the majority of the impoverished citizens.

According to 2000 U.S. Census data, Durham county is 50.9% White, 39.5% Black, and 7.6% Latino. The city of Durham is 45.5, 43.8, and 8.6% White, Black and Latino respectively. The Latino population has grown rapidly in the Durham area and in the state in general. Some estimates suggest that the Latino population has grown over 200% in the last 10 years. All of these facts and figures have an impact on the WIC program
here in Durham. Whether it be the language barrier for Latinos or the general lack of resources of the nutritionally at risk population, they all have an effect.

What this study looks to do is analyze and evaluate the Durham WIC program and examine the social, political, economic and cultural barriers to care for the at risk population. What changes need be made to accommodate the growing Latino population? How can service utilization be increased, not only for nutrition but health in general? Additionally, we will compare the attitudes and beliefs of the clients with those of the WIC staff. Lastly, this research looks to make policy recommendations for the improvement of the program and possible ways to integrate the WIC program with other social and health services.

**Literature Review**

There have been numerous studies on the efficacy, satisfaction rate and quality of the federal WIC program. Besharov & Germanis (1999) suggested that the eligibility requirement of “nutritionally at risk” is neither adequately defined, nor stringent enough. They assert that “because of…loose interpretations of “nutritional risk”, and the fact that the middle class is having relatively fewer children than in the past… a surprisingly large proportion of Americans receive WIC benefits: nearly half of all infants, one-quarter of all children one to five, and the same proportion of pregnant women.” They add that WIC has in some ways lost its focus on the truly nutritionally at risk population and has become largely based on income requirements. They propose that another 10 percent of American children are eligible for WIC, but do not receive benefits because WIC is not
an entitlement program. This means that the number of people to be served each year is determined by Congressional appropriations and any added state funds. They argue that the intake process become more focused at those below the federal poverty line and suggests that some of those most needy people are not receiving any benefits.

The National WIC Evaluation examined WIC’s effectiveness in terms of nutritional outcomes for participants versus at risk non-participants. The research, conducted in the 1980’s in NYC and NC suggested that WIC does have a measurable effect, but not to the extent previously believed. They found that overall caloric intake was not increased for infants on the program, but that intake of particular nutrients like iron, vitamin C, but lower intakes of calcium. This study did have numerous methodological studies though, so its results cannot be generalized.

Besharov and Germanis conclude that WIC needs to target more resources at the most needy families. They cite that “50% of all infant formula sold in the United States is purchased with WIC dollars.” Why is a program for low-income women and children so broad so as to include so many people? Something needs to change. Lastly they call for WIC to become more integrated with other social services and public health networks. While WIC is a federal program, state and local health departments, making integration very feasible, administer it.

In this paper, the issue of integration of services and streamlining of WIC bureaucracy will be very important. Besharov and Germanis have correctly asserted that there are issues with enrollment to the WIC program. We are potentially missing a large number of at risk women and children and there are both social and institutional reasons behind this. They have given one reason as the broad definition of nutritional risk, but
there are others. A 1992 study by Kahler, et al. examined other barriers to service utilization. Some of the reasons they offer include: “child care and transportation difficulties, a perceived lack of benefits of program participation, negative cultural attitudes, and embarrassment about receiving a handout.” The researchers studied 200 women over a three-month period in Buffalo, New York. They administered a questionnaire to those meeting the eligibility requirements for WIC. They found a large difference in WIC participation based on where mothers received prenatal care. Women who went to hospital clinics or private physicians had a 53% enrollment rate, while those who received care at health department clinics or a community-sponsored clinic had enrollment rates of 98 and 77% respectively. These findings suggest that private practice physicians and hospital clinics need to do a better job of educating and referring eligible patients to available services like WIC.

They found that there was major under use of the prenatal WIC services by almost one-third of eligible women in this study. Policy wise they suggest that WIC requires better recruitment programs for pregnant women, minimized paperwork, and follow ups to determine client enrollment.

Methods

The researcher created two surveys: one for WIC clients, and one for the nutritionists working in the WIC office (see appendices A & B). The client survey was a composite of original questions and questions from the NC WIC Survey. The survey was administered in both Spanish and English. The nutritionist survey is a completely original document created for the purpose of this research. The survey was not pre-tested.
Further study is recommended to elucidate some of the issues and problems facing this WIC population. This study is preliminary, as are the survey tools.

