Welfare Reform and Women's Health

Opportunities to Advance the Public Response to the Health Needs of Women on Welfare through Collaboration

U.S. Department of Health and Human Services
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Introduction

In August 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193; PROWRA) was signed into law ending a 60-year federal entitlement guaranteeing families a basic level of assistance during periods of economic hardship. Evaluations and policy studies examining the impact of welfare reform, as implemented through the Temporary Assistance for Needy Families (TANF) Program, thus far have focused almost exclusively on economic and child health outcomes.[1-6] The impact of welfare reform on women's health, a potentially important factor in achieving full economic self-sufficiency, has been a minor consideration in research studies with the exception of access to health insurance.[7-13] Several aspects of the PROWRA have the potential to impact the health and well-being of women. These issues highlight areas of need and opportunity for state MCH Programs, offices on women's health, and welfare agencies to initiative new and/or strengthen current efforts on behalf of women and their families.

As a component of its work with the federal Maternal and Child Health Bureau to assist states in this regard, the Women's and Children's Health Policy Center (WCHPC) at the Johns Hopkins University School of Public Health undertook two related activities beginning in 1997. The first activity involved an extensive literature review examining the relationship between welfare, employment and health status (physical and mental), domestic violence, and access to health insurance. The findings from the literature review (*Journal of Public Health Policy*, Winter 1999) form the basis of a policy framework for monitoring the impact of welfare reform on women's health and well-being.[14] These findings also provided the basis for articulating a set of strategies that states might pursue relative to protecting women's health interests under welfare reform. The second component of the WCHPC's work in this regard involved interviews with state and regional women's health and welfare officials. In these discussions, which took place between April 1999 and June 2000, the WCHPC sought to better understand selected aspects of activities in states concerning the health impacts of welfare reform for women.

This brief summarizes key results of the *state interviews* and highlights potential venues through which state program directors and policymakers concerned with women's health and well-being might collaborate to advance public response to their needs.

Issues Noted in the Literature

Evidence from the literature review suggests that welfare reform can affect women's health in several ways. On the positive side, employment is associated with better psychological health, although these effects are not uniform for all types of employment. Low-wage, low-control jobs with little opportunity for personal input and self-development are associated with poor mental health outcomes (e.g., higher levels of depression, stress, and lower self-esteem.) Other findings show that domestic violence, poor health (chronic conditions, mental health conditions) and need for health insurance are significant barriers to leaving welfare and maintaining stable employment.

In addition, examination of the provisions of PROWRA reveal that certain groups of women are particularly vulnerable. For example, poor immigrant women, particularly those who entered the United States after August 1996 are no longer eligible for most Medicaid services. Moreover, efforts to implement the focus on abstinence-only education provisions suggest the need to be vigilant about also ensuring that appropriate public health STD prevention measures are applied in order to avoid increases in adolescent disease rates. States therefore need to devise strategies to otherwise ensure access to health care for these women, regardless of pregnancy status, in order to protect both individual and population health.

Changes in welfare instituted by PROWRA require poor women to enter the workforce. Findings from the literature review suggest these jobs are low-wage positions with few or no health benefits. In addition, many beneficiaries of the TANF program are offered few opportunities for training or educational advancement and, thus, it is unclear whether over the long-term these women will be able to work themselves and their families out of poverty. The most recent

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findings from the Urban Institute indicate that while women who have left welfare since PROWRA was enacted are marginally better off in terms of earnings compared to their working poor counterparts, they have not made substantive economic progress. One-third continue to experience difficulty providing sufficient food and shelter for their families.[23]

Because welfare reform has the potential to affect women's health, monitoring and tracking the health and well-being of adult female TANF clients can provide important information about the links between welfare reform and women's health. The WCHPC therefore conducted a series of brief telephone interviews with regional and state level women's health and TANF officials to examine more fully the status of relevant monitoring activities.[†] The goals of these interviews were to:
1) assess current activities underway in the states designed to monitor the health and well-being of female TANF clients (current and former); 2) assess the interest among state officials in monitoring the health and well-being of female TANF clients (current and former) or improving current monitoring efforts; 3) assess levels of collaboration and information sharing between women's health and TANF officials; and 4) raise awareness about the implications of welfare reform on women's health and well-being among state public health and human service program leaders and other policymakers.

