ADVOCATES FOR YOUTH

Date: 6/4/96 **Time:** 1:30 pm

To: Jennifer Klein

Company: White House

Fax: 456-2878

From: Susan Pagliaro

Pages: 10 **(including cover sheet)**

Hi Jennifer,

Here's the information on the school-based program. My contact is Kathy Bowman-Harrow:

phone (407) 312-3200 x 2791
FAX (407) 312-3369.

I'll let you know what else I come up with.

Susan

PLEASE PRINT

YES! I want to be an advocate for youth!

If you are interested in becoming an advocate for youth, you can join our Advocates Alert Network—an educational project to share information between the state and federal levels. The free Alerts are published on an as-needed basis and address legislative efforts around adolescentreproductive and sexual health.

NAME _____
TITLE _____
ORGANIZATION _____
STREET ADDRESS _____
CITY, STATE, ZIP _____

Please send my alert by:

☐ FAX _____ (YOUR FAX NUMBER)
☐ ELECTRONIC MAIL _____ (YOUR E-MAIL ADDRESS)
☐ LETTER

Suite 200 1025 Vermont Avenue, NW Washington, DC 20005 USA 202.347.5700 202.347.2263 Fax

ORANGE COUNTY PUBLIC SCHOOLS
SEXUALITY EDUCATION AND
COMPREHENSIVE HEALTH EDUCATION

THE DATA

The alarming rate of early pregnancy, coupled with the fact that a large percentage of these girls are unwed, results in young mothers and children at great risk for poverty and the need to be supported by tax dollars. In 1988 Orange County reported 1,356 babies born to women under the age of 18 with 33 of those young women under the age of 14. Recent Orange County schools dropout records reveal that 463 females of that same age group received Aid to Families with Dependent Children.

Aside from the high cost for taxpayers, early pregnancies pose a health risk for both mother and child. Babies born to teen mothers are more likely to die, be of low birth weight, have low intelligence and suffer serious birth defects. Early pregnancy not only affects the female but also impacts the lives of the teen father, their families and society in general. In addition, the teen parent is usually not prepared to shoulder the responsibilities of rearing a child, thus, complicating and compounding the cycle of dysfunctional families.

The possibility of teen pregnancy knows no economic, social or ethnic barriers. Factors contributing to the problem of teenage pregnancy include substance abuse, dysfunctional families, low self-esteem and lack of factual knowledge of human reproduction. An absence of skills in decision making and in communicating with parents or other adults often contributes to the situation. In addition to the concern about early pregnancy, sexually active young people face the risk of contracting sexually transmitted diseases including HIV/AIDS.

REQUIREMENTS FOR K-12 COMPREHENSIVE HEALTH EDUCATION

Comprehensive Health Education has been required in Florida schools since 1973. Florida Statute 233.067 Comprehensive health education and substance abuse prevention, section (2) states that *The Legislature recognizes that sound health habits are essential to the educational and personal success of the student. The Legislature further recognizes that schools are uniquely situated to effectively promote the establishment of sound health habits among our youth, including prevention of substance abuse and an awareness of the benefits of sexual abstinence and the consequences of teenage pregnancy. To this end, it is the intent of the Legislature to implement a comprehensive health education and substance abuse prevention program in Florida's public schools.*

In the past, most health education programs focused on the human body and hygiene. While this information is still cosidered essential today, the emphasis is now on wellness--the highest level of health to which an individual can aspire. Health programs based on wellness provide information that will enable students to make positive, informed choices regarding their health and well-being. Acquiring the knowledge, skills and attitudes necessary to achieve and maintain wellness helps children learn to take a major responsibility for their own health.

LOCAL RESPONSE

Concern about teenage pregnancy and related problems became an item of special interest of the District Advisory Committee. During the November 1986 District Advisory Committee(DAC) meeting, the health education and substance abuse subcommittee discussed the lack of sex education in schools. The advisory committee displayed interest in assessing needs and presenting a program on that subject. The

conducted by the subcommittee. Fifteen of 19 principals indicated that more sex education would be beneficial. As a result of this study, the school board directed the Superintendent to establish a committee with broad community representation to further study sex education and the development of an appropriate sex education program for Orange County Schools. The membership of the sex education committee was chosen with representation from clegy, students, parents, educators, county and state agencies, and various community organizations. Twenty-eight members were selected and meet for approximately 18 months.

The Sex Education Committee appointed by the Superintendent held four public forums. Approximately 100 persons spoke to members of the committee during the forums. During the same period, a sex education survey was prepared and distributed to parents of students K-12 and high school students. One thousand parents and 600 students responded to the survey. The results indicated support for a sex education program in the Orange County Public Schools.

Based on the survey responses, forum input, review of available information, extensive discussion by the members, it was the committee's recommendation that a sexuality education program be developed and implemented in Orange County schools. In addition, curriculum guidelines and concepts were developed and recommendations generated for implementation, teacher training and parent education.

In December 1989 principals, directors and county staff identified elementary, middle and high school teachers, guidance counselors and curriculum resource teachers to make up the writing team. The writing team worked from January through August 1990 on the curriculum to be piloted during the 1990-91 school year.

STATE RESPONSE

On June 29, 1990 the Florida Legislature passed House Bill 1739 which amplified Florida Statute 233.067 Comprehensive health education and substance abuse prevention. Florida Statute 233.067 (c) states that the comprehensive health education and substance abuse prevention program shall include the following in all public and laboratory schools:

(9) Instruction in reproductive health, interpersonal skills, and parenting to reduce pregnancy and promote healthy behavior in Florida's children for all students in kindergarten through grade 12, beginning with the 1991-1992 school year. In order that children make informed and constructive decisions about their lives, complete and accurate comprehensive health education shall be made available to all young people. Curriculum will be developed to reduce destructive behavior in children, including:

- *early sexual involvement,*
- *substance abuse,*
- *suicide,*
- *activities which result in sexually transmitted diseases . . . and*
- *early teenage pregnancy,*

with subject materials appropriate to the grade level and values consistent with those of the community. Instruction shall also include:

- *an understanding of the body and its system,*
- *identification and prevention of child abuse in the lower grades,*
- *decision-making in the middle and higher grades.*

Instruction of human sexuality will take into account the whole person, present ethical and moral dimensions, shall not be an expression of any one sectarian or secular philosophy, and shall respect theconscience and rights of students and parents. School districts and laboratory schools are encouraged to provide written materials on reproductive health to parents, as well as opportunities for parents to become informed about the instruction their children are receiving and to receive instruction themselves. All course materials and oral or visual instruction shall conform to the requisites and intent of all Florida law and the state constitution. All instructional materials, including teachers' manuals, films, tapes., and other supplementary instructional material shall be available for inspection by parents or guardians of the children engaged in such classes.

