Linking Family Planning With Other Social Services:
The Perspectives of State Family Planning Administrators

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in Partnership with State Family Planning Administrators (SFPA)
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Introduction

One of the four stated purposes of the nation’s welfare program (TANF) is to “prevent and reduce the incidence of out-of-wedlock pregnancies.” This raises the fundamental question of whether welfare and family planning agencies work together effectively.

Congress first tried to link welfare with family planning in 1967 when it required states to make voluntary family planning services available to welfare recipients upon request. Whether, and to what extent, states translated this little-known AFDC provision from paper to practice is not known. However, there are indications that the interaction between welfare and family planning agencies has traditionally been quite limited. For example, in 1992 the Nevada welfare department surveyed AFDC recipients and discovered that 10% of the respondents were pregnant. Of that group, 70% had not received family planning counseling, but nearly 50% said they would have utilized such services had they been offered.

Under TANF, welfare funds are not limited to recipients of cash aid – funds may be spent on individuals who have never been part of the welfare system. In addition, welfare funds can be used for a wide array of services and benefits, including family planning, reproductive health and teen pregnancy prevention services. These fundamental policy changes, along with $7.6 billion of unspent welfare funds, have created an opportunity for states to invest in a variety of strategies to prevent unintended pregnancy.

Little national research has been done to ascertain whether states are taking advantage of this new opportunity to link welfare and family planning services. One preliminary review, however, found that there are significant barriers to “creating welfare programs that explicitly stress pregnancy prevention.” At the same time, it increasingly appears that states and localities, while not necessarily creating specific welfare programs that stress pregnancy prevention, are now beginning to accomplish important interactions between welfare and family planning agencies. For example:

- In Alaska, the family planning agency developed a curriculum which trains welfare staff to address basic reproductive health issues and make appropriate family planning referrals;
- In Washington, the Medicaid agency contracts with local Title X agencies to have itinerant nurses provide family planning services in 75% of the state’s welfare offices;
- In Georgia, $11 million in TANF funds support a variety of adolescent health and youth development services across the state, including mentoring and case management of adolescents by former welfare recipients;
- In California, the welfare agency collaborated with the Medicaid agency to provide recipients with materials that invited them to call the family planning agency’s hotline for more information about no and low-cost family planning services, birth control supplies, education and pregnancy prevention;
In South Carolina, the family planning program secured a provision in the state welfare law which requires employers to grant TANF recipients four hours of unpaid leave each year so they can obtain family planning services, if they so desire.  

Each of these initiatives requires overcoming political barriers and the inherent “cultural” differences between the welfare and family planning agencies. Welfare is a system largely based on eligibility and participation requirements: clients must conform to these requirements to receive benefits, and welfare workers must ensure that clients are meeting them. Family planning providers, on the other hand, offer services that eligible women and men may elect to utilize for their own health or well-being. One family planning administrator explains that the approach to clients of the two agencies can therefore be quite different. “In the welfare office, the staff seem to focus on the ‘yes’ or ‘no’ of whether a person meets the rules for assistance. Whereas, in the family planning agency, staff are in an environment where they can view their job as highlighting and explaining clients’ options to them.” Another family planning administrator adds that welfare caseworkers are “nervous about discussing family planning.” Echoing those sentiments, a third family planning administrator elaborates: “Welfare caseworkers are overwhelmed; they feel they can’t take on one more thing – especially if it has to do with sexuality.”

These differences appear to impede collaboration between the two agencies. Reflecting on the differences between the cultures of the two agencies, a long time family planning administrator explains: “Only one time in 20 years have I been given the opportunity to train welfare staff about family planning.”

To gain a better understanding of the emerging links between welfare and family planning agencies and to assess how much of a barrier the cultural differences pose, CLASP embarked on a partnership with State Family Planning Administrators (SFPA). Typically, these administrators run some or all of the state’s Title X program. CLASP distributed a set of questions to the state family planning administrators in all 50 states, the District of Columbia and United States Territories (hereafter collectively referred to as “the states”).

The questions asked about the nature and extent of the interactions occurring between family planning programs and welfare agencies. We also inquired about the interactions with other social service agencies (e.g. food stamps, the Special Supplemental Nutrition Program for Women Infants and Children (WIC) and subsidized housing programs). The latter questions were included, in part, because the rapidly decreasing welfare caseloads raise the question of whether family planning services should be integrated with other social service programs, not just welfare.