About the Interviews

A total of 78 individuals were interviewed by telephone from April, 1999 to June, 2000. Participation was arranged through an introductory letter followed up by two to three phone calls, and in some cases a final faxed letter. Typically only one person was interviewed but in some cases additional colleagues identified by the primary contact were included in the discussions. The final group of respondents included nine (of 10) regional women's health coordinators, 36 state women's health coordinators, 7 (of 10) regional TANF representa-tives, and 26 state TANF program managers. In total, 44 states, including the District of Columbia, were represented. The WCHPC was unable to obtain information for Massachusetts, Missouri, Okla-homa, Pennsylvania, South Dakota, Wisconsin, or Wyoming.

An interview guide was prepared for each of the four groups of informants. These were developed in a sequential and iterative manner such that the responses from one set of responses informed the nature of the next set of interviews. In addition, being aware beforehand that not all categories of informants would be equally knowledgeable about monitoring activities, interviews were tailored to reflect this variability.

The interview guide developed for the Regional Women's Health Coordinators was composed entirely of open ended questions that focused on three areas 1) their perceptions of how welfare reform was impacting poor women, adolescent women, immigrant women, and women facing domestic violence; 2) the types of monitoring activities taking place in their region; and 3) the women's health activities taking place in their region. Interviews with the Regional TANF Administrators focused almost exclusively on monitoring issues, specifically with respect to employment and wages, and various aspects of women's health. In addition, a scale was used to ascertain their ratings of state capacity within their region to implement a comprehensive monitoring system, and we inquired about their collaboration with women's health and maternal and child health officials at the state and federal levels.

Interviews with State Women's Health Contacts, in addition to having the goals outlined above, also sought to examine the extent of the informants' involvement, knowledge, and perceptions about welfare reform. In addition, these interviews included a series of open and closed-ended questions intended to solicit information on the level of involvement and interest in welfare reform issues both within their office and within their agency.

Information was sought also regarding monitoring of women's health insurance, health status and domestic violence. Finally, recommendations for heightening awareness of women's health monitoring were discussed. Interviews with State TANF contacts combined most of the elements of the state women's health and regional TANF instruments and added one additional item. For those states with county administered programs, we asked how this decentralization affected uniform

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[†] Because the term "health and well-being" encompasses an extraordinarily broad range of issues, we limited our analysis to monitoring activities related to: economic well-being (employment, wages); adolescent outcomes (education, employment and fertility); health insurance status, social support benefits (food stamps, child care and others); TANF diversionary program strategies; health barriers to work (chronic physical health problems and disabilities, mental health conditions, substance abuse); domestic violence, and family planning.

The term "monitoring" is defined to include any activity undertaken on a routine or periodic basis to collect and track information for the purposes of evaluation, program planning or program management. These included data gathering activities for routine reports as well as special studies, and short and long-term outcome evaluations. With respect to health barriers and domestic violence, monitoring activities also included screening and follow-up treatment protocols. We did not consider assessments that rely solely on self-disclosure to constitute monitoring.

Because other welfare-specific surveys with state Title V Maternal and Child Health Programs were otherwise underway,[8, 13] the WCHPC chose to explore the specified issues with women's health contacts identified by the Office on Women's Health within the Department of Health and Human Services (DHHS), as well as TANF program officials identified by the Administration for Children and Families (ACF). These included designated personnel in each of the 10 Regional Offices and for each state including the District of Columbia. State Women's Health Contacts are appointed by their public health commissioner and serve as a contact for the Office on Women's Health. Their role is loosely defined and they work generally to promote women's health issues within their state; they do this as part of or in addition to other duties of their position. Most of these individuals function within the maternal and child health or reproductive health units of their health departments, although a few are positioned within a chronic disease, primary care or a women's health office. Regional Women's Health Coordinators are staff of DHHS; their role is solely dedicated to assisting the states in their region to promote and address women's health issues. They also serve as liaisons between the states and the federal Office on Women's Health. The coordinators meet within their region and in Washington, D.C. on a periodic basis to share information, exchange ideas and promote initiatives addressing issues of concern to women's health.

The Administration for Children and Families (ACF) has a similar network of state and regional TANF contacts. The Regional TANF Administrators are primarily responsible for assisting the states in their region to comply with federal mandates and address implementation issues and concerns. The State TANF contacts serve solely as point of contact for the ACF; they do not as a group meet routinely with either the regional TANF contact or federal ACF staff. Typically they are the commissioner or director of the human services agency responsible for TANF within the state. Our first communication with the TANF agency in each state was through these contacts, and in most cases we were referred to other personnel (i.e., TANF program managers) within the agency appointed for the interview.

data collections. Interviews were intended to last no more than 45 minutes; in some cases they were much shorter depending on the informant's familiarity with the topics. State evaluations of welfare reform provided to the WCHPC by those surveyed and those posted on the web site of the Research Forum[‡] on the Children's, Families, and The New Federalism also were reviewed in order to provide additional background or contextual information.