Given the demographics of the Durham community, this research focuses on Black and Latino clients. Only Black and Latino clients were surveyed and client participation was completely voluntary. Respondents were chosen at random from people in the waiting room. They were instructed that the survey was anonymous and had no bearing on their WIC certification. It was presented as a WIC Survey.

While Blacks greatly outnumber Latinos in the greater Durham population, in the WIC program there is almost equal representation. The estimated breakdown is 55% Black and 40% Latino. The number of Black and Latino clients surveyed reflects this fact. The sample size is 47 Blacks and 40 Latinos.

There are some limitations to the applicability of this survey both due to methodology and logistical confines. Surveys were only collected on Monday, Wednesday and Friday late-afternoons. Clients must arrive by 3:30PM for certification, making it more likely that one would see more of those clients in the morning or early afternoon. Additionally, there was a long delay in getting the survey translated in Spanish. The English and Spanish surveys were administered at different times, with all the English surveys collected at the beginning of the research at the Spanish ones at the end. Also, there were some issues with clients, particularly Spanish speakers understanding the survey. Several surveys were completed incorrectly or incompletely and had to be removed from the sample.

The nutritionist survey was designed to mirror the client survey in order to assess the difference in perception and beliefs between the two groups and examine the effect if
any this had on outcomes. Most of the questions are client questions rephrased. The sample size was nine. One major issue is the evaluative part of the survey. The problem is that the nutritionist survey asks them to evaluate the program and their role within it, but a similar question was not asked of the clients. Without that, a major indicator is unavailable.

The intent of the both surveys was to gather information about attitudes towards nutrition and also determine perceived barriers to care. For the clients, the indicator used to judge barriers was immunization rate. The clients were asked if their children were up to date with their immunizations. If not, they were asked to give a reason why with forced choice answers. Nutritionists were asked to comment on the reasons why the immunization rate at 24 months for the population they serve was so low. The number quoted on the nutritionist survey was 56%, an alarmingly low number in any context. The number was a part of the experiment, as it is totally inaccurate. The actual number is 88%, and the rate is on the increase due to special programs. By state law, Lincoln “is responsible for the immunization of every child who comes to the center…this also applies to every child in the WIC Program who comes to LCHC because LCHC is the WIC agency for the County.” The goal was to see how they would react to this very low and off-base number, and if it was accepted, who would be blamed?

**Results**

The majority of participants enrolled in the WIC program are children 1-5. 53% of respondents said that they had a child between those ages on WIC. The next largest group was infants under one year old. They made up 25%, with breastfeeding and postpartum women making up a combined 21%. 52.4% of the English speakers said they
had one child with 31% having two or three and 16.6% with four or more. For Spanish
speakers the numbers were similar, with 27.7% having one child, 61% with two and 31%
with three or more children. Age distribution was again similar for both language groups
with one exception. For the Latino patients, children’s ages were clustered at the lower
end with respondents saying they had children over 13. 42.6% of English respondents
and 57.1% of Spanish respondents had children under two years old. 37.3 and 42.5% of
English and Spanish respondents had children between three and eight. 20% of English
respondents had children eight or older.

Only two respondents from each language group said they did not have their
children up to date with immunizations. Reasons given were: cannot get appointment or
missed appointment, or do not know when children need them. Spanish speakers more
often selected that they did not know when their children needed immunizing and that
they could not pay. This means that they are unaware of the immunization programs, and
that they are free. Mailed reminders might be helpful to combat this problem. A large
majority of both English (71%) and Spanish (62%) speakers said that they would be more
likely to have their children up to date with their shots if it were part of WIC.

There were differences between the language groups in terms of barriers to
nutrition education. Two-thirds of Spanish speakers said they would have an easier time
getting nutrition education appointments if they had transportation. 61% of English
speakers felt it would be easier if the WIC office was open after their work hours.

There were some issues with non-responses for Spanish speakers on the last three
questions. This makes the sample size smaller and the data less reliable. For English
speakers, there was no problem with responsiveness. Respondents were allowed to pick
as many answers as they would like for two of the last three questions. One of the questions, asking what way the client best likes to learn about nutrition, was a single response question. Yet, clients selected multiple answers, so that must be taken into consideration.

When asked what they would like to know more about, 23% of responses were for losing weight. 16% were for good snacks, with 14.4% for how to use available health services and programs. The next three choices with 12.7, 11.9 and 10.2% respectively were: how to save money on food bills, nutrition for healthy teeth, and what foods are best for my family. These should be areas to focus on with pamphlets and dialogue. For those Spanish speakers that did respond to this question, there was no clear majority response. The responses were very evenly spread with all choices within a few percentage points of each other and every choice represented except how to prepare formula for infants.