Abstinence: Florida Statute 233.0672 (2) states that, *Throughout instruction in acquired immune deficiency syndrome, sexually transmitted diseases, or health education, when such instruction and course material contains instruction in human sexuality, a school shall:*

(a) Teach abstinence from sexual activity outside of marriage as the expected standard for all school-age children while teaching the benefits of monogamous heterosexual marriage.

(b) Emphasize that abstinence from sexual activity is a certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, including acquired immune deficiency syndrome, and other associated health problems.

(c) Teach that each student has the power to control personal behavior and encourage students to base action on reasoning, self-esteem, and respect for others.

(d) Provide instruction and material that is appropriate for the grade and age of the student.

Exemption from Instruction: Florida Statute 233.067 (4) 5. states that, *Any student whose parent makes written request to the school principal shall be exempt from reproductive health or AIDS instructional activities, as requested.*

PILOT PROGRAM

When the Florida Legislature passed House Bill 1739 in June of 1990, Orange County Public Schools found that the work that had begun in 1986 was in line with the state mandated requirements. The law required that during the 1990-91 school year instruction was to begin in the middle grades of 6th, 7th and 8th. Orange County's master plan went beyond the state requirement with a pilot program schedule to be implemented in ten schools; 5 elementary, 2 middle and 3 high schools. The pilot schools were:

Elementary Schools:	Arbor Ridge	Ridgewood Park
	Blankner	Windermere
	Richmond Heights	
Middle Schools:	Jackson	Lee
High Schools:	Apopka	University
	Jones	

Prior to the implementation of the pilot sexuality education program, training was provided for the teachers in the schools and information about the curriculum was given to parents.

It is recognized that the basic responsibility for sex education belongs to the home, while the church, school, and other community agencies have supplementary roles in strengthening the efforts of parents. Although the school can contribute to and reinforce wholesome attitudes while presenting factual information, it is the parents who can best give these facts their special spiritual and emotional quality. Classroom instruction in this area should support the family as the basic unit of society and provide the individual learner with a foundation for future decision making.

To communicate information regarding the Sexuality Education program the advisory committee that developed the guidelines for the curriculum presented a general overview of the program to parents at the Orange County Council of PTAs in January 1990. In addition the district sponsored three parent workshops on answering kids' questions about sex, the abstinence message and AIDS that were designed to encourage parent/student communication. At each of these sessions, parents could ask questions of OCPS district employees coordinating the program.

Parents also were invited, during a four-month period, to the Educational Leadership Center to review the materials used in the sexuality education curriculum. In addition curriculum guides were available at the main downtown library and the nine branch libraries. After looking at the materials, parents could record their comments on a form designed for that purpose. Additionally, OCPS district employees made presentations about the program at selected schools. The curriculum was discussed by parents and their recommendations and concerns were recorded and incorporated in the sexuality education curriculum revision process.

PILOT PROGRAM EVALUATION AND REVISIONS

Curriculum revision workshops were held for all teachers who implemented the program in the pilot schools. They provided input about the pre- and post staff development training they received and made recommendations for modifications to the course content. Two teachers per grade level were selected from each of the pilot schools to participate in the curriculum revision and rewrite process.

In addition to parent, pilot teacher and pilot school secondary student recommendations a formal evaluation of the curriculum was completed by the OCPS Program and Evaluation Department. The Program Evaluator evaluated the curriculum according to the District Curriculum Guidelines. Before recommended revisions were included in the rewrite process they were also evaluated according to the curriculum guidelines that were established by the local Sexuality Education Advisory Committee. Although the pilot school evaluation process is complete, an evaluation of the curriculum including books and audio-visual materials recommended for use with the curriculum, will be an on going process each year. Parents as well as teachers are invited to take an active part in the process.

IMPLEMENTATION OF THE CURRICULUM

- Sexuality Education will be made available to all students enrolled in Orange County Public Schools beginning with the 1991-92 school year.

- Teachers must attend staff development training before teaching the curriculum.

- The validity and success of this curriculum is dependent upon careful selection of the teaching personnel. Administrators should be careful to select people who are capable, willing, trained and who are supportive of the program and the curriculum guidelines.

- Whenever possible the sexuality education curriculum in elementary schools should be taught by the classroom teacher. Assistance from other school personnel and approved outside resources may be appropriate as long as all involved are capable, willing and trained to follow the curriculum guidelines.

- The middle school curriculum will be implemented through seventh grade comprehensive health education. In grades six and eight, the sexuality education curriculum will be infused into existing content curriculum. These teachers will be selected by the building level principal. Selected teachers will receive specialized training.

- The high school curriculum will be implemented through the required Life Management Skills course which is also part of comprehensive health education. Instruction will be provided for eleventh and twelfth grade students through seminars titled "Women's Issues" and "Men's Issues". Approved speakers trained to follow the curriculum guidelines and concepts will present current, factual information and answer student questions.

- The curriculum strongly reaffirms the existing position of the school board to present a balanced perspective on all controversial issues pertinent to the sexuality education curriculum.

- Parent and Family Enrichment activities are designed to encourage communication within the family. Students are encouraged to take the activities home and discuss them with their parents. Students should not be penalized if they are unable to obtain family involvement. Parent involvement enhances the program.

- It is intended that the teacher will spend a few minutes at the beginning of each class period reviewing Parent and Family Enrichment activities as applicable.

- Teachers may modify the lessons to best meet the needs of each class, but objectives that meet county guidelines should not be compromised and no other materials may be used.

- The teacher needs to stress the abstinence message and to present all information in a factual, non-judgemental manner.

- The teacher needs to be aware of and sensitive to the various maturity levels in their classroom. It is expected that the teacher will encourage a well organized, mature and "safe" classroom environment for the students.

- Grades can not be used to penalize students that have been opted out of the Sexuality Education Program.

TO THE TEACHER

This curriculum guide provides the teacher with the objectives, content, and activities that reflect the Orange County School Board approved grade level concepts and curriculum guidelines for Sexuality Education. Various educational materials and community resources have been recommended to support the effective implementation of the program. No other materials may be used.

HOW TO USE THE CURRICULUM GUIDE

1. Before beginning instruction review the Curriculum Guidelines found on page vii and the Appendix.

2. Objectives and recommended activities are listed under each concept.

3. The estimated class time is approximate.

4. The teacher should review the Teacher Resources and Student Materials sections prior to planning and preparing materials.

5. Parent activities are listed for most, but not all objectives. These can be assigned as homework, extra credit, or no credit. Students should not be penalized if they can not get parent(s)/family involved.

6. The teacher should cover Classroom Ground Rules before implementing the Sexuality Education curriculum as it deals with personal and sensitive issues.