Reported Challenges and Opportunities for Interagency Collaboration

Collaboration between women's health and TANF officials was believed to be an important area of consideration since the successful implementation of welfare reform involves creating a host of partnerships including labor, employment, education, and health, to name a few. Our interviews revealed overall unevenness based, at least in part we assume, in the differential degree of familiarity with welfare populations and programming among our total group of both women's health, and TANF interviewees.

Perhaps understandably, such knowledge was more limited on the part of public health agency representatives interviewed. For example, interviews revealed that approximately one-half of the State Women's Health Contacts did not have any information about whether or how health insurance status or health barriers of TANF program participants were monitored in their state. While nearly all the State Women's Health Contacts we interviewed had some knowledge of domestic violence issues, many were not aware of how domestic violence was addressed for TANF clients.

Our findings show that at the regional level interagency collaboration is fairly routine. However, a high degree of collaboration or partnering between public health and human services agencies responsible for TANF was not reflected in interviews with State Women's Health Contacts (mean reported collaboration = 2.8). The State Women's Health Contacts perceived interagency collaboration to be greater for their agency as a whole than for the specific office in which they were located. Again, this lower collaboration rating may be due to less familiarity with issues regarding welfare reform.

We probed the women's health informants to tell us why they rated as they did their level of office or agency involvement in welfare reform and interagency collaboration. A few themes emerged, although within a wide range of responses. Nearly one-third of the State Women's Health Contacts noted constraints in involvement in welfare reform because of staff shortages, time limitations, or the focus of their position did not include welfare reform (n=10). Overall, eight State Women's Health Contacts expressed an interest in becoming more informed or involved in welfare reform issues, particularly with

‡ Sponsored by the National Center for Children in Poverty at Columbia University, this web site reviews and lists all evaluations conducted at the state and federal levels to assess the impact of welfare reform. http://www.researchforum.org.

respect to monitoring the impact of welfare reform on women's health. A few (n=3), nonetheless, indicated barriers in this regard related to "agency turfism."

Among those women's health informants who believed interagency collaboration around welfare reform issues was good (a rating of 4 or 5), the most frequently cited reason was a positive environment of information exchange and sharing. Other reasons mentioned were statewide, multi-agency initiatives and proactive leadership among division and agency supervisors. These collaborations were most frequently related to welfare reform task forces, abstinence education for adolescents, and family planning programs for TANF clients. Cross-training of TANF case managers and eligibility workers and Medicaid access for TANF clients were other areas of collaboration. Although domestic violence is an area in which women's health contacts reported involvement, only two were actively coordinating with TANF staff on these issues.

Overall, the state TANF informants perceived a greater degree of interagency collaboration than the women's health informants (Mean rating of 4.1 *vs.* 2.8). Many noted that they generally worked with or communicated regularly with external programs and agencies, and they perceived it as an essential component of their work. The area with the highest degree of reported interagency collaboration was domestic violence, although most of this collaboration was with local domestic violence shelters and not through the public health agency or unit in their state. However, few TANF informants said that they or their staff work or communicate with women's health colleagues unless they needed to address abstinence policies, family planning, or Medicaid. A moderate level of involvement with other public health officials was reported, usually local health departments, on issues related to child health and other safety net services.

What States Reported About Monitoring Efforts

Economic Well-Being. Monitoring the economic well-being of clients is an issue of great concern to policymakers at the state and federal levels. Nearly all the states participating in the interviews reported that some system is in place to track the employment status and wages of current TANF recipients. This is likely because all states are required by PROWRA to report this information on a routine basis to the U.S. Department of Health and Human Services. The level of sophistication in tracking economic indicators, however, varies substantially from state to state. Eight of the states reported the capacity to routinely track the employment and wages of former clients through well integrated statewide labor data systems, through studies of former TANF clients (also known as "leavers studies"), or a combination of both. A few states also have data sharing agreements with states that border them to allow the tracking of clients who leave state. A number of states (n=11 in this study), however, do not have these types of information systems or arrangements, and rely primarily on leavers studies to periodically monitor economic indicators. Nine of the participating states reported undertaking extensive longitudinal studies (two or more years after leaving TANF) of former clients.