Both groups felt that speaking to a nutritionist was a good way to learn about nutrition. For English speakers, reading a pamphlet was also very good, while Spanish speakers chose going to a class as the next best choice. Each group also felt that nutrition education would be better if they had more time with the nutritionist. Yet, again, more pamphlets was very highly rated for English speakers. They chose that more than having more time with nutritionists.

There were several discrepancies between nutritionists’ beliefs and clients self-reported feelings. There is a disclaimer to these results. While the nutritionist survey had answer choices that were both institutionally and individually based, the client survey only had
the institutional part. There were no answer choices that allowed the client to place blame on themselves for any shortcomings with the program or dissatisfaction.

The clients all reported that they felt nutrition was very important while nutritionists said the clients though nutrition was only somewhat important. Also, only one nutritionist thought they could do a better job with clients if they had more time with them. Three felt that they needed more pamphlets, with one specifying Spanish pamphlets. The common response was, and it occurred on two-thirds of the surveys, if clients were more interested in nutrition education. The language barrier was mentioned frequently as a problem in dealing with and educating patients. Most nutritionists felt that WIC needed more money, more translators and changes to the rules and regulations.

**Discussion**

Nationally, there are currently initiatives linking WIC and immunizations. They have proven very effective, increasing rates from 56% to 89% in Chicago, and preventing another measles outbreak in New York City.\(^\text{vi}\) “The CDC and USDA recommend that WIC and vaccination programs: integrate service delivery, consider incentives for the complete vaccination of children, conduct outreach and tracking of undervaccinated children, and employ automated assessment modules and area-wide vaccination data registries.”\(^\text{vii}\) This may not be necessary, given the current fairly high immunization rate. But, there is a problem with communication within LCHC about immunization initiatives. If the center is responsible for immunizing every child enrolled in WIC, then nutritionists should be involved, or at the very least aware of the initiative. 1) Nobody recognized the rate as a false. Nutritionists readily accepted the alarmingly low rate,
meaning they felt it was possible. 2) The possible choices for reasons why the rate was so low were either institutional (i.e. cannot get appointment, long waits) or individual (i.e. parents’ faults). The majority of nutritionist blamed the parents. This belief limits the ability to improve the immunization level.

Though there was no quantitative data collected on client satisfaction, the researcher’s interaction with clients provided qualitative information. The most commonly heard complaints regarded long waits, clients who arrived too late for certification, or did not bring the required paperwork with them and thus could not be processed. The sheer number of clients who were turned away for either not having proper ID for themselves or their child or who did not have a valid statement of income, was staggering. The situation was frustrating for both staff and clients. A better effort must be made to inform and remind clients of the requirements. In the long run it will save time and energy. It upsets nutritionists to get ready and prepare for a particular client and then have to send them away. It costs time and contributes to unnecessarily long waits. The long waits are not only a problem identified by this research, but other research as well. A Wisconsin study (Shefer, et al., 1998) found many of the same issues as this research did. Complaints ranged from long waits, appointments getting off schedule [there are no appointments at LCHC, only walk-ins], transportation problems.

Through the course of this research, it also seemed that clients saw the program as a way for low-income women to get milk for their children and not necessarily nutritional. While clients did rate nutrition as important, it was not clear they connected with the WIC program. They did not seem to understand the true purpose of the program. A 1994 study (Hamilton, et al.) of Ohio WIC participants (Appendix C) found
that “families who participate in WIC do not seem to realize that their children receive WIC because they are some nutritional risk.”

The study suggests as this research does, that the criteria for enrollment, beyond income, be properly explained to clients. “In the future, focusing on nutritional risk may be important, politically, to maintain WIC as a nutrition program rather than an entitlement program, and professionally to ensure that dieticians are recognized as the most appropriate health professionals to perform WIC certifications.”

In general, the nutritionists felt they had a large impact on their clients’ lives and that they made a difference. One respondent who felt they made a moderate difference said, “mostly on the mothers receiving formula and I think it is more of a financial impact than anything.” These nutritionists do a very tough job, with not always the most compliant clientele. They should be commended. They also make some very important policy recommendations. One suggestion was that the process for giving milk to mothers be standardized. Meaning that breastfeeding mothers and bottle feeding mothers should get a predetermined amount of milk. Currently, there is variation. Another suggestion was that there should be appointments for all clients and a walk-in clinic for new and transferring clients only. They felt this would make things more orderly. Lastly, there was a call for a more streamlined pick-up procedure. There should be an official list of names and a valid number procedure. She said some people “wait, cannot hear the clerk’s calls and wait not knowing what is happening.”