We received information on the policy choices and interactions occurring in all 50 states, the District of Columbia and the U.S. Virgin Islands. Although policy decisions are made on an on-going basis, data collection efforts like this one can only capture the policies in effect at the time the questions are answered. The policy choices in this
document reflect a snapshot of state family planning administrators’ reports of policies effective in mid-1999.18

We have attempted to summarize the data and describe the linkages family planning agencies and welfare agencies are making with each other. We shared preliminary results of our analysis with the SFPA Steering Committee to draw upon their day-to-day experience as we tried to cull meaning and messages from the responses. What follows is both a summary of the data and our efforts to make sense of the findings. [Appendix I lists the original questions with a breakdown of responses from the states. It also includes additional analyses, for example cross-tabulations of states’ responses to more than one question and comparisons to information contained in other reports and studies.]

Our overall impression is that family planning programs are, in some measure, interacting with welfare and other social service programs throughout the country. In addition, many states are trying to expand or enhance family planning related services and programs by tapping into a variety of funding streams. Although interactions appear to be occurring, the nature and extent of the interactions appear to vary considerably.

On the one hand, there has been almost no interaction between welfare and family planning agencies regarding welfare program mandates about reproductive health. For example, around 20 states have adopted a “family cap,” a policy that prohibits families from receiving the traditional incremental increase in the family’s grant when an additional child is born. Yet, only two of these states involved the family planning program in the design or implementation of this policy. On the other hand, many states appear to be recognizing the value of involving the family planning agency in certain reproductive health related matters. Of the 34 states using TANF funds for a family planning or pregnancy prevention project, 20 involved the family planning agency in the planning of the project.

In many ways, it appears that basic linkages have been made. Most state family planning agencies provide family planning information to welfare recipients. Twenty-five states report some type of referral arrangement between the welfare and family planning agencies. However, of these states, only 15 involved the family planning agency in the design of its referral policy. This suggests a missed opportunity.

It may be rather simple for the welfare agency to adopt a policy requiring caseworkers to refer all clients to the family planning agency, especially if this requirement can be fulfilled by giving a client the address and phone number of the local Title X clinic. On the other hand, having family planning and welfare administrators sit down together to design a referral system takes more time and effort. The family planning agency might survey welfare staff to assess what information they need to make effective referrals. The two agencies might design an integrated computer system that allows a welfare caseworker to make a referral with the click of a mouse, while providing the family planning agency with all the information it needs to schedule an appointment. The findings from our project with SFPA seem to indicate that family planning agencies have
initiated basic links with welfare and other social service agencies, but that additional steps are needed to solidify existing links and bridge new ones.

The interpretations suggested in this report are not meant to be definitive, but to spark further inquiry into how to make more effective links between family planning programs and welfare or other social service programs. We believe the perspectives and voices of state family planning administrators enhance our knowledge about linking family planning with other social service programs. Their insights also raise new questions about how to make the most of these interactions. For example:

- Should co-location involve coordinating services or is merely sharing a roof sufficient?
- Does an effective referral entail making a phone call or filling out a form or does it require something more?
- Why aren’t the majority of states providing welfare agency staff with family planning training – do welfare staff have enough information already?
- How much family planning training do welfare (and other social services) staff need – is the intention to make these staff members family planning counselors or simply to help them make effective referrals?
- When is interaction at the planning or policy level vital or at least valuable?
- When is interaction at the planning or policy level superfluous?
- When should coordination choices be devolved to the local level and when should they remain at the state level?
- Does the opportunity to tap TANF funds spur collaboration in the family planning arena?

We hope family planning, welfare and other social service officials will consider the evidence that interactions are beginning to occur and ponder the preceding questions as they seek to improve access to family planning services for low income individuals throughout the country.
Reports from State Family Planning Administrators:

Most states report that their family planning program reaches out to potential clients through the welfare program or other social service programs.²⁰

- 43 states report a state level project or activity designed to reach clients through the welfare system or other social service programs.
- Of these 43 states, 28 report utilizing both the welfare system and other social service programs to reach clients; 14 states focus only on recipients of other social services (e.g. WIC, food stamps, and subsidized housing) and one state reports outreach only through the welfare program.²²
- Of the eight states not targeting welfare recipients or other social service recipients through those programs, only one anticipates such outreach in the future.

States use varying mechanisms to reach welfare recipients and other social service clients; information dissemination is the most common tool, followed by co-location, referral systems and training initiatives.