7. All pages are keyed as follows:

Single page number = Concept Lesson plan(s)	Example: 22
Support materials for Concept pages will be followed by sequential numbers	Example: 22.1
Support materials that are intended as student handouts will end in an H	Example: 22.1H
Support materials that are intended to be used as transparencies will end in a T	Example: 22.2T
Support materials that are teacher resources will end in an R	Example: 22.3R
Support materials that are Parent or Family Enrichment Activities will end in a P	Example: 22.4P

ORANGE COUNTY PUBLIC SCHOOLS
SEXUALITY EDUCATION
SCHOOL BOARD APPROVED CONCEPTS

Concepts are the same for designated grade levels, content is different.

ELEMENTARY K-1-2-3

I. PERSONAL DEVELOPMENT
- A. Socialization Skills
- B. Roles and Responsibilities of Family Members
- C. Abstinence (Decision Making)
- D. Handling Conflict
- E. Identifying Pressures of Society
- F. Drug Awareness
- G. Emotions and Feelings Caused by Body Changes

II. HUMAN BODY
- A. Knowledge of Human Body
- B. Awareness of Child Abuse
- C. Hygiene
- D. HIV/AIDS Awareness

ELEMENTARY 4-5

I. PERSONAL DEVELOPMENT/ SOCIALIZATION
- A. Roles and Responsibilities of Family Members
- B. Personal and Social Responsibilities
- C. Handling Conflict
- D. Dealing with Pressures of Society
- E. Dealing with Alcohol/Drug Abuse
- F. Dealing with Emotions and Feelings Caused by Body Changes

II. HUMAN BODY
- A. Hygiene
- B. Knowledge of Human Reproductive System
- C. Awareness of Child Abuse
- D. HIV/AIDS Prevention

III. TEENAGE PREGNANCY PREVENTIC
- A. Abstinence/Decision Making

SCHOOL BOARD APPROVED CONCEPTS

Concepts are the same for designated grade levels, content is different.

SECONDARY 6 & 8

I. PERSONAL DEVELOPMENT/ SOCIALIZATION
- A. Personal and Societal Standards
- B. Roles and Responsibilities of Family Members
- C. Handling Conflict/Decision Making
- D. Dealing with Pressures of Society
- E. Dealing with Alcohol/Drug Abuse

II. HUMAN BODY
- A. Knowledge of Human Body and Reproductive System
- B. Fertilization to Birth
- C. Dealing with Emotions and Feelings Caused by Body Changes
- D. Hygiene
- E. Child Abuse
- F. Sexual Abuse/Rape Awareness
- G. HIV/AIDS Prevention
- H. STD Prevention

III. TEENAGE PREGNANCY
- A. Preventing Teen Pregnancy
  1. Abstinence
  2. Contraception/Birth Control
- B. Teen Pregnancy Options
  1. Child Rearing
  2. Adoption
  3. Abortion

SECONDARY 7, 9-10

*I. PERSONAL DEVELOPMENT/ SOCIALIZATION
- A. Roles and Responsibilities of Family Members
- B. Personal and Community Standards
- C. Handling Conflict/Decision Making
- D Identifying Pressures of Society
- E. Dealing with Emotions and Feelings Caused by Body Changes
- F. Dealing with Alcohol and Drug Abus

*These concepts are a part of the 7th grade Health and 9th-10th g Life Management Skills comprehensive health/home economics curriculum. Teachers may integrate activities from the above concepts into the required units of instruction.

II. HUMAN SEXUALITY
- A. Knowledge of Human Reproductive System
- B. Hygiene
- C. HIV/AIDS Prevention
- D. STD Prevention

III. SEXUAL ABUSE
- A. Awareness of Child Abuse
- B. Rape Awareness

IV. TEENAGE PREGNANCY
- A. Preventing Teen Pregnancy
  1. Abstinence
  2. Contraception/Birth Control
- B. Teen Pregnancy Options
  1. Child Rearing
  2. Adoption
  3. Abortion

CURRICULUM GUIDELINES

The following guidelines were established by the Sex Education Committee to help provide clear, concise directives for sexuality educators. The committee membership included representatives from the clergy, students, parents, educators, county and state agencies and various community organizations.

1 Decision-making skills should be stressed at every level throughout the sexuality education curriculum.

2 A positive, proactive and practical message of abstinence from sexual activity before marriage should pervade the entire curriculum, especially at middle and high school levels. Strong curriculum emphasis on self-esteem should be the foundation of a convincing abstinence message.

3 The sexuality education curriculum should incorporate concepts for teaching abstinence that are practical and will equip the student with specific skills to reinforce the abstinence message.

4 In the context of family planning, contraception/birth control needs to be presented, but not to the extent that the abstinence message is diluted. Facts about contraceptives should be given along with the failure rates and consequences.

5 The demonstration or classroom circulation of contraceptives is prohibited from the sexuality education program.

6 Community societal standards such as: equality, honesty, promise keeping, respect, responsibility, self-control and social justice shall be integrated into the sexuality education curriculum.

7 Knowledge of the human reproductive system should be taught in a sensitive fashion with consideration for the developmental level of all students.

8 The curriculum's emphasis on abstinence should be reaffirmed in any discussion of teenage pregnancy options.

9 It is the position of the committee that the teen pregnancy options of child rearing, adoption and abortion should be presented in a factual manner, emphasizing that the options are, in fact, controversial and emotional. In addition, it should be emphasized that all these options would have an adverse impact on the pregnant teen, the father, their families, the child and society.

10 In K-3, HIV/AIDS should be taught in the context of health instruction on disease prevention with emphasis on transmission through blood contact with an infected person. Further development of the topic should begin in the fourth grade. Instruction in the causes, transmission, and prevention of HIV/AIDS and other sexually transmissible diseases shall be included in the 6-12 sexuality education curriculum.. Factual information about the use of condoms and their failure rates will be presented in the discussion of HIV/AIDS and sexually transmissible diseases with emphasis on abstinence as the only effective means of preventing these diseases.

11 As questions about homosexuality are asked by students in any portion of the sexuality education curriculum, homosexuality should be presented in a factual manner as it relates to the significant health risks associated with HIV/AIDS and other sexually transmitted diseases. Respect for all people shall be affirmed.

ENABL

"Education Now and Babies Later"

The Florida ENABL program is a multifaceted program of direct education, mass media, parental involvement and community support. The Florida Legislature mandated the program in the Spring of 1995. Local County Public Health Units in coordination with local School Districts and Community Agencies will implement the community based education component. The ENABL program has four major components:

- Community Based Direct Education. Provision of the **Postponing Sexual Involvement (PSI) for Preteens** curriculum with middle school-aged children.

- Statewide Media and Public Relations Campaign. The State Health Office in coordination with the Ounce of Prevention Fund will create and mount an advertising campaign reinforcing the Education Now and Babies Later theme while encouraging parental and community involvement.

- Evaluation of the program by process, outcome and impact evaluations. The State Health Office will coordinate an evaluation of the initial pilot site grants for ENABL programs. An extensive evaluation will assess the impact of the program on reducing teenage sexual activity.