Overall, the program well. There is a wonderful program to increase breastfeeding among the clients. It encourages them by explaining it is healthier and
saves money. Yet, there are some areas that could be improved to increase efficiency.

Listed below are policy recommendations based on this preliminary research.

**Policy Recommendations**

1. Many of the problems mentioned stem from a lack of resources. Funding is limited and is federal, making this a difficult problem to tackle. With increased funding though, several key changes could be made. Hire more nutritionists, with a focus on getting bilingual people. Hire a specialist to take care of paperwork to allow nutritionists to focus on seeing clients.

2. Use the nutritionists’ own suggestions. They know the program better than anyone does else does. The suggestions outlined above are excellent.

3. Increase communication between clients and staff. Explain what nutritional risk is. Also increase communication between staff members and other areas of LCHC.

4. Explain to parents what proper portion sizes are and stress the importance of avoiding excess sweets, sodas, and fats. The growing population of low-income obese children in North Carolina means WIC is failing in this area.

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<th>% Of Low-income children overweight</th>
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5. Distribute more materials to parents about nutrition. Give them out during certification instead of leaving them out on the desk to be picked up. They may have more impact this way. According to the client survey, they find them helpful and want more.

6. Integrate WIC more into the public health network. Do not neglect the program’s tri-fold purpose, one of which is to be a referral agency for other services. Especially strong should be ties to other clinics within LCHC: OB/Baby Love and Pediatrics.

7. More nutrition education beyond going through clients’ dietary intake and explaining missed food groups and the food pyramid. Clients need to understand how nutrition and health are related, that does not seem to be the case right now.\textsuperscript{xi}

\textsuperscript{1} Besharov, D., & Germanis, P., Is WIC as good as they say? The Public Interest, Winter 1999; 34:21.
\textsuperscript{2} Besharov, D., & Germanis, P., Is WIC as they say? The Public Interest, Winter 1999; 34:21.
\textsuperscript{iii} Durham Data Book 2000
\textsuperscript{iv} Kahler, et al., Factors associated with rates of participation in WIC by eligible pregnant women. Public Health Reports, Jan-Feb 1992; 107:60-6.
\textsuperscript{v} Project Report Narratives, Lincoln Community Health Center Project # 5H27-CS01739-32.
\textsuperscript{vi} DeNoon, DJ., CDC working to link welfare to vaccination of children. AIDS Weekly Plus, 4/22/1996: 19.
\textsuperscript{vii} Hamlinet, et al., Nutrition attitudes, practices, and views of selected Ohio WIC participants. Journal of the American Dietetic Association, August 1994; 94(8):899
\textsuperscript{viii} Hamilton, et al., , 1994.
\textsuperscript{i} North Carolina Child Health Report Card, 2000.

\textsuperscript{x} Author is Erica Warner, a student at Duke University. Please email any comments to etw2@duke.edu.
1. Quién en su familia está en el programa WIC?
   ____ Mujer dando el pecho  ____ Mujer con niño recién nacido
   __ Niño (de 1 a 5 años)  ____ Bebé (menor del un año)

2. Cuántos niños tiene? (Si cero, pase a la pregunta 7)
   ____ 0  ____ 2  ____ 4
   ____ 1  ____ 3  ____ 5+

3. Qué edad tiene(n)? (Marque la(s) que correspondan)
   Menos de un año 3-4 años 8-13
   1-2 años 5-8 años 13+

4. Todos tienen sus inmunizaciones al día?
   Yes  No

5. Si no, por qué?
   ____ No puedo conseguir una cita
   ____ No se cuando los niños necesitan vacunas
   ____ No pienso que sean necesarias
   ____ Creo que las vacunas son peligrosas
   ____ No las puedo pagar
   ____ Otro ______________________________

6. Si las inmunizaciones fueran parte de WIC le sería posible a usted mantener a sus hijos al día con las vacunas? (Marque la respuesta)
   De acuerdo  Casi de acuerdo  No estoy segura
   No estoy totalmente en desacuerdo  Estoy in desacuerdo