- 42 states report that state or local family planning programs employ an information dissemination strategy to try to reach welfare or other social service program clients.
- 39 states report that family planning services are co-located with the welfare office or the offices of other social service programs.
- 38 states report that state or local family planning programs have established a referral system with the welfare agency or other social services providers.
- 31 states report that their state family planning program has trained staff of the welfare agency or other social service programs about family planning.
- Most states use more than one of these mechanisms to reach out to welfare and other social service recipients.²³

Most states undertake information dissemination efforts and the majority of the states that do so target clients through both welfare and other social service programs.

- Of the 42 states undertaking information dissemination, 30 states utilize both the welfare system and other social service programs to reach out to clients.
- Eight utilize other social service programs (but not welfare) and four rely solely on the welfare program.

Information dissemination efforts are determined at the state level about twice as often as at the local level.

- 28 states reported that information dissemination initiatives occur at the state level.
- 14 states reported that information dissemination efforts are determined by local policy.
Most states use a variety of methods to disseminate information.

- The most common dissemination method entails distributing brochures; 40 states use this method.
- 21 states use telephone hotlines, 20 states use flyers and 15 states undertake media campaigns.
- Most states use more than one method to get out the information; only 8 states employ a single information dissemination tool.  

A variety of funding sources supports the information dissemination initiatives.

- 33 states report using Title X funds to disseminate information; 21 states use state funds; 16 states rely on Medicaid funds and 13 states tap TANF funds for this purpose.
- 29 states use a combination of funding sources to support their information dissemination efforts.

Co-location of family planning services is quite common with the WIC program and occurs to a lesser degree with welfare and food stamps programs.

- Of the 39 states reporting some type of co-location, 37 states co-locate with the WIC program; 15 co-locate with the welfare office and 7 co-locate with food stamps agencies.
- About half of the states (20) that employ a co-location strategy, co-locate with more than one program.

Most states have referral systems and the majority of the states that do, maintain referral systems with both welfare and other social service programs.

- Of the 38 states with referral systems, 23 have established systems with both the welfare program and other social service programs.
- 10 states have created referral arrangements with other social services programs (but not welfare) while 2 states have developed referral arrangements only with the welfare agency.  

The nature of the referral arrangements is determined at the local level almost as often as at the state level.

- 20 states set referral policy at the state level.
- 18 states establish referral policy at the local level.
States use various referral arrangements to connect with welfare or other social service programs, but are likely to employ only one referral mechanism.

- 15 states utilize an interagency agreement; 12 states rely upon a special referral form; 9 states provide special scheduling for referred clients; and 4 states track referred clients to determine if they keep appointments.
- Of the 38 states with referral systems, 23 use only one referral mechanism.

An assortment of funding sources supports the referral systems.

- Title X funding is the most common support for referral systems (18 states), but Medicaid funds and state funds are utilized almost as frequently (13 states take advantage of each of those sources). In addition, eight states tap TANF to support their referral systems.
- Slightly more than half the states (20) with a referral system report using multiple funding sources to support the arrangements.  

Family planning programs provide some type of training to the staff of other programs in many states, most commonly to welfare or WIC staff.

- Of the 31 states that engage in training initiatives, 21 undertook training welfare staff and 20 provided training to WIC staff; about half the states (15) that engaged in training offered the training to staff in more than one program.
- In addition to staff training efforts, five states report that they are training welfare or other social service clients to serve as “peer educators” for other recipients.

The majority of states (34) are tapping into the TANF funding stream for a variety of family planning, reproductive health or teen pregnancy prevention projects.

- Some states (at least nine) rely on TANF to provide clinical family planning services.
- Some states (at least 14) use TANF for projects that focus on teens.
- A few states (at least two) tap TANF to support abstinence-only education programs.
- At least one state uses TANF to support a Statutory Rape Taskforce.
- Of the sixteen states not tapping TANF, five indicate that they are considering future use of TANF funds.

States have also expanded their Medicaid programs or created state-funded family planning programs.

