Welfare Reform and Women’s Health: Challenges and Opportunities to Advance the Public Response to the Health Needs of Poor Women Through Monitoring and Collaboration

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SUMMARY. The WCHPC studied the extent of collaboration between state women’s health officials and TANF officials with respect to programs that affect the health and well-being of poor women. The kinds and extent of monitoring activities designed to gather information on the health status of this population were also examined. Great unevenness across states was revealed for both collaboration and monitoring. State-level interest in im-

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proving both was assessed, barriers to improvement were identified, and recommendations for steps forward were solicited. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.haworthpress.com> © 2002 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

In August 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193; PRWORA) 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 program known as Temporary Assistance for Needy Families (TANF), thus far have focused almost exclusively on economic and child health outcomes (Acemoglu, 1996; Connolly, 2000; Haskins, Sawhill & Weaver, 2001; Loprest, 1999; Chapin Hall Center, 2000; Cherlin et al., 2001). 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 (Callahan, 1999; Chavkin, Romero & Wise, 2000; Danziger et al., 1999; Garret & Holahan, 2000; Kneipp, 2000; Kramer, 2001; Winn & Lennon, 2000). Several aspects of the PRWORA 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 initiate 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 Bloomberg 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 form the basis of a policy framework for monitoring the impact of welfare reform on women’s health and well-being (O’Campo & Rojas Smith, 1998). These findings also provide 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 article 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.

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 and physical 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, 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, vigilance is needed to ensure that appropriate public health prevention measures are in place in order to avoid increases in communicable disease rates among adolescents. 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 PRWORA require poor women to enter the work force. 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 these women will be able to work themselves and their families out of poverty. Findings from the Urban Institute indicate that while women who have left welfare since PRWORA 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.

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 activities, currently 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 in improving current monitoring efforts;
3. assess levels of collaboration and information sharing between women’s health officials 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.

METHOD

Interview participants came from two sources: the Office on Women’s Health within the Department of Health and Human Services (DHHS), and TANF program officials identified by the Administration for Children and Families (ACF). Both sources included designated personnel for each of the 10 Regional Offices of the relevant federal agency and for each state including the District of Columbia.

Potential interviewees provided by the Office on Women’s Health came from both state and federal appointments. A women’s health contact is appointed by each state’s public health commissioner and serves as a contact with the Office on Women’s Health. This role is loosely defined; generally the contacts work to promote women’s health issues within their state, and 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 women’s health office. At the federal level, regional women’s health coordinators are staff members of DHHS. Their role is solely dedicated to assisting the states in their region to promote awareness of 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 on a periodic basis both within their region and in Washington, D.C. in order to share information, exchange ideas and promote initiatives addressing issues of concern to women’s health. (Though they were part of the larger study, material from the 10 Regional Offices has not been included in this article.)

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 commissioners or directors of the human services agencies responsible for TANF within their states. Our first communication with the TANF agency in each state was through these contacts, and in most cases we were referred to other personnel within the agency (i.e., TANF program managers) who had been appointed for an interview.

From April, 1999 to June, 2000 a total of 62 State Women’s Health Contacts (n = 36) and TANF officials (n = 26) were interviewed by telephone. 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 were identified by the primary contact and included in the discussions. Forty-four states, including the District of Columbia, were represented in the sample in some way. The WCHPC was unable to obtain interviews from contacts in Massachusetts, Missouri, Oklahoma, Pennsylvania, South Dakota, Wisconsin, or Wyoming. Interviews were designed to last no more than 45 minutes; in some cases, depending on the informant’s familiarity with the topics, they were much shorter.

In addition to the interviews, in order to provide additional background and contextual information, the study also reviewed state evaluations of welfare reform provided to the WCHPC by the respondents and evaluations posted on the website of the Research Forum on Children, Families and New Federalism. (Sponsored by the National
Center for Children in Poverty at Columbia University, this website reviews and lists all evaluations conducted at the state and federal levels to assess the impact of welfare reform, and is available at: http://www.researchforum.org.)