7. Siento que aprender sobre nutrición es: ________________ (Marque la respuesta apropiada)
   No es importante  De alguna importancia  Muy importante
8. Sería más fácil para mi hacer citas para recibir educación en nutrición si: (Marque la respuesta apropiada)

___ Tuviera transporte

___ Tuviera que cuide a mi niño

___ La oficina de WIC estuviera abierta después de mis horas de trabajo

___ Otro ________________________________

9. Me gustaría saber más acerca de ____________ (Marque la respuesta apropiada)

___ Cómo usar las comidas de WIC ___ Amamantar (Dar el pecho)

___ Cómo ahorrar dinero al comprar alimentos ___ Buenos boacados

___ Cómo usar los servicios y programas del salud ___ Alimentando a mi bebé

___ Cuáles comidas son mejor para mi familia ___ Perdiendo peso

Nutrición para tener clientes saludables

___ Comidas para mujeres embarazadas ___ Como preparar formula para infantes

___ Cómo se relaciona la nutrición a la salud

___ Otro sugerencia ________________________________

10. La mejor manera y las más divertida para recibir información sobre nutrición es:

___ Hablando con la nutricionista ___ Ir a clases

___ Hablando con el doctor ___ Viendo una película

___ Hablando con la enfermera ___ Leyendo un pamfleto

___ Otro ________________________________

11. Yo creo que la educación en nutrición sería mejor si:

___ Hubiera más clases

___ Hubiera más tiempos con la nutricionista

___ Las clases fueran por la noche

___ Hubieran más películas sobre nutrición

___ Las sesiones de orientación fueran más cortas

___ Hubiera más pamfletos

___ Otro ________________________________
WIC Survey

1. Who in your family is on the WIC program? (mark box for answer below)
   
   ____ Breast feeding woman  ____ Child (1 to 5 years old)
   ____ Postpartum Woman  ____ Baby (less than 1 year)

2. How many children do you have? (If zero, skip to question 7)
   
   ___ 0  ___ 2  ___ 4
   ___ 1  ___ 3  ___ 5+

3. What is/are their ages? (circle all that apply)
   
   Less than one year  3-4 years  8-13
   1-2 years  5-8 years  13+

4. Are they all up to date with their immunizations?
   
   Yes  No

5. If no, why?
   
   ____ Cannot get an appointment
   ____ Do not know when children need immunizations
   ____ Do not think they are necessary
   ____ Believe immunizations are dangerous
   ____ Cannot afford them
   ____ Other ________________________________

6. If immunizations were a part of WIC would you be more likely to have your children up to date? (circle response)
   
   Agree  Mostly agree  Not Sure
   Mostly Disagree  Disagree

7. I feel that learning about nutrition is:  （circle response from below）
   
   not important  somewhat important  very important
8. It would be easier for me to get appointments for nutrition education if: (check all that apply)
   ___ I had transportation
   ___ I had someone to take care of my child
   ___ The WIC office was open after my work hours
   ___ Other

9. I would like to know more about ________________ (check all that apply)
   ___ How to use WIC foods
   ___ How to prepare infant formula
   ___ How to save money on food bills
   ___ Feeding my baby
   ___ What foods are best for my family
   ___ Good Snacks
   ___ How nutrition relates to health
   ___ Losing weight
   ___ How to use available health services and programs
   ___ Breastfeeding
   ___ Nutrition for healthy teeth
   ___ Foods needed for pregnant women
   ___ Other suggestions

10. The easiest and most enjoyable way for me to get information about nutrition is through
    ___ Talking with a nutritionist
    ___ Going to a class
    ___ Talking with the doctor
    ___ Seeing a Movie
    ___ Talking with the nurse
    ___ Reading a pamphlet
    ___ Other

11. I think nutrition education would be better if:
    ___ There were more classes
    ___ There was more time with the nutritionist
    ___ Classes were at night
    ___ More movies about nutrition were shown
    ___ Counseling sessions were shorter
    ___ More pamphlets were available
    ___ Other
Nutritionist Survey

Please complete this form at your convenience, I will be back to pick them up on April 27. Do not put your name on them. Thank you very much for your time, Erica Warner.

1). I believe healthcare is a:
   Right                         Privilege

2). What percentage of the nutritionally at risk population do you feel your office serves? (Write in a number between 0 and 100).