- Training of local ENABL program staff, peer counselors, and community leaders. The State Health Office will coordinate a training program for the PSI teachers and peer counselors and provide technical assistance on ENABL.

The **Postponing Sexual Involvement** (PSI) curriculum developed by Dr. Marion Howard at Emory University has preteen and parent components. The PSI for Preteens is designed for the middle school (5th and 6th grade) students. PSI measurably reduces initiation of sexual activity and reduces teen pregnancy.

PSI consists of five one hour classes offered to teens by a trained teacher and trained peer counselors. Homework assignments are designed to involve parents. The curriculum develops communication skills. The curriculum enables youth to resist pressures to become sexually involved. Teaching methods include: videotapes, role-playing, class discussions, and group process.

PSI teaches communication skills helping children respond to the pressures from peers, media and society to engage in sexual activities. The curriculum mentions birth control, however, it does not teach how to use birth control methods. The emphasis is on why young people are having sex and how they might avoid it. The program dissuades children from sexual activity, teaches about the consequences of too early pregnancy and encourages responsible decision making.

Eleven (11) counties were selected through competitive bid process to pilot the ENABL program in Florida. About $260,000 in grants and $300,000 in-kind contributions provide the means for about 9,000 5th and 6th graders to take the PSI program. Five other counties are providing PSI training as in-kind participants in the Florida ENABL program.

Local Contact:

State Contact: Virginia Miller
Women's Health, Family Health Services
SunCom 278-2901 or (904)488-2901

Post-it® Fax Note 7671	Date 3/8/96	# of pages ▶ 12
To Debbie Fine	From Linda Sutherland	
Co./Dept. White House	Co. OCPS	
Phone #	Phone # 407-849-3231	
Fax # 202-456-7028	Fax # 407-849-3242	

APPENDIX V: RISK INDICATORS CHART

Directions: Complete the chart below with data on your county. Use the most recent data available. Report race when available. This data may be obtained from the following resources:

1. Florida Vital Statistics, 1993 or 1994, if available.
2. Quality Improvement Data Used for the County Public Health Unit Quality Improvement.
3. Key Facts About the Children: A Report on the Status of Florida's Children: Volume V: The 1994 Florida Kids Count Data Book.
4. Public Health Information Data Systems, 1994.
5. Family Planning Data Summary, June 12, 1995.

Indicators	Total	White	Nonwhite
LOW BIRTH WEIGHT - 1994			
Percent of Live Births	8.2%	6.6%	12.6%
TEENAGE PREGNANCY - 1994			
Number of birth mothers under 18 years old	731	380	351
Rate of births per 1,000 females under 18 years old	20	15	38
Percent of repeat teenage birth mothers aged 15-19	23.1%	NA	NA
POVERTY			
Number of children of mothers on AFDC (1994)	25,000	25.19%	74.81%
Children in poverty under 6 (# & %) (1994)	13,276	NA	NA
Children in poverty under 18 (# & %) (1994)	36,827	29.84%	66.96%
Median income of county	$30,352	NA	NA
Percent students on free/reduced lunch (Feb. 1994 districtwide)	37.8%	NA	NA
SCHOOL MEASURES			
Graduation rate (1994 districtwide)	77.8%	NA	NA
In-school suspensions (1994 districtwide)	F 6,375 M 14,313	2,193 5,542	4,182 8,771
Out-of-school suspensions (1994 districtwide)	F 5,616 M 17,467	1,537 5,902	4,079 11,565
CRIME AND DELINQUENCY			
Delinquency cases (received 1994)	9,901	4,952	4,861
Juvenile detentions	1,317	553	758
Transfers to adult court	325	146	179

ENABL

APPLICATION FOR PROGRAM DESIGN

FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

AND

DEPARTMENT OF EDUCATION

Funding to begin November 1, 1995. Subsequent funding for ENABL is contingent upon legislative appropriations and satisfactory program progress.

Name of County: Orange County

Summary:

Total In-Kind Contributions:	$ 11,079
Total amount requested from DHRS:	$ 11,079
Total Budget:	$ 22,158
Number of schools participating:	3
Total number of students in program:	965
Approximate cost per student:	$ 23

Send to:

HRS/Family Health Services, Family Planning Office, HSFHG
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

If delivering through a commercial parcel carrier, the street address is:

HRS/Family Health Services, Family Planning Office, HSFHG
2551 Executive Center Circle, West
214 Lafayette Building
Tallahassee, Florida 32301

It is the applicant's responsibility to ensure the receipt of the application by September 15, 1995, which is the due date for this proposal.

A. DESCRIPTION OF PROGRAM

Directions:

Please limit your submission of Section A to no more than five typed pages.

Address each of the following items by number. These pages will provide a summary of the project you propose. Failure to address any of the following issues will result in a lower score.

1. **Include a brief statement of the county's needs and how this project will address those needs (teenage pregnancy rates, births to girls under 15 years of age, HIV/AIDS transmission and reported cases among teens and young adults, teenage pregnancy programs, repeat teenage pregnancies, graduating students, cocaine babies, school dropouts, suspensions, juvenile arrests, juveniles in detention and other related high risk behaviors). Complete the Risk Indicators Chart making it a page of the final application. (See Appendix V: Risk Indicators Chart. The Family Planning Office will help you with the information needed for this page.)**

   Pregnancy among teenagers is considered very problematic because of its potential adverse health, economic, and psychosocial consequences. In Orange County, the birth rates to girls 14 and under have continued to climb since 1988, as have the non-white rates for 15- to 19-year olds. These statistics point to an immediate and urgent need for comprehensive prevention programs.

   Three middle schools in Orange County have been selected to participate in the ENABL program. These schools are located in areas with the highest teenage pregnancy rates, poorest maternal and child health outcomes, and the highest incidence of reported AIDS cases. They are: Carver Middle School (32805), Memorial Middle School (32805), and Robinswood Middle School (32818). The proposal targets sixth graders in these middle schools.

   Live births in Orange County totaled 11,932 in 1994. Of these, 1,737 were born to teens. Vital statistics analysis conducted for the Coalition by Healthy Beginnings at the University of South Florida (USF) College of Public Health indicated that the average birth rate for teenagers age 14 and under in Orange County from 1987 to 1990 was 2.0 per 1,000 females. The goal in the 1989 Florida State Health Plan was 1.5 per 1,000. The birth rates for teenagers in Orange County, ages 15 through 19, was 69.1 per 1,000, which is higher than the Coalition's Year 2000 goal of 40 per 1,000. The 1987 to 1990 average non-white birth rate was 128.2 per 1,000, which is significantly higher than the goal of 75 per 1,000 in the 1989 Florida State Health Plan.