- 12 states have expanded their Medicaid programs to provide family planning services to people who would otherwise be ineligible for Medicaid services.
- 10 states have developed special state-funded family planning programs.
- Three states have expanded Medicaid, tapped TANF and developed state-funded family planning programs.
- Nine states have chosen not to expand Medicaid, tap TANF or create a state-funded family planning program.\footnote{33}

**Few state family planning programs have been involved in the design or implementation of welfare program mandates related to reproduction.**

- 23 states have “family cap” policies\footnote{34} which preclude a welfare family from receiving the traditional incremental increase in the family’s grant when a child is born. Yet, only two of those states involved the family planning program in the development or implementation of this policy.
- Ten states permit or require a family planning component in a client’s “individual responsibility agreement” with the welfare agency.\footnote{35} Yet, only three states involved the family planning program in the design or application of this policy.
- Of the 25 states with a referral arrangement between the family planning program and the welfare agency, only 15 of those states involved the family planning program in the development of the welfare agency’s referral policy.

**Even when the family planning program and other social service programs interact at the programmatic level, they do not necessarily interact at the planning level.**

- Of the 42 states with family planning information dissemination initiatives targeting welfare or other social services recipients, only about half (23) gave the targeted social services program a role in the development of materials.
- Of the 34 states that tap TANF funds for reproductive health, family planning or teen pregnancy prevention, 20 involved the family planning program in project planning for the TANF-funded initiative(s), but 14 did not.\footnote{36}

**Even when the family planning program and other social service programs link at the structural level, the connection may be tenuous and difficult to maintain.**

- One state allocated TANF funds for a variety of reproductive health services, including outreach and pregnancy prevention programs for teens. However, the state initially required income eligibility determinations for each person receiving TANF-funded services.\footnote{37} The family planning administrator in this state notes that it was difficult to build the rapport needed to conduct effective outreach and pregnancy prevention while simultaneously inquiring about family income and requesting documentation of that income.
- One state allocated TANF funds for clinical family planning services but only about 30% of the allocated funds were actually used – the rest of the funding remained unspent.\footnote{38} The president of the state’s Family Health Council reports that the state’s income and resource restrictions, along with its reporting and documentation requirements, made it difficult to use the money.\footnote{39}
In some states, it appears that the welfare agency and the family planning programs are unaware of the other agency’s initiatives and policies.

- Human services administrators in six states report using TANF funds to reduce teen pregnancy or out-of-wedlock births, while family planning administrators in those same states report that TANF funds are not being used for reproductive health, family planning or teen pregnancy prevention.  
- The human services administrator in one state reports that TANF funds are being used to provide contraceptive care while the SFPA respondent in that state reports that TANF funds are being used to support an information dissemination initiative.  
- The SFPA respondent in one state reports that her state does not have a family cap provision or a policy of including family planning components in clients’ “individual responsibility agreements,” when, in fact, her state has both such policies.

Conclusion

States and localities have an unprecedented opportunity to increase access to family planning services for low income individuals. The new welfare law allows TANF funds to be spent on a variety of family planning and pregnancy prevention services to men and women in a wide range of age and income groups. In addition, substantial amounts of TANF funds remain unspent. The information collected from state family planning administrators indicates that many states are taking advantage of these opportunities and working to link family planning services with welfare and other social service programs. On the other hand, it appears that the level of integration is often perfunctory. The differing mindsets of the two agencies and their institutional constructs have impeded smooth integration in a variety of ways. As Karen Edlund, acting chair of SFPA, explains: “The cultures of the welfare agency and the family planning agency are so divergent, integrating our missions is often a struggle – but it can be done.” In fact, it is being done. The information provided by family planning administrators throughout the country offers valuable lessons, both about the links that can be made and about the challenges to solidifying those links.

1 In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which replaced the Aid to Families with Dependent Children (AFDC) entitlement program with the Temporary Assistance to Needy Families (TANF) block grant.

2 PRWORA eliminated this provision in 1996; prior to that, the requirement was codified at 42 U.S.C. 602(a)(15).

3 State AFDC plans did not delineate how states implemented 42 U.S.C. 602(a)(15) and no separate analysis of the Administration for Children and Families (ACF) collected information on this topic. Authors’ correspondence with ACF, December 1999.

The 1996 law based state TANF allocations on the caseload levels of the early 1990’s. Since then caseloads have declined and, as of March 1999, states reported $7.6 billion in unspent TANF funds. “TANF Program Expenditures Through the Second Quarter” available at: http://www.acf.dhhs.gov/programs/ofc/data/q299/index.html.


8 Family Planning Referral: States Train Welfare Staff, CLASP UPDATE, July 31, 1999.


12 This information was obtained through the data collection efforts of this project, which are described below.

13 Authors’ conversation with Sharon McAllister, State Family Planning Administrator from Washington, September 1999.

14 Authors’ conversation with Cheryl Robbins, former State Family Planning Administrator from Florida and former chair of the State Family Planning Administrators, September 1999.