3). Immunization rates at 24 months for Durham stand at 56%, the equivalent of some developing nations, why do you think this is so?
   a). Parents do not know when their children need them
   b). They feel they cannot afford them
   c). They believe they are dangerous
   d). They cannot get appointments or there are long waits
   e). Lack of available services or parents just do not know about programs
   f). Other

4). How important do you think your clients feel nutrition is?
   Very important    Important    Somewhat important    Not important

5). How strong a relationship do you feel there is between nutrition and health?
   Very strong        Strong        Somewhat strong      Not strong

6). Utilization of WIC services could be increased if: (Select all that apply)
   a). A better effort was made to inform the public about the program
   b). The rules for acceptance into the program were altered (i.e. Required ID, etc)
   c). Our office had extended hours for certifications
   d). We had better transportation assistance services
   e). Utilization does not need to be increased we are reaching the target population
   f). Other

7). The WIC program at Lincoln Community Health Center would be improved by:
   (Select all that apply)
   a) Increased funding
   b) More nutritionists
   c) More translators
   d) Changes to the rules and regulations
   e) No improvements necessary
   f) Other
8). I could do a better job with clients if: (Select all that apply)
   a) I had more time with them
   b) They were more interested in nutrition education
   c) Services were better integrated; I could help them with the other factors of life that influence nutrition.
   d) We removed the language barrier (I spoke their language or we had more translators)
   e) We had more pamphlets to distribute

9). The biggest obstacle facing the population I serve is:
   a) Getting adequate health care
   b) Poverty, lack of resources
   c) Lack of education
   d) Bureaucracy of public health system
   e) Level of public health service integration
   f) Other

10). How large an impact do you feel the WIC program has on clients’ lives?
    Very large    Large    Moderate    Not much

11). The best way for people to learn about nutrition is:
    Talking with a nutritionist    Talking with a doctor
    Talking with a Nurse    Seeing a Movie    Reading a pamphlet

12)*****Free Response*****
Please assess the quality of the WIC program and your role within it. Do you feel you make a difference in your clients’ lives? Are you satisfied with the program as it is? What changes do you feel are necessary, if any? What do you find most frustrating about your job? What keeps you motivated?
Journal of the American Dietetic Association, August 1994 v94 n8 p899(3)

Nutrition attitudes, practices, and views of selected Ohio WIC participants. (Special Supplemental Food Program for Women, Infants, and Children) Corey Young Hamilton; M. Roxia Schiller; Linda Bone.

Abstract: A three-part survey was used to study the attitudes and practices of participants in the Special Supplemental Food Program for Women, Infants, and Children (WIC). The survey was conducted to determine nutrition attitudes and practices in relation to WIC nutrition education. There were responses from 338 families and the average respondent was a white woman aged 21 to 30 years. It was discovered that the WIC participants had positive nutrition attitudes and practices.

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The Special Supplemental Food Program for Women, Infants, and Children (WIC) began in 1973. Nutrition education became mandatory in 1975, and now lies greater than 16% of the total WIC budget goes to this service. Each 6-month eligibility-certification period must include at least two nutrition education sessions (1).

Evaluation studies show that WIC is a beneficial program (1,2) that has a positive impact on infant health (3) and pregnancy outcome (4-5), reduces medical costs for newborns (10,11), and increases food intakes of families (12) and preschoolers (13). Despite these positive outcomes, increased dietary intakes occur only during program participation (14,15). Initiatives are needed to help sustain good nutrition practices established during WIC participation. We undertook a study to ascertain nutrition-related attitudes and practices as they relate to WIC nutrition education.

METHODS

A three-part survey instrument was designed, pilot-tested for clarity, and field-tested to establish content validity. The first part sought demographic data. The second part sought information about WIC participants' nutrition attitudes and views of WIC; a four-point Likert scale was used to represent answers ranging from strongly agree to strongly disagree. The third portion of the questionnaire related to nutrition practices. Here also a four-point scale was used; answers ranged from never to always. A neutral response was excluded to simplify the instrument.

Permission to conduct the study was secured from the bureau chief of the Ohio WIC program and from The Ohio State University Human Subjects Review Committee.

Five WIC sites were selected for data collection. Sites varied in size (large, medium, TABULAR DATA OMITTED TABULAR DATA OMITTED and small) and method of food procurement (home delivery and food vouchers). Data were collected over a 12-week period from mid-April to mid-July 1992. The investigator (C.Y.H.) initially visited each site to train staff members on subject selection and data collection procedures.