   The Florida State Health Plan Standard for 1995 indicates that birth rates for teens aged 15-19 should not exceed 40 per 1,000 females. In zip code 32805 in 1993 this number was 141/1,000. The rates for the 32818 zip code were calculated with the rates of births in 34716 and 34787. These three zip codes had a rate of ~~30~~ 201/1,000.

   Since it usually takes 10-12 years after infection for a person to be diagnosed with AIDS, it is difficult to realize the impact of this infection among sexually active teens in the 13- to 19-year-old range. In 1993 HIV infection/AIDS was the leading cause of death among persons aged 25 to 44 years in Orange County. As of August 1995 there were 2,650 total AIDS cases reported in Orange County.

   There were two reported AIDS cases in Orange County among teens aged 13-19. There were 13 cases among young adults ages 20-24 and 56 cases among those ages 25-29. There were eight HIV positive mothers in Orange County who gave birth between 10/94 and 7/95; one of their babies was HIV positive. Considering the lengthy gap from time of infection to the onset of AIDS, and given that HIV infection is spreading fastest among heterosexual young people, these figures reveal the devastating effects of early onset intercourse.

According to HRS statistics, as of July 1995 there were 163 reported cases of babies born to cocaine-addicted mothers in Orange County. It is expected that there are actually 1,193 substance-exposed infants born each year.

Orange County reported 1,317 youths detained for delinquency in 1993-94. Of these, 46.6% were teens ages 10-15. Orange County is ranked fifth among the top seven counties with the most at-risk students according to a 1993-94 Safe and Drug-Free Schools Needs Assessment.

Zip code areas which encompass the highest risk neighborhoods in Orange County for poor maternal and child health outcomes were targeted by the Healthy Start Coalition. One of these geographical clusters surrounds the urban area of Parramore Street (32805 zip code). This cluster also includes two of the middle schools, Carver and Memorial, targeted to implement the ENABL program. The 32805 zip code had higher rates than the county average for teen pregnancy.

One of Parramore's census tracts, 106, had a teen pregnancy rate of 35%. The repeat teen pregnancy rate in this census tract is an astounding 46%. The Parramore area, located in the center of Orange County, is adjacent to the downtown Orlando Business District and has a population of 29,263 individuals. In 1993, residents there were 76.1% black, 20.0% white, and 3.9% Hispanic. The area includes two of the lowest income census tracts in the county ($7,237 and $11,029 annual income respectively), as well as working class areas where incomes range from $15,000-$20,000 per family. This area has the heaviest concentration of AFDC recipients in Orange County. Fifty-five percent of the population in this area is below the poverty level ($12,674 or less annually). Only 29% of the Parramore residents surveyed have a high school diploma.

Neighborhood	Zip Code	Census Tract(s)	Item	State Goal	County Rate	Zip Rate	Tract Rate
Parramore	32805	106	Birth to Teens	9%	9.40%	28%	35%
			Repeat Births to Teens	None	28%	39%	46%
			Late or No Prenatal Care	10%	23%	43%	44%
			Low Birth Weight	5%	7.80%	13.60%	18.40%

Another high-risk zip code area, West Pine Hills (zip code 32818), is located in the northwest quadrant of Orange County. It has a population of 30,491 individuals. Pine Hills population has traditionally been diverse. There are 24.3% black, 64.4% white and 11.3% Hispanic residents. The per capita income for Pine Hills is $14,570 compared to $16,094 for the county. The area has a heavy concentration of AFDC recipients. Census tract analysis of zip code areas 32818, 34787, 32781 indicated the teen pregnancy rate at ~~26~~ 201 per 1,000.

- CARVER MIDDLE SCHOOL—Located in the Orlando urban area in zip code 32805 . The enrollment is majority-minority (10.57% white, 84.58% black, 3.74 Hispanic, 1.10% other). Sixty-six percent of the students are on free or reduced lunch; 40% are bussed. The out-of-school suspension rate is 30% which is significantly higher than the state and district averages. In the last five years, reading scores have remained the same (25) and math scores have decreased from 23 to 21. Writing scores are below district and state averages. The school reported 1,161 incidents of disorderly conduct, crime and violence in 1994. The average daily attendance is below district and state averages.

- MEMORIAL MIDDLE SCHOOL—Located in the Orlando urban area in zip code 32805. The enrollment is majority-minority (15.67% white, 78.61% black, 5.26% Hispanic, .44% other). Seventy percent of the students are on free or reduced lunch; 45% are bussed. The out-of-school suspension rate is 26.4% which is significantly higher than the state and district averages. Reading scores have decreased in the last five years (36 to 27). Math scores have decreased from 30 to 15 in the past five years. Writing scores are below district and state averages. There were 1,073 reported incidents of disorderly conduct, crime and violence in 1994. The average daily attendance is below district and state averages.

- ROBINSWOOD MIDDLE SCHOOL—Located just outside the Orlando urban area in zip code 32818 and in the northwest quadrant of the county. The enrollment is majority-minority (23% white, 65% black, 3% Hispanic, 9% other). Fifty-two % of the students are on free or reduced lunch; 48% are bussed. The out-of-school suspension rate (28.8%) is significantly higher than the state and district averages. There was one expulsion in 1994. In the past five years reading scores have dropped from 42 to 33; math scores from 34 to 30. Writing scores are below district and state averages. There were 861 reported incidents of disorderly conduct, crime and violence in 1994. The average daily attendance is below district and state averages. The student population represents 35 countries, making it the most culturally diverse middle school in the county.

In conclusion, teen pregnancy is the direct result of not abstaining from sexual intercourse and initiating sexual relations early. Teens may adopt these behaviors in response to the psychosocial stresses and social norms that are pervasive in their communities. These behaviors are not being countered adequately by the positive support of their families, peers, others in their communities, and the media.

2. **Describe how the ENABL program will be implemented in the county to promote sexual abstinence and postpone sexual involvement among teens. Identify the agency whose staff will be employed to carry out the organizing, planning and teaching of the ENABL program. Indicate the number of students and schools that will be served by the project. Please indicate the grade level (5th or 6th grade) at which the ENABL program will be taught. Describe how the ENABL program will interface with any existing teen pregnancy prevention programs in your county.**

   The ENABL program will be implemented through the Human Sexuality Education program which is mandated as a component of the Comprehensive Health Education Bill, Florida Statute 233.067. This curriculum is taught in grades K-12 in all Orange County Public Schools. The instructional support teacher for Health/Human Sexuality at the district level will manage all aspects of the implementation as it relates to the school.

   The sixth grade students (total of 965) from three middle schools (Carver, Memorial, Robinswood) identified by specific needs assessments to be in "high risk" zip codes will receive the ENABL program through classroom instruction in science classes (Carver) and physical education classes (Robinswood and Memorial). The teachers and the three principals involved have previous experience in implementing materials relative to the human sexuality curriculum. There is already close communication and coordination between the schools and the district office as it relates to such curriculum.