The interview guide developed for the state women’s health contacts was composed entirely of open-ended questions that focused on four areas: (1) their perceptions of how welfare reform was affecting the health and well-being of poor women, adolescent women, immigrant women, and women facing domestic violence; (2) the types of monitoring activities (e.g., health insurance, health status, and domestic violence) taking place in their region; and (3) the extent of the informants’ and their agency’s involvement in, knowledge about, and perceptions of welfare reform issues.

In addition, a scale was developed to measure an informant’s perceptions of each state’s capacity to implement a comprehensive monitoring system, together with the level of collaboration between women’s health and TANF officials at the state and federal levels.

Finally, recommendations were solicited for ways to heighten awareness of women’s health monitoring in the context of welfare reform.

Because the term “health and well-being” covers 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. For those respondents with high concentrations of immigrants we also asked about the effect of welfare reform on immigrant women’s access to health care.

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 carried out by any state agency or independent contractor for the purpose of preparing routine reports, 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 information obtained solely through self-disclosure by the client to constitute monitoring (e.g., a client revealing unsolicited information about a health problem to a case worker), although information obtained through a client survey (a form of self-disclosure) was considered a monitoring activity. The interview guides were developed in a sequential and iterative manner such that the responses from one set of responses informed the content 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.

Interviews with State TANF contacts contained most of the elements used for the state women’s health officials and added one additional item. For those states with decentralized programs administered by the county, we asked how decentralization affected uniform data collection.

RESULTS

Challenges and Opportunities for Interagency Collaboration

Since the successful implementation of welfare reform involves creating a host of partnerships including labor, employment, education, and health, to name a few, it has been suggested that collaboration between women’s health officials and TANF officials should be an important area of consideration. The interviews revealed an overall unevenness in collaborative activities (see Table 1). This is based, apparently at least in part, on the differential degree of familiarity among this group of women’s health and TANF interviewees with welfare populations and the programs offered to them.

Perhaps understandably, knowledge about welfare populations and programs was more limited on the part of the 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.

The interviews did find that interagency collaboration was fairly routine at the regional level. 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
TABLE 1. Cross-Agency Welfare Reform Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>State Women’s Health Contact</th>
<th>TANF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 36 % (n)</td>
<td>n = 25 % (n)</td>
</tr>
<tr>
<td>serving on welfare reform planning group</td>
<td>31% (11)</td>
<td>20% (5)</td>
</tr>
<tr>
<td>implementing abstinence/fp programs</td>
<td>36% (13)</td>
<td>36% (9)</td>
</tr>
<tr>
<td>cross training staff/caseworkers</td>
<td>11% (4)</td>
<td>0</td>
</tr>
<tr>
<td>health department</td>
<td>n/a</td>
<td>20% (5)</td>
</tr>
<tr>
<td>domestic violence</td>
<td>5% (2)</td>
<td>44% (11)</td>
</tr>
<tr>
<td>mental health/substance abuse</td>
<td>0</td>
<td>12% (3)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>16% (6)</td>
<td>28% (7)</td>
</tr>
<tr>
<td>employment/labor department</td>
<td>0</td>
<td>32% (8)</td>
</tr>
</tbody>
</table>

located. Again, this lower collaboration rating may have been due to less familiarity with issues regarding welfare reform.

Women’s health respondents were asked to explain why they gave the ratings they did to their office or agency’s level of 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 on their involvement in welfare reform because of staff shortages, time limitations, or because 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 respect to monitoring the impact of welfare reform on women’s health. A few, nonetheless, indicated that barriers in this regard were related to “agency turfism” (n = 3).

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 within their agency. 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. Other areas of collaboration included the cross-training of TANF case managers and eligibility workers, and providing Medicaid access for TANF clients. Although domestic violence is an area in which women’s health officials reported involvement, only two were actively coordinating with TANF staff on these issues.

State TANF informants perceived a greater degree of interagency collaboration than did the respondents who discussed women’s health (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. Most of this collaboration, though, was with local domestic violence shelters and not through a public health agency or unit in their state. Other than domestic violence, 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

Just as interviews revealed an unevenness in the extent of collaborations between state women’s health officials and TANF officials, a similar unevenness was discovered to be the case when it came to the variety of monitoring activities that could potentially be undertaken to gather information concerning the health and well-being of poor women. (See Table 2.)