Much of the policy emanating from PROWRA focused on adolescents in the form of pregnancy prevention, abstinence education, and requirements to live in an adult supervised setting. In our sample, eight states undertook efforts to monitor the social and economic outcomes (educational attainment, employment and fertility) of adolescent parents receiving TANF. Where it exists, this monitoring is conducted either as part of the routine data collection and evaluation activities or through evaluations of special programs for parenting adolescents. Though most states report having the capacity to identify adolescents within their databases, they do not routinely report data separately for adolescents. Some of the TANF informants noted that the proportion of adolescent clients was too small to warrant additional reporting.

Other Public Benefit Use. Over two thirds of the states participating in the interviews monitored the receipt of other support services such as Food Stamps, child care subsidies, transportation subsidies, and other assistance to current and former welfare clients. As with other economic indicators, the sophistication of the monitoring activities reported varies widely. Some of the states reported having integrated databases for TANF, Food Stamps and other benefits as well as the ability to routinely assess receipt of these services. Others rely primarily on periodic surveys and evaluations to monitor publicly funded support services.

Health Insurance Status. Most TANF clients are eligible for Medicaid coverage while participating in the program, yet because most states have now delinked cash assistance from Medicaid, the risk of becoming uninsured due to administrative errors is greater than before. Thus, monitoring health insurance status among current and former clients is a key concern. Thirty three (33) of the states interviewed reported collecting some type of information on the health insurance status of their current and/or former clients; approximately 12 do so on a routine basis. The others use periodic

Table 1. State Reports About Monitoring Selected Aspects of Women's Health (N=44)

	Wages from Employ-ment	Adolescent Pregnancy	Insurance	Benefits	Disability	Substance Abuse	Mental Health	Domestic Violence	Family Planning
Yes	38	10	33	35	16	28	20	19	1
DK		2	10	8	27	14	21	21	5
No		14	1	1	1	1	3	4	19

surveys and evaluations to monitor health insurance status.

In addition to asking key informants about monitoring activities, some of the discussions also touched on activities states have undertaken to inform women about their eligibility for Medicaid and other benefits once they leave TANF. Twelve states reported having implemented public information campaigns, distributing brochures, and/or sending letters to former TANF clients. Four of the states participating in WCHPC interviews reported that automatic redetermination systems were in place to ensure that women would not be automatically dropped from the Medicaid program once they left TANF. Four other states reported problems enrolling former clients in Medicaid. In these cases, the state was either not able to make contact with the former clients, and/or Medicaid coverage was mistakenly terminated even though the former client was still eligible for transitional coverage.

Three of the states interviewed reported conducting a statewide women's health survey that gathers data on a range of health indicators including health insurance. Other states indicated that they rely on the Behavioral Risk Factor Survey to assess the health insurance status of their residents. Informants from one state reported that their state was implementing a statewide survey of insurance status. These types of surveys would provide statewide estimates of uninsurance for a number of vulnerable groups; few states, however, have the capacity to identify TANF recipients within their sample or to provide reliable estimates for this population.

Health Barriers to Work

Chronic Conditions and Physical Disabilities. Federal reporting requirements mandate that all states report the number of clients exempted from work activities due to a physical disability. Beyond this basic level of tracking, however, reported monitoring of physical health barriers is uniformly limited. Most of our informants indicated that they collected only the information needed to keep track of the number of exemptions. None of the states interviewed reported having an assessment protocol in place to screen for latent physical disabilities that might potentially affect the type and duration of work activity. Only two (2) states reported any special efforts to assist persons with disabilities to obtain work. A few (n=3), however, included physical disabilities in their outcome evaluations either as a descriptor or as one of a list of reasons for losing a job or returning to TANF.

Substance Use. According to our interviews, of all the health barriers, substance use receives the most attention. Over one-half of the states (n=28) reported the existence of some type of system to address substance abuse, although the types of monitoring activities varied widely. Ten of these states noted having either a formal screening tool or a specialist contracted to counsel and assist substance using clients. A few states told us they assessed substance abuse mainly through self-disclosure. Other sources, however, indicate that 42 states use this form of detection.[15] Approximately 10 states also reported having a system in place to monitor the receipt of treatment services although they did not necessarily have a formal assessment protocol. Where tracking of treatment does not occur, the respondents noted that confidentiality concerns prevented them from obtaining detailed information from substance abuse providers. In some states tracking of treatment occurs through TANF contracts that stipulate treatment as a condition of receiving cash assistance, or treatment is viewed as a work activity.

Mental Health Conditions. Twenty of the states in our sample reported that they monitored mental health conditions either through a screening tool or a contracted mental health professional. Only about half of these states reported the ability to monitor the receipt of services due to the confidentiality reasons previously mentioned. Our review of the state evaluations of TANF programs showed that only 2 states examined mental health outcomes (e.g., depression, stress etc.).