Families who had one or more children aged 1 through 4 years and were receiving WIC services were eligible to participate. If a pregnant woman or her infant was receiving WIC services, the family was excluded from the study. All eligible families who came for WIC recertification during the designated period were asked to participate in the study. Signed consent was obtained from each respondent. An identification number was used to ensure anonymity and prevent obtaining multiple surveys from the same family.

RESULTS

Usable surveys were obtained from 338 families. The typical respondent was a white woman (67.9%) man (96.4%), aged 21 to 30 years (59.3%), with one child receiving WIC services (74.5%). Most respondents had completed high school (77.6%); 42.9% were employed and 78% received other government aid. Most were from single-parent households (45.5%) and had been participating in WIC less than 2 years (45%).

Table 1

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I thought my child would have trouble eating or gaining weight if I didn't participate in WIC</td>
<td>60.3</td>
<td>46.8</td>
<td>1.8</td>
<td>0.9</td>
<td>1.53</td>
<td>0.55</td>
</tr>
<tr>
<td>2. I had some number of family members eligible for WIC (N = 329)</td>
<td>34.6</td>
<td>64.5</td>
<td>16.3</td>
<td>0.3</td>
<td>1.77</td>
<td>0.65</td>
</tr>
<tr>
<td>3. I talk to WIC workers about feeding my kids (N = 334)</td>
<td>25.7</td>
<td>66.1</td>
<td>8.1</td>
<td>1.5</td>
<td>1.88</td>
<td>0.61</td>
</tr>
<tr>
<td>4. I didn't get WIC foods because I had some family at the store (N = 329)</td>
<td>26.1</td>
<td>59.3</td>
<td>13.4</td>
<td>1.2</td>
<td>1.96</td>
<td>0.65</td>
</tr>
<tr>
<td>5. I think the people at WIC (1) helped keep getting counseling (N = 333)</td>
<td>16.8</td>
<td>65.5</td>
<td>15.6</td>
<td>3.1</td>
<td>2.05</td>
<td>0.68</td>
</tr>
<tr>
<td>6. I went to WIC classes to learn more about nutrition (N = 317)</td>
<td>18.9</td>
<td>58.6</td>
<td>21.5</td>
<td>3.8</td>
<td>2.10</td>
<td>0.74</td>
</tr>
<tr>
<td>7. My kids get WIC because they are at nutritional risk (N = 336)</td>
<td>8.5</td>
<td>42.1</td>
<td>42.7</td>
<td>6.7</td>
<td>2.46</td>
<td>0.75</td>
</tr>
<tr>
<td>8. I had a choice between getting WIC or getting more food stamps every month (N = 336)</td>
<td>3.6</td>
<td>20.1</td>
<td>55.5</td>
<td>20.5</td>
<td>2.03</td>
<td>0.71</td>
</tr>
<tr>
<td>9. I learned about nutrition while attending WIC (N = 329)</td>
<td>7.9</td>
<td>48.5</td>
<td>36.7</td>
<td>4.9</td>
<td>2.41</td>
<td>0.71</td>
</tr>
<tr>
<td>10. Kids should be expected to eat their vegetables because they are good for them (N = 328)</td>
<td>21.6</td>
<td>54.9</td>
<td>30.6</td>
<td>3.6</td>
<td>2.28</td>
<td>0.80</td>
</tr>
<tr>
<td>11. Kids should not eat eggs because they are too high in cholesterol (N = 326)</td>
<td>2.7</td>
<td>9.8</td>
<td>12.2</td>
<td>13.5</td>
<td>2.96</td>
<td>0.60</td>
</tr>
<tr>
<td>12. I don't care how much my kids eat (N = 332)</td>
<td>1.5</td>
<td>3.9</td>
<td>56.9</td>
<td>40.7</td>
<td>3.04</td>
<td>0.65</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Never</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I make my kids eat all the food stamps they bring home (N = 333)</td>
<td>28.1</td>
<td>24.8</td>
<td>21.1</td>
<td>15.4</td>
<td>2.46</td>
<td>0.66</td>
</tr>
<tr>
<td>2. I make my kids eat everything or their plate at night (N = 329)</td>
<td>13.5</td>
<td>26.1</td>
<td>38.6</td>
<td>22.6</td>
<td>2.73</td>
<td>0.99</td>
</tr>
<tr>
<td>3. I make my kids eat food that is good for them even if they don't like it (N = 336)</td>
<td>13.5</td>
<td>26.1</td>
<td>38.6</td>
<td>22.6</td>
<td>2.73</td>
<td>0.99</td>
</tr>
<tr>
<td>4. I give my kids something to eat even if they don't feel like it (N = 335)</td>
<td>28.6</td>
<td>55.5</td>
<td>20.5</td>
<td>3.6</td>
<td>2.03</td>
<td>0.71</td>
</tr>
<tr>
<td>5. My kids have more food variety than other kids (N = 333)</td>
<td>4.8</td>
<td>13.9</td>
<td>80.3</td>
<td>21.5</td>
<td>3.96</td>
<td>0.50</td>
</tr>
<tr>
<td>6. I go to WIC classes (N = 336)</td>
<td>9.6</td>
<td>14.1</td>
<td>27.1</td>
<td>46.6</td>
<td>2.13</td>
<td>0.95</td>
</tr>
<tr>
<td>7. Kids don't like what I'm having because I'm having something different (N = 336)</td>
<td>13.8</td>
<td>12.4</td>
<td>39.7</td>
<td>40.7</td>
<td>3.24</td>
<td>0.80</td>
</tr>
<tr>
<td>8. I make my kids food or candy as a bribe to get them to do what I want (N = 324)</td>
<td>0.6</td>
<td>12.7</td>
<td>27.2</td>
<td>71.0</td>
<td>3.69</td>
<td>0.50</td>
</tr>
</tbody>
</table>
Table 1 shows representative self-reported views of WIC participants. A majority of respondents said they participated in WIC to learn about feeding their children and would seek the dietitian's advice if their child had eating or growing problems. Most would prefer WIC food vouchers to an increased monthly food stamp allowance and would ask WIC personnel if they needed assistance obtaining health care.