15 Authors’ conversation with Karen Edlund, State Family Planning Administrator from Massachusetts and acting chair of the State Family Planning Administrators, September 1999.

16 Authors’ conversation with David Dornan, State Family Planning Administrator from Michigan, September 1999.

17 The intent of this project was to ascertain the perspectives of state family planning administrators. Some administrators appear to have sent the questions on to other agencies to answer. Thus, not all of the data reflects the knowledge and impressions of SFPA members. In addition, while most family planning administrators run Title X (family planning) programs, some run Title V (Maternal Child Health) programs or other programs that provide family planning services as one part of their mission. Forty-three SFPA members administer Title X programs (in 33 states, they administer all of the Title X funds and in 10 other states they administer some of the Title X funds) and, thus, the information collected through our partnership with SFPA most often represents the perspective of those operating Title X programs.

18 The questions were distributed in February 1999. Some responses were submitted immediately while others were not obtained or clarified until August 1999.

19 Our question asked whether these programs targeted recipients through welfare or other social service programs, but responses suggest that some may have read the question as asking, instead, whether their
programs targeted recipients of welfare or other social service programs. As a result, the numbers we report may overstate the actual use of welfare and social service programs to reach clients.

20 We provided examples of other social service programs with our questions, but did not define the term. The comments suggest that respondents may have interpreted this phrase differently – for example, some states included the Medicaid program within the definition while others did not.

21 We asked a series of questions about the state family planning program or administration’s involvement in certain policies and projects. However, it appears that some respondents did not interpret the questions this way. For example, they answered “yes” to these questions, indicating that the state administration was involved, but then described all of the involvement as occurring at the local level. Thus, the numbers we report may overstate the actual involvement of state level administrators.

22 One state that reported that it targeted welfare recipients or recipients of other social services did not indicate which program was utilized to reach these recipients.

23 Four states that indicated that their state family planning program did not target welfare or other social service recipients, nonetheless indicated that local programs utilized these outreach mechanisms. Of the 47 states reporting state or local use of these mechanisms, 43 reported using more than one.

24 Our questions about information dissemination methods, referral mechanisms and funding sources included an “other” category. Similarly, the questions about co-location and training contained an “other” category – e.g. co-located with or trained staff from “other” programs. In our tabulations, we counted “other” as a single entity. For example, a state that marked “Title X” and “other” as the funding supports for its referral system would be counted as a state using two funding sources when the state may have marked “other” to reflect several alternative funding sources. Thus, our conclusions about the number of mechanisms or methods employed, the number of programs co-located with or whose staff were trained and the number of funding sources tapped may underreport the actual numbers.

25 The nature of the co-location appears to vary from state to state. For example, some state responses suggest that family planning services are coordinated with welfare or WIC services, while other state responses suggest that the services are merely available in the same building.

26 Three states did not indicate whether their referral systems were with welfare or other social service programs.

27 Thirteen states report relying on only one funding source and five states did not provide information about the funding of their referral systems.

28 The depth of the training is not captured by our question, but some additional comments suggest that the depth varies quite a bit. In some states the training is described as “informal in-services” while in other states a specific training curriculum has been developed.

29 At least one state, Massachusetts, mentioned that it was training peer educators to inform community members and social service clients about how to prevent HIV transmission. Other states may be providing such training as well, although they did not include such information in response to our question about peer education for “reproductive health.”

30 Information about the nature of the TANF spending comes from narrative descriptions offered by respondents. Some states did not provide descriptions of their initiatives, while other states noted that the decision of how to spend TANF funds is a local one. Thus, we were not able to identify all the ways TANF funds are being used. We provide these highlights of statewide efforts to demonstrate the range of options that could be undertaken.