   At this time the existing teen pregnancy prevention programs in Orange County are offered primarily in centers that provide after-school programs. The Orange County Teen Pregnancy Prevention Task Force is currently working to identify successful programs and to provide an official forum for the various agencies involved in teen pregnancy prevention to interface.

3. **Describe the selection process to be used for identifying teachers and peer counselors. Identify professional qualifications for PSI teachers (e.g., professional nurse, certified teacher, certified health educator, psychologist, social worker, etc.).**

   Teachers will be selected by the school principals with assistance from the instructional support teacher for Health/Human Sexuality from the district

office. They know well the benefit of choosing a qualified individual to teach lessons related to the human sexuality curriculum. There is ongoing assistance available through the district office. All teachers must be state certified to teach in Orange County, thus insuring professional integrity. Most physical education teachers and science teachers have experience in teaching health related issues. As the principals know, and the district realizes, it is paramount that the teachers selected to teach the PSI curriculum have an excellent rapport with students and parents. The three middle schools involved have strong peer mediation groups which will provide a representative pool of students who may be chosen as peer counselors for the PSI curriculum.

4. **Describe the referral system for children and families who request or need other health or social services, that may include, without limitation, primary health care, family planning, STD treatment, HIV counseling, HIV testing, referral for alcohol and drug abuse treatment, mental health services, housing assistance, transportation, and nutrition services.**

   Orange County has a strong base of community resources and an intact referral system to deal with children and families who have the need for or request various health services. The school system coordinates with many of these community and county agencies to ensure that needs are met to the greatest degree possible. The Orange CPHU can currently assist children and families with primary health care, family planning, STD treatment, HIV counseling and testing, and nutrition services. There are specific county agencies identified and used in referrals to deal with alcohol and drug abuse prevention, mental health services, housing assistance and transportation. In addition, all middle schools are staffed by a SAFE coordinator who is trained to provide assistance for children and families in crisis. There is a strong network of assistance throughout the county/community.

   Counselors and social workers have at their fingertips a state-of-the-art electronic referral system, the result of a collaborative effort among community workers. For those who cannot access the electronic system, there is a loose-leaf resource manual which is updated annually.

5. **Describe how the CPHU and school district will encourage the participation of community representatives in planning and operationalizing the ENABL program. Identify the community agencies with which you will be working.**

   The ENABL program will encourage the support and assistance of various community agencies such as the Healthy Start Coalition, the Orange County Teenage Pregnancy Prevention Task Force, the Orange County Citizens Commission for Children, the Orange County Tenants Association, the Orlando Housing Authority, PTA's, Ministerial Alliances, the Orange County Medical Association, Orlando Regional Health Care System, the Children's Home Society, Frontline Outreach, the Metropolitan Orlando Urban League, Allen Outreach, the District VII HIV/AIDS Prevention Community Planning Partnership Coalition, and local churches, teachers, and parents.

6. **Describe the strategies to reinforce and disseminate the ENABL message in the community, through involvement of parents, schools, churches, and other community groups and organizations.**

   The Postponing Sexual Involvement parent module will be purchased and available as a resource at each selected school, the Orange County Public Library and the Orange County Public Schools district office. Copies will also be available to lend out to committed assisting agencies. The curriculum will be promoted and advertised to familiarize parents and community members. This can best be done through the supporting community agencies as well as through media promotions via the TV, newspapers, and local radio stations. Any Statewide Media Campaign materials will be used as well. ENABL bookcovers, balloons, pencils, and T-shirts will be distributed to the students. Local convenience stores will be solicited to display posters with the "Education Now and Babies Later" message.

   Each school will also host a parent orientation event to allow parents to review and become familiar with the curriculum and program expectations.

7. **Describe the procedure for parents to exempt their child from the ENABL program. Enclose the written request form to opt out of the ENABL program.**

   Orange County has an intact system with opt-out forms for parents who do not want their child to participate in all/part of the Human Sexuality curriculum. These forms can be used or revised to include an outline of the ENABL program. It is not anticipated that parents will find objections to this curriculum. A copy of our current form (English and Spanish) is included. The PSI curriculum is intended to be considered as an additional resource to the existing curriculum. It can effectively be used to enhance instruction for already established objectives.

8. **Describe the capacity to match funds: One dollar ($1) cash or in-kind matching services is required for every one dollar ($1) provided by the grant. Provide letters of agreement from members of the community or other agencies making a commitment of time, dollars, services, goods or other in-kind contributions.**

   The school district will provide matching funds as follows:

Personnel

Substitutes to release teachers for training	$ 1,033
15% of instructional support teacher to coordinate project activities among schools	4,743
2% of 8 health teachers' classroom instruction	4,843
Indirect cost	460
	$11,079

The Orange County Public Health Unit will maintain documentation of services provided to students and will submit the quarterly reports of project activities. The OCPHU will coordinate the administration of customer satisfaction surveys of students, faculty, parents and community. They will assist in pre- and post-testing and any follow up requirements. The OCPHU will assist with communicating and coordinating with the applicable community members at large.

9. **Describe federal, private foundation, or other funding opportunities that you will explore to further develop and expand the ENABL program in your county.**

   The Orange County Public Health Unit (OCPHU) and Orange County Public Schools will continue to research and seek additional funding to expand the ENABL program into 7th and 8th grades in all middle schools in Orange County. It is anticipated that as the success of the program becomes known there will be additional financial support from the various community agencies who share an interest in the welfare of children and who support the philosophy of the ENABL campaign.

10. **Describe how you will assist the State Health Office identifying and linking up with media to publicize the purposes and goals of the ENABL program and to promote the Statewide Media Campaign.**

    Orange County Public Schools will provide the State Health Office with a complete listing of all television and radio stations operating and airing in Orange County. The list will include the name and addresses of the stations, the contact person for commercial advertising, and the contact person for public service advertising. Contacts for the local newspaper can be provided as well. If needed, translation services will also be sought from community agencies that deal with these issues. It is anticipated that there will be a donation of billboard space within the target zip code area. The bus lines will be invited to support the ENABL campaign through bus board advertising and contacts will be provided.

B. BUDGET

Directions:

For FY 1995-96 funding is anticipated to begin November 1, 1995. Budget narrative is required to justify expenses for a 12-month funding period. This section should be no longer than five pages.

Non-Allowable Costs:

The funding does not provide for physical space, rent , furniture, computers, telephones or capital outlay. Indirect costs are not allowed. Staff training expenses will be paid separately by the State Health Office in coordination with the Department of Education.

Allowable Costs:

Allowable costs include: Salaries and benefits, and expenses such as supplies, travel, contracts, costs for PSI curricula, supplies and materials for distribution during the educational sessions.

Parts of the Budget:

Part 1 Proposed Personnel Costs: This page should be used for personnel.