Domestic Violence. Nearly half of the 36 states for which we were able to obtain information on this topic reported monitoring domestic violence to some degree. However,

about half of these states rely primarily on interviews by intake workers and their competency to probe such sensitive issues was reported to vary widely. Only a handful of the states in our sample (n=7) use a formal screening tool or domestic violence counselor to conduct assessments. Few states reported monitoring whether the client has received necessary services (n=3). The State Women's Health Contacts pointed out as well that even though their states have screening protocols in place, TANF clients are not being counseled and linked to services. Nine (9) states reported having conducted special studies or otherwise examined in their evaluations domestic violence as a barrier to employment.

Family Planning. Although family planning has received a great deal of attention with respect to welfare reform via adolescent pregnancy prevention and bonuses provided to states for reducing out-of-wedlock birth rates, very little in the way of monitoring is reported. Only one state indicated routine assessment of the family planning needs of all female clients at intake, provision of counseling on site, and tracking of referrals. A small number of states indicated that they counsel clients about family planning services; however, these are reported to be relatively informal arrangements with no system in place to ensure the counseling is done. A small number of states reported using TANF block grant funds to purchase contraceptives for clients, while others reported using these funds to support abstinence education and shore up otherwise limited resources for other public family planning services.

Reported Interest in and Capacity for Monitoring Women's Health

In order to gain a greater appreciation for the status of welfare reform monitoring activities, the WCHPC sought to learn about states' interest and capacity for monitoring as perceived by the informants. We asked the state women's health and TANF informants to rate on a scale of one to five the level of interest within their state in long-term monitoring of: 1) economic welfare of current and former TANF clients; 2) poor women's access to health insurance; 3) domestic violence among TANF clients; 4) measures of poor women's physical and mental health; and 5) occupational health hazards among women working in the low-wage sector.

The State Women's Health Contacts rated all items lower than the TANF informants and were less sure of what the level of state interest was overall -- ranging in all areas between 3.2 and 3.6. Nearly a fifth did not know or did not feel comfortable giving a rating for economic welfare or domestic violence. The TANF program ratings of interest with respect to these five areas was notably higher -- ranging between 3.9 and 4.6. The TANF informants rated interest in economic welfare most highly, which could be expected given the focus on economic indicators in reporting requirements and evaluation studies. Similarly, the TANF contacts assigned their lowest rating to physical and mental health. Their ratings, however, reflected a higher level of interest than that of the women's health informants. It is unclear whether the higher ratings by the TANF informants conveys a higher level of interest, or perhaps primarily a greater awareness of the activities underway.

With respect to assessment of state capacity to implement a comprehensive monitoring system that included the items in the scales, ratings were notably lower than those given for interest -- again, an expected finding given that *interest* in monitoring does not necessarily correlate with *capacity* to monitor. TANF informants, however, did rate capacity higher than the women's health informants, which again may have to do with their different exposures to the issue, or to the relevance of data collection to the functions of their office.

Three barriers were cited repeatedly in response to questions about the most significant challenges to building an infrastructure for monitoring: 1) data integration; 2) data sharing; and 3) lack of interest. Many of the states reported grappling with how to link and interface data systems, particularly given few fiscal or human resources available to devote to such tasks. Several states indicated that they were in the midst of adapting to completely "new and improved" information systems and had encountered the need to invest heavily in worker retraining. Disruptions in the routine flow of reports and statistics needed for daily management of programs and contracts also were reported in a number of these instances.

Other informants believe their states have adequate information but that problems arise in the dissemination of that information. A number of informants expressed frustration with the many administrative obstacles they confronted in obtaining data about TANF clients in preparation for their interview. Better coordination and accessibility of existing data for them is the most important step towards building a better infrastructure either through a central data warehouse or a web-based access system. A common barrier cited was the lack of interest or leadership necessary to develop an integrated information system.

Another issue that is of particular concern in monitoring substance abuse, mental health and domestic violence is the need to protect the client's confidentiality. In this regard, a number of informants reported

difficulty establishing collaborative partnerships with mental health and substance abuse agencies, thus they have been unable to collectively address the issues of confidentiality and monitoring. Informants from states that have had some success in developing their information infrastructure were asked to tell us how their states had achieved those successes. Integrated eligibility data bases for Medicaid, Food Stamps, Child Care and other support services were repeatedly cited as a key aid in coordinating monitoring and tracking activities. A few states received external funding to integrate their information systems and a few were planning to use their TANF surplus to upgrade their information systems. One state used the mandated federal reporting requirements as political leverage to obtain additional state appropriations to upgrade their information systems.