WIC was the only source of nutrition information for more than a third of respondents. Data reflected acceptance of concepts usually taught during nutrition counseling. For example, most respondents avoided using vitamin supplements to replace food, using food to bribe or reward their children, and allowing their children to eat while watching television. Respondents who had been receiving WIC services longer were more likely to eat meals with their children (P is less than .05), eat three meals a day (P is less than .05), and make their children sit at the table until the end of a meal (P is less than .05). Those who had been participating in WIC 4 years or more were more likely to attend WIC classes than shorter-term recipients (P is less than .05).

Two-parent families had a more positive view of WIC (P is less than .001) and were more likely to attend WIC classes (P is less than .002). Extended families cared least to learn more about nutrition (P is less than .001) and were more likely to plan ahead for meals (P is less than .05).

DISCUSSION

Results of this study indicated positive perceptions of WIC and favorable nutrition attitudes and practices among WIC participants. Most participants understood WIC to be more than “free food.” They considered WIC to be a source of nutrition information and a path to other health care services. For most, the nutrition education component of WIC is valuable because it helps improve health care use, health-related practices, and health knowledge (5).

Families who participate in WIC do not seem to realize that their children receive WIC services because they are at some nutritional risk. Perhaps WIC personnel need to do a better job of explaining to participants potential health problems and the reasons they qualify to receive WIC services. In the future, focusing on nutritional risk may be important, politically, to maintain WIC as a nutrition program rather than an entitlement program, and professionally, to ensure that dietitians are recognized as the most appropriate health professionals to perform WIC certifications.

Participants in this study were interested in learning more about nutrition. This finding may reflect the program's commitment to offer both individual and group nutrition counseling. Our data suggest that over time WIC recipients are making behavioral changes in line with sound nutrition attitudes and practices advocated by WIC dietitians.

Surprisingly, employed parents were more likely to attend WIC classes than unemployed parents. Motivational techniques and scheduling class times for the convenience of those who work are important considerations when planning educational programs.

APPLICATIONS

Because this study was limited to a small group of participants in Ohio, results may not be generalizable to other situations. Nevertheless, the findings raise specific issues of concern to WIC dietitians. A majority of participants in the study reported that they did not attend WIC nutrition classes. Yet, many, especially those who had participated in WIC for longer periods, expressed a desire to learn more about nutrition. WIC was the only source of nutrition information for some participants. Dietitians may wish to examine the value of revising their schedules, class content, and teaching methods to better accommodate the needs of this group.

Dietitians should point out the potential for nutritional risk among children participating in WIC. They should continue to work closely with families using WIC services to emphasize the relationship between optimal health and good nutrition and to promote healthful eating habits among all family members.

References


http://web2.infras.egalegroup.com/cookieinfo/88597155059907e3/purwvc1_EIM_0_A15714468&dyan=Var_from_tse&ypb=vsap&dase_perkins


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