Part 2 Expenses: This page is to be used for expenses and contracted services.

Part 3 In-Kind Contributions: This page should be used to document all In-Kind contributions which are required for the dollar-for-dollar match as outlined in the ENABL legislation.

Part 4 Budget Narrative: This page should be used to describe and justify each item of the budget.

B. BUDGET: PART 1. PROPOSED PERSONNEL COSTS

Complete this section for personnel who are to be funded through this application. Round off all numbers to the dollar amount.

Personnel: Approximately 70% of the requested budget may be used for personnel (salaries or wages plus fringe benefits). The amount and type of personnel must be consistent with the program for which you are applying. Indicate if the positions are Career Service (CS) or Other Personnel Services (OPS). Note: 1 FTE=2,080 hours per year.

CS Personnel: 1995-96

CS Class/Title	FTE	Amount Required
	.....	.....
	Total CS	Subtotal

CS Fringe Benefits are calculated @ 35% of salaries _____

Total CS Salaries/Fringe _____

OPS Personnel: 1995-96

OPS Class/Title	FTE	Amount Required
Substitute Teachers		$ 960
Part-time Clerical		$ 420
	.....	.....
		$ 1,380
	Total OPS	Subtotal

OPS FICA @ 7.65% and retirement $ 179

Total OPS Salaries $ 1559

B. BUDGET: PART 2. EXPENSES

1995-96

Expenses:	Amount Requested
Travel. This is routine travel within the school district	$ 1,305
Supplies and Materials. These are supplies, such as PSI curriculum, office supplies, paper, pamphlets, videos, educational materials required by ENABL or the curriculum	$ 4,600
Printing, Photocopying and Postage	$ 1,150
Contracted Services	$ 1,700
Peer Counselors	$ 765
TOTAL EXPENSES:	$ 9,520
Budget Summary:	
Total CPHU Personnel Cost	$ 1,599
Total Expenses	$ 9,520
Total In-Kind Contributions	$11,079
Total Budget	$22,158
Total amount request from DHRS	$11,079
Total number of students in program	965
Approximate cost per student	$ 23

B. BUDGET: PART 3. IN-KIND CONTRIBUTIONS

Directions:

Itemize below the in-kind contributions which are supported by the attached letters of agreement.

Donor	Contributed Item(s)	Amount/Value
Orange County Public Schools	In-Kind Personnel	$10,619
Orange County Public Schools	Indirect Cost	$ 460
	TOTAL	$11,079

B. BUDGET: PART 4. BUDGET NARRATIVE

Directions:

The budget narrative should include a brief justification for each item in the budget. This narrative should reflect how the dollar amounts and the need for items requested were determined. Address each of the following by number.

1. **Describe a plan for the project coordinator to track all revenues and expenses related to the project by category. The project coordinator must be able to provide a report of these upon request. In addition, reports on all revenues and expenses connected with the project will be reviewed during Quality Improvement Visits and be part of the mandated quarterly reports.**

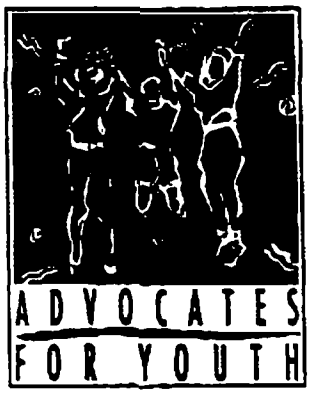
2. **Provide a description/justification for each line item. Justify staff personnel in terms of project activities that will require their specified knowledge, skills, and experience.**

3. **Report the anticipated cost per student in the project schools.**

1. The school district will establish a project account and a record of all project expenses will be maintained using the accounting system of the Florida Department of Education. The instructional support teacher will maintain a log of her time and the time spent by the involved eight classroom teachers to verify our in-kind personnel contributions.

2. See attached budget narrative.

3. The budget request and the in-kind contributions total $22,158. We anticipate serving 965 students at a cost of $23 per student.



Date: 6/4/96 **Time:** 3pm

To: Jennifer Klein

Company: White House

Fax: 456-2878

From: Susan Pagliaro

Pages: _____ **(including cover sheet)**

Hi Jennifer,

Enclosed is a Girls Inc. Program in Winter Haven which is about 30 minutes from Orlando.

Also, you mentioned that you had been in contact with Saxzone from the Orange County Healthy Start Coalition. If this has been unsuccessful, I tracked down these contacts:

Jackie Shuler or Linda Stone

407 - 740-6307

407 - 740-6777

Let me know if there's anything else I can do to help!

Susan

PLEASE PRINT

YES! I want to be an advocate for youth!

If you are interested in becoming an advocate for youth, you can join our Advocates Alert Network—an educational project to share information between the state and federal levels. The free Alerts are published on an as-needed basis and address legislative efforts around adolescentreproductive and sexual health.

NAME _____

TITLE _____

ORGANIZATION _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

Please send my alert by:

☐ FAX _____ (YOUR FAX NUMBER)

☐ ELECTRONIC MAIL _____ (YOUR E-MAIL ADDRESS)

☐ LETTER

Suite 200 1025 Vermont Avenue, NW Washington, DC 20005 USA 202.347.5700 202.347.2263 Fax

Girls Incorporated Preventing Adolescent Pregnancy®

Girls Incorporated Preventing Adolescent Pregnancy® is an effective and comprehensive program that gives girls the information, skills and confidence they need to avoid early pregnancy and plan full and satisfying lives. Four age appropriate curricula address the needs of girls ages 9 to 18. Together, these programs cover: developing parent-daughter communication, assertiveness skills and the ability to say "no," awareness of contraception and disease protection, and career and education planning. HIV/AIDS education is incorporated throughout each curriculum. Since 1989, over 66,000 girls across the nation have taken Preventing Adolescent Pregnancy workshops. Results from the evaluation report released in 1991 indicated that:

- Older teens who completed the program were half as likely to get pregnant as those who participated less or not at all and
- Younger teens who completed the program were twice as likely to postpone sexual intercourse.

Advocates for Youth
1996-1997 Pregnancy Prevention Program Survey

Name of program: GIRLS INCORPORATED OF WINTER HAVEN
Address: PO BOX 1913
WINTER HAVEN, FL 33883-1913

Phone: 941-967-2874 FAX: 941-967-2864 - CALL 1ST
Email: _____

Director of program/title: PEGGY SPILLANE, EXECUTIVE DIRECTOR
Contact person/title: MICKEY WRIGHT, PROGRAM DIRECTOR

Name of sponsoring agency: _____
Sponsoring agency
contact person/title: _____

Address: _____

Phone: _____ FAX: _____
Email: _____

Person completing form PEGGY SPILLANE

If you are **unable** to complete the enclosed questionnaire, please submit this completed form by **Wednesday, April 19, 1996**, to:

Susan Pagliaro
Pregnancy Prevention Program
Advocates for Youth
1025 Vermont Ave., NW, Suite 200
Washington, D.C. 20005
FAX: (202)347-2263

Please check if applicable:

- ☐ We do have programs relevant to this survey but we are unable to participate at this time.
- ☐ We do not have any adolescent programs related to adolescent sexual reproductive health.
- ☑ We wish to be included in Advocates for Youth's mailings.