Reported Challenges to and Opportunities for Monitoring Health Impacts of Welfare Reform on Women

Barriers to Monitoring. We asked the informants how the interest and capacity for women's health monitoring could be improved and a number of key barriers emerged: 1) limited awareness of the issues among political and/or administrative leaders; 2) limited political support for monitoring; and 3) limited attention to data coordination and distribution problems. At least a third of all of our interview participants felt that greater interest and political will among top administrators and legislators was needed to acquire the resources for a comprehensive monitoring of women's health indicators. Nonetheless, a few of the individuals with whom we spoke acknowledged that funding requests for monitoring might not be well-received because of political concerns about potentially uncovering problems and issues that might cost the state even more money. A mandate for better monitoring of women's health they believed could only occur if citizens and service providers in poor communities actively advocated for better data on the effects of welfare reform. Moreover, some of the women's health informants suggested that the prominence of women's health issues generally would have to be heightened among state administrators and political leaders before monitoring could be addressed within the context of welfare reform.

The TANF informants noted a number barriers to evaluating the impact of welfare; foremost among these was the difficulty in tracking clients after they left the TANF program either because they have moved or the clients simply wanted no further contact with the TANF staff. One TANF informant, however, indicated success in contacting former clients (over 90%) for their leavers study, due primarily to the persistence of their field staff.

Another issue cited by numerous informants was the problem of accessing client data. Because many services for TANF clients are subcontracted, collecting and integrating data from these providers can be difficult. Sharing data with mental health and substance abuse providers was especially difficult due to the confidentiality concerns noted previously. A number of the informants talked of moving to a web-based system that would allow providers and TANF staff to input and download client data in a more efficient and coordinated fashion.

Other barriers that were mentioned less often but which are probably concerns in other states are inadequate capacity to evaluate programs and an over-reliance on periodic studies. One informant pointed out the need for building and developing local capacity to conduct welfare reform evaluations. In that state, researchers were contracted from the local university instead of an external consulting group with expertise in welfare reform. The local researchers had little experience in conducting welfare reform studies so there was a requisite learning period that delayed the implementation of their study. This case shows that relying on resources within the state may not be the most timely means of carrying out evaluations in the short term. In the long run, however, the development of a cadre of local researchers with an intimate knowledge of the culture, politics, and policies of their state can be an enduring asset to TANF administrators.

A few of the TANF informants also admitted that they would like to see their state rely less exclusively on periodic, "one-shot" studies that quickly become outdated and forgotten. They hoped to develop a more institutionalized system of monitoring and tracking that would provide routine analysis and estimates of key indicators of well-being. Such a system, they told us, would allow them to track their progress over time and be a useful tool for managing and developing programs suited to the needs of the client.

A few TANF informants whose states had used external consultants raised concerns. One noted difficulties encountered with their evaluators in developing a feasible study design. The researchers, this person told us, insisted on a sample size for the control group that was entirely unreasonable given their small state population. A similar disregard for the limitations of the local environment, was voiced by another informant. These reports suggest that while external consultants may be well versed in statistical methodologies and study design overall, they may have difficulty adapting traditional research methods to practical circumstances.

An issue discussed by a TANF informant that pertains to states with

county administered programs was the issue of state versus local control for monitoring and evaluation activities. Data for TANF programs that were state administered were centrally coordinated and thus generally more uniform. Moreover, state administrators determined what and how data should be collected and distributed. For county administered programs, however, the locus of control for data collection was much more widely dispersed and state administrators might have little control over how monitoring was conducted. Developing a uniform monitoring system thus entailed significantly greater negotiation among many more players. In one county-administered state we surveyed, this issue had been successfully addressed and a uniform data collection system implemented. Another state, however, reported having to resort to legal action to prompt a number of their counties to comply with federal reporting requirements.

Factors Enabling Improved Monitoring. In addition to discussing the barriers to monitoring, we encouraged those we interviewed to tell us what types of policies, resources and other assistance would help improve the monitoring of women's health in their state. Their responses were varied, but TANF and women's health informants both emphasized the need for fiscal and human resources to upgrade and integrate information systems. One individual suggested that the federal government develop a national employment database to help track clients who move from state to state. Some of the informants indicated the need for agency staff assigned exclusively to evaluation and research functions and better indicators of performance with which to measure outcomes.