31 Two states reported that they did not know whether their states were tapping TANF.
Federal Medicaid law requires states to offer maternity care services to pregnant women, with incomes up to 133% of the poverty level, maternity care services. Maternity care services include family planning services for two months following the pregnancy. States have the option to offer such services to pregnant women with incomes up to 185% of poverty (state “disregard” calculations may result in women with higher incomes receiving services). In addition, states may seek a waiver to expand Medicaid family planning coverage beyond this option. The answers to our question indicate that respondents interpreted the phrase “expanded Medicaid” in different ways. Some answered “yes” because their state has an approved waiver from the Health Care Financing Administration (HCFA). Others answered “yes” because their state has submitted or is contemplating pursuing such a waiver. Still others answered “yes” because their state has elected to offer maternity care services to women between 133% and 185% of poverty. We reviewed these comments and decided to report only those states with an approved waiver either to continue Medicaid family planning services to women who have exhausted their two months of post-pregnancy family planning services or to provide Medicaid family planning services to low income men and women who do not meet the state’s regular Medicaid eligibility criteria. California recently obtained a waiver to provide family planning services to men and women with incomes under 200% of the poverty level. However, since the waiver had not been approved at the time our data collection was completed, we have not included California in our list of states with Medicaid family planning waivers.

Two states have not expanded Medicaid or tapped TANF, but have created a state-funded family planning program. Four states have expanded Medicaid but not tapped TANF or developed a state-funded program. Twenty-three states have tapped TANF, but have not expanded Medicaid or created a state-funded family planning program. Nine states combine two of these three methods of expanding or enhancing family planning services. Two states did not provide sufficient responses to characterize them in this manner.

Two of these states provide “flat grants” for all families, regardless of size. The other 21 states have policies that prohibit the traditional incremental increase when a child is born while the family is receiving cash assistance. Excluded Children: Family Cap in a New Era, Shelley Stark and Jodie Levin-Epstein, February 1999, available at http://www.clasp.org.

CLASP has reviewed family cap policies and “individual responsibility agreement” provisions in other publications. Appendix II includes a list of these and other reproductive health related publications produced by CLASP.

There are a number of potential reasons that the state family planning administrator might not have been involved in the project planning. In some cases, the state family planning administrator’s lack of involvement in project planning does not necessarily mean that the project was developed without the involvement of any family planning professionals. For example, the funds may have been transferred to Title XX to provide family planning services. Similarly, decision-making about the project may have been devolved to the local level where local family planning providers were involved in project design – even though the state family planning program was not. On the other hand, the lack of involvement on the part of the state family planning administrator could signify that a reproductive health related project was developed with no consultation from family planning professionals. For example, the legislature might have appropriated funds for the project and mandated specific guidelines about how the program would be run. Or, the funds may support a project administered by someone other than the family planning agency (e.g. the funds are used for an abstinence-only project run out of the governor’s office).

The family planning administrator from North Carolina subsequently reported that the legislature removed this requirement for pregnancy prevention services late in the 1999 legislative session. It is important to note that although state legislation in this particular state required income eligibility determinations for such services, the final federal TANF regulations do not. The determination of eligibility must be based on objective, but not necessarily financial, criteria. The Final TANF Regulations:
A Preliminary Analysis, by Mark Greenberg and Steve Savner, (available at http://www.clasp.org) offers more detailed information on the provisions of the regulations.

38 Authors’ correspondence with Christy Tittle of the Indiana Family and Social Services Administration, January 2000.


40 The human services administrators responded to an inquiry from the American Public Human Services Association (APHSA) that asked: “Can you describe how you designed TANF policy or used TANF funds to reduce the out-of-wedlock birthrate or teen pregnancy?” and “Can you give an example of how abstinence education funds have been used in a strategy to reduce out-of-wedlock birthrates?” John Sciamanna, a Senior Policy Associate at APHSA, reported the results of this survey in July 1999 in State Teen Pregnancy Prevention and Abstinence Education Efforts: Survey Results on the Use of TANF and Title V Funds. This report describes TANF-funded teen programs, abstinence education initiatives and/or media campaigns in six states where SFPA respondents indicated that TANF funds were not being used for any reproductive health, family planning or teen pregnancy prevention projects. These differences may be no more than an artifact of the methodology used to collect the data from these two sources. On the other hand, the findings suggest that, at least in these states, the welfare agency may be engaged in or funding family planning related activities about which the family planning administrator is unaware.

41 Both administrators could be correct; the TANF agency could be using TANF funds to provide contraceptives while the family planning administration could be using TANF funds to disseminate information. Since the two administrators report different uses of the money, this suggests the possibility that they may not know how each other are utilizing TANF funds.

42 When we notified this respondent that we understood her state to have adopted these policies, she continued to maintain that it had not. When we supplied her with the specific language and the name of our contact in the TANF agency, who had verified these policies in conjunction with another project, she indicated that she had not been able to get much information or cooperation from the TANF agency and had no idea such policies were in place.