Economic Well-Being

Monitoring the economic well-being of clients was an issue of great concern to informants at the state level. Nearly all the states participating in the interviews reported that some system was in place to track the employment status and wages of current TANF recipients. This was probably because all states were required by PRWORA 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, varied 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 (known as “leavers studies”), or a combination of both. A few states also had data sharing agreements with bordering states that allow them to track clients who leave their
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 relied 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 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 used periodic surveys and evaluations to monitor health insurance status.

In addition to asking key informants about monitoring activities, 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 in our sample had conducted statewide women’s health surveys to gather data on health status and health insurance coverage. Other states indicated that they used the Behavioral Risk Factor Survey to gather similar information. One state was planning to implement a statewide survey of health insurance status. Only one of these states, however, had 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 was 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 states reported any special efforts to assist persons with disabilities to obtain work. A few, 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 (n = 3).

Substance Use. According to our interviews, of all the health barriers, substance use received 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, indicated that 42 states use this form of detection (National Center on Addiction and Substance Abuse, 1999). 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 did not occur, the respondents noted that confidentiality concerns prevented them from obtaining detailed information from substance abuse treatment facilities. In some states, tracking of treatment occurred through TANF contracts that stipulated treatment as a condition of receiving cash assistance, or treatment was considered an acceptable substitute for 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 two 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 relied 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) used a formal screening tool or domestic vi-

olence counselor to conduct assessments. Few states reported monitoring whether the client had received necessary services (n = 3). A number of the State Women’s Health Contacts pointed out that even though their states had screening protocols in place, TANF clients were not being counseled and linked to services. Nine 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 was 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 counseled clients about family planning services; however, these were reported to be relatively informal arrangements with no system in place to ensure the counseling was done on a routine basis. 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 investigators 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 did 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 were 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 in-
structure were asked to tell us how their states had achieved those successes. Integrated eligibility databases 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 had either received external funding or were planning to use their TANF surplus to upgrade their information systems. In one case, a state had 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 were needed to acquire the resources for a comprehensive monitoring of women’s health indicators. Moreover, 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. Better monitoring of women’s health, they believed, could occur only if there was a public mandate to hold public officials accountable for 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 of 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 had 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 were subcontracted, collecting and integrating data from these providers was difficult. Sharing data with mental health and substance abuse providers was especially difficult due to the concerns regarding confidentiality 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.

Inadequate capacity to evaluate programs and the need to build and develop local capacity to conduct welfare reform evaluations were also mentioned as concerns. In one state, the decision was made to hire local researchers with limited experience in welfare reform to conduct the TANF evaluation instead of an outside group of experts. The state’s decision to invest in local capacity proved to be a prudent one. While there was an initial methodological learning curve to overcome, the local research group’s knowledge of the culture and politics of their state added value to the evaluation. Moreover, their newly acquired expertise provided TANF administrators with a long-term asset that could be called upon for future studies and evaluations.

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 given the state’s small population size. A similar disregard for the limitations of the local environment was voiced by another informant. These reports suggested that while external consultants were well versed in statistical methodologies and study design overall, they and their clients had difficulty adapting rigorous research methods to practical circumstances.

A small number of the TANF informants believed their states relied too heavily on periodic, “one-shot” studies that quickly became outdated and forgotten. They hoped their states would develop a more institutionalized monitoring system 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.

An issue discussed by a TANF informant that pertained 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, resorted 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 the development of better indicators/measures of performance.

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, a few informants 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 an audit of the TANF program could be similarly instrumental. These responses indicated 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 suggested that a greater federal role either in the form of mandates, audits or technical assistance could be helpful and constructive in these situations.


**DISCUSSION**

The monitoring of welfare reform and women's health has received little attention among policymakers, but 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; foremost among these was a 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 exclu-

sively 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 article focus specifically on Office on Women's Health (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 Maternal and Child Health (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 enhancements 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 programs. 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