A less prominent but important finding that emerged from this portion of the interviews dealt with the role of the federal government. While a very small number of informants believed the federal reporting requirements to be cumbersome and unreasonable, there were a few informants who welcomed a stronger federal presence. In two states, the federal reporting mandates had been helpful not only in the identification of key indicators but in securing additional resources for system upgrades. In another state, a federal audit of the Medicaid program had provided the external pressure necessary to compel the state legislature to address inadequacies in the system. The informants from this state believed that a similar audit of the TANF program could be similarly instrumental. These responses indicate that despite the rhetoric of "local control," program administrators may feel powerless to address important but unpopular issues due to the constraints of their political environment. These cases suggest that a federal role either in the form of mandates, audits or technical assistance could be enormously helpful and constructive in these situations.

Summary and Implications

The monitoring of welfare reform and women's health has received little attention among policymakers and it presents numerous opportunities for communication and collaboration across disciplines and agencies. Our interviews with women's health and TANF informants indicated that economic welfare, other public benefit use, health insurance and substance abuse were the most closely monitored indicators of women's health and well-being. However, the breadth and scope of this monitoring was reported to vary substantially. Domestic violence and mental health conditions were less closely monitored but still received at least moderate levels of attention among those states for which we were able to obtain information. Physical disabilities and family planning were reported to be the least closely monitored. Almost none of the states we interviewed had a substantive system in place to monitor these health conditions or included them in their evaluations. Overall, our TANF informants believed their state would be interested in monitoring women's health and well-being. The State Women's Health Contacts rated state interest in monitoring more moderately. In general, our informants rated their state capacity for monitoring lower than their interest, although the state TANF informants gave higher ratings than the State Women's Health Contacts.

Our women's health informants were as a group less familiar with welfare reform issues and were less involved in activities that entailed interacting with TANF colleagues. Of those who did collaborate with TANF colleagues, most were involved in projects related to abstinence education, family planning services and/or cross-training of TANF case workers on these and other health programs. Domestic violence was reported to be a high priority issue for many of the women's informants but very few were working with TANF colleagues on this issue.

Our informants cited numerous barriers to monitoring women's health and foremost among these was the lack of interest among program administrators and legislators. Many of the informants indicated that generating greater political will would be an essential prerequisite to address another frequently mentioned barrier, inadequate information systems. Data issues featured prominently in our discussions with many of our informants including challenges to developing new information systems, retraining workers to new systems, and disseminating available

information in a timely and efficient manner.

A number of issues related to evaluation capacity also emerged from our interviews including the need for more resources devoted exclusively to such activity, the challenges of building up local capacity, and working with external evaluators to develop feasible study designs. Confidentiality was repeatedly mentioned as a concern among those we interviewed. Many noted this was a key issue in monitoring substance abuse, mental illness, and domestic violence. Thus, while at least half or more of the states for which we were able to obtain information routinely screened for these conditions, few states reported developing a system for ensuring women received needed services, or that these services were of a high quality.

Beyond the barriers identified, one interesting and noteworthy enabling factor emerged from our interviews. In a few of the states, a constructive federal presence had facilitated better monitoring either through helping to secure additional state appropriations for evaluations or helping evaluators to develop a set of core indicators for a new monitoring system.

The discussions with women's health and TANF informants highlighted a number of opportunities to improve the monitoring of the health and well-being of current and former participants in the TANF program. While the WCHPC interviews and this brief focus specifically on OWH and ACF professionals involved with women's health, our findings point also to the relevant and important roles that state Title V Maternal and Children Health programs can play in strategies to address concerns identified in this brief. State MCH programs can offer specific expertise related to a number of women's health issues that surfaced from the interviews, but especially in areas such as data and information on women's health and health status, strategies and tools for clinical screening of women regarding their risk status for health conditions relevant to welfare reform (e.g., substance abuse, contraceptive use), and referral and tracking of women who require specialized services and care.

In light of these findings, we hope that states will consider pursuing the following strategies to further ensure greater appreciation for and commitment to addressing the effects that welfare reform may have on the woman's total well-being.

1. Continue to build awareness of the broad spectrum of women's health concerns, and incorporate welfare reform as part of the women's health agenda.

The implications of welfare reform on women's health could be more readily understood if women's health professionals and advocates at both the state and regional levels were kept abreast of welfare reform policy. Similarly, systems enhance-ments might arise if welfare officials had a better understanding of women's health. Sponsoring joint educational conferences and policy forums might facilitate this awareness. Greater efforts also could be given to dissemination of relevant data reports and study findings.

2. Increase awareness of the need for better monitoring of women's health generally, and in specific regard to women participating in welfare program. Increase collaborative efforts for this monitoring.

The monitoring of welfare reform is a cross-cutting endeavor that has the potential to bring together various agencies responsible for the health and social services needs of poor women. Abstinence education, family planning, access to Medicaid and other health insurance, and domestic violence are all areas of mutual concern to women's health, TANF, and Title V MCH professionals. Discussions regarding how these issues can best be monitored could serve as a fertile ground for unique and constructive partnerships among these groups.

For instance, while there appears to be concerted efforts in some states to monitor economic well-being, public benefit use and health insurance status, more attention is needed in the areas of physical disabilities, mental health, substance abuse, domestic violence and family planning. In this particular regard, state Title V MCH programs might be called upon as partners in identifying existing and/or developing new screening and assessment instruments and to confer with welfare officials about referral resources and protocols.

Additionally, as noted by a number of those interviewed by the WCHPC, a federal role in this regard may be important, and valued by the states. Consideration might profitably be given to a federal-regional-state effort among women's health, TANF, and Title V (and others, such as SAMHSA, OPA, HCFA, etc.) to develop national indicators, and provide technical assistance for states.

References

[1] Acs, G., Pavetti, L. Study of the Employment Patterns of Young Women and the Implication for Welfare Mothers: How Much More Can They Work? Setting Realistic Expectations for Welfare Mothers. July, 1997. Assessing the New Federalism Project. Urban Institute. Washington. D.C.

[2] Connolly, L.S. "The effect of welfare reform on the incomes and earning of low-income families: Evidence from the Current Population Survey." Paper presented at the Rural Dimension of Welfare Reform: A Research Conference on Poverty, Welfare and Food Assistance. Washington D.C., May 4-5, 2000.

[3] Haskins, R. Sawhill, I., Weaver, K. Welfare Reform: An Overview of Effects to Date. WR&B Policy Brief 1. January, 2001. Brookings Institution. Washington, D.C.

[4] Loprest, P. "How families that left welfare are doing: A national picture." 1999 Brief Series B, No B-1. Assessing the New Federalism. The Urban Institute.. Washington D.C.

[5] Monitoring Child and Family Social Program Outcomes: Before and After Welfare Reform in Four States: Outcomes for the Income Maintenance Caseload during Receipt. January, 2000. Chapin Hall Center for Children. University of Chicago. Chicago, Illinois.

[6] Sanctions and Case Closings for Noncompliance. Who is Affected and Why. Welfare, Children and Families: A Three City Study. February, 2001. Policy Brief 01-1. The Johns Hopkins University. Baltimore, Maryland.

[7] Callahan, S. Understanding Health Status Barriers that Hinder the Transition from Welfare to Work. 1999. National Governor's Association. Washington, .D.C.

[8] Chavkin, W. Romero, D., Wise, P.H. State welfare reform policies and declines in health insurance. American Journal of Public Health. 2000. 90(6):900-8.

[9] Danzinger, S. Corocoran, M. Danzinger, S. Heflin, D.M., Kalil, A., Levine, J. Rosen, D., Seefeldt, K., Siefert, K. Tolman, R. Barriers to the Employment of Welfare Recipients. Working Paper No. 90. May, 1999. Joint Center for Poverty Research. Chicago, Illinois.

[10] Garret, G. Holahan, J. Welfare Leavers, Medicaid Coverage and Private Insurance. Brief No.13. March 2000. Assessing the New Federalism Policy Analysis Project. Urban Institute. Washington, D.C.

[11] Kneipp S.M. "The health of women in transition from welfare to employment." Western Journal of Nursing Research. 2000. (6):656-74.

[12] Kramer, F.D. Screening and Assessment for Physical and Mental Health Issues that Impact TANF Recipients Ability to Work. Issue Notes. Welfare Information Network. http://www.welfareinfo.org

[13] Winn, E. Lennon, M.C. The Role of Administrative Data and National Data Sets in Understanding Welfare Reform. March, 2000. The Forum, Vol. 3, No. 1. Research Forum on Children, Families and the New Federalism. http://www.researchforum.org.

[14] O'Campo, P. Rojas-Smith, L. Welfare reform and women's health: Review of the literature and implication for state policy. Journal of Public Health Policy. Winter, 1998. 19 (4): 420-446.

[15] Building Bridges: States Respond to Substance Abuse and Welfare Reform. National Center on Addiction and Substance Abuse. August, 1999. Columbia University, New York, New York.

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Notes

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