1025 VERMONT AVENUE, N.W. SUITE 200
WASHINGTON, D.C. 20005 USA

ADVOCATES FOR YOUTH

202/347-5700
FAX 202/347-2263

Please check all that apply:

Primary Goal(s) of This Program

- ☑ Primary pregnancy prevention for adolescents (prevention of first pregnancy)
- ☐ Prevention of subsequent adolescent pregnancy
- ☑ Adolescent HIV/AIDS prevention education
- ☐ Adolescent HIV/AIDS treatment
- ☑ Adolescent STD prevention education
- ☐ Adolescent STD treatment
- ☑ Enhancement of the general health and well-being of adolescents
- Other:_____

Types of Services Offered by This Program	On Site	Referral
Child care	☑	☐
Contraceptive Access	☐	☑
Contraceptive Education	☐	☑
Cultural Awareness	☑	☐
Education/Tutoring Services	☑	☐
Eating Disorder Services	☐	☑
Family Counseling	☐	☑
HIV/AIDS Prevention Education	☑	☑
HIV/AIDS Screening	☐	☑
HIV/AIDS Treatment	☐	☑
Life Skills (Communication, Decision-making, Goal setting)	☑	☐
Mental Health Counseling	☐	☑
Mentoring	☑	☑
Nutrition Education	☑	☐
Parenting Education/Training for Adolescent Parents	☐	☑
Parenting Education/Training for Parents of Adolescents	☐	☑
Peer Education/Counseling	☑	☐
Pregnancy Options Counseling:		
Abortion	☐	☐
Adoption	☐	☐
Parenting	☐	☐
Pregnancy Options Services:		
Abortion	☐	☐
Adoption	☐	☐
Prenatal Care	☐	☐
Primary Health Care	☐	☑
Sexual Abuse Assessment	☐	☑
Sexual Abuse Counseling	☐	☑
Sexuality Education:		
Information on abstinence only	☑	☐
Information on abstinence and contraception	☐	☐
Sports/Recreation/Fitness	☑	☐
STD Prevention Education	☑	☐
STD Screening	☐	☑
STD Treatment	☐	☑
Substance Abuse Education (alcohol, drugs, tobacco)	☑	☐
Substance Abuse Counseling	☐	☑
Support Groups	☐	☑
Violence Prevention/Conflict Resolution	☑	☐
Vocational Employment/Placement	☐	☑
Vocational Training	☐	☑

Other:_____

Please return to: Advocates For Youth 1025 Vermont Avenue, NW, Suite 200 Washington, DC 20005 FAX:202/347-2263

Geographic Area Served by This Program (indicate largest area served)

☒ Neighborhood ☐ School ☐ School District ☐ Town/City ☑ County
☐ Multi-County ☐ State ☐ Regional ☐ National ☐ Country
☐ Multi-Country
Other:_____

Populations Targeted by This Program (check all primary audiences)

☑ Rural Youth ☑ Urban Youth ☑ Suburban Youth
☑ Youth From Low-Income Families ☑ Adolescent Females ☐ Adolescent Males
☐ Parenting Adolescents ☐ Extended Family ☐ Gay/Lesbian/Bisexual Youth
Specific Racial/Ethnic Group: ☐ Youth with Disabilities ☐ Youth in Treatment Facilities
☑ African American ☐ Out of School Youth ☐ Youth in Detention Centers
☑ Hispanic ☐ Street/Homeless/Runaway Youth
☐ Native American/Alaska Native
☑ Asian/Pacific Islander
☑ Caucasian
Other Populations Targeted by This Program:_____

Age of Participants in This Program

☑ 0-8 ☑ 9 ☑ 10 ☑ 11 ☑ 12 ☑ 13 ☑ 14 ☑ 15 ☑ 16 ☑ 17 ☑ 18 ☐ 19
☐ 20-24 ☐ >24

Program Delivery Site(s) (check all that apply)

☑ Elementary School ☐ Middle School ☐ High School/Secondary School
☑ Neighborhood Center ☐ Social Service Agency ☐ Health Center/Clinic
☐ Hospital ☐ HMO ☐ Place of Worship
☐ Recreational Facility ☐ College/University ☐ Subsidized Housing Development
☐ Detention Center ☐ Shelter ☐ Community Agency
☐ Family Planning Clinic ☐ Treatment Facility ☐ Military Base
☐ Home-based services ☐ Other:_____

Has This Program Been Professionally Evaluated? ☑ Yes ☐ No ☐ In Process
Name of Evaluator:_____ Address:_____
Affiliation: GIRLS INCORPORATED _____
Phone:(___)_____-_____ _____

List This Program's Three Primary Funding Sources

1. UNITED WAY OF CENTRAL FLORIDA
2. PUBLIX CHARITIES
3. PRIVATE DONATIONS

Please estimate the percentage of funding derived from public/private sources

U.W Public ☐ 10% ☐ 20% ☐ 30% ☑ 35% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Private ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☑ 65% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

DRAFT

Testimony of

Dr. Henry Foster

at

Subcommittee on Human Resources and

Intergovernmental Relations of the House Committee on Government

Reform and Oversight

"Preventing Teen Pregnancy in America:

Coordinating Community Efforts"

April 30, 1996

It is an honor to be here today to testify at this important hearing on preventing teen pregnancy.

For almost four decades, as a teacher, as a university leader, as a practicing obstetrician/gynecologist, I have dedicated my life to bringing healthy lives into this world -- and to helping people reach their full potential.

And I bring this commitment and enthusiasm to my new role as the President's Senior Advisor for Teen Pregnancy and Youth Issues and liaison to the National Campaign to Prevent Teen Pregnancy -- a recently-formed private-sector effort led by a diverse group of prominent Americans.

In my new role, I've enjoyed a number of great opportunities:

The opportunity to learn more about the Clinton Administration's comprehensive strategy to prevent teen pregnancy – which includes demonstration grants to communities, state-of-the-art research, and a strong prevention message from the top.

The opportunity to see first-hand innovative prevention strategies being developed at the grass-roots level, many of which have federal support.

And perhaps most uplifting, the opportunity to join the President in challenging all caring adults to listen to our young people, help them form positive goals, and give them the support to achieve them.

And make no mistake, that part includes helping our young people remain abstinent and postpone pregnancy until they are ready to care for both themselves and their children.

Why is teen pregnancy such a big problem?

Early sex and early pregnancy so often compounds problems already evident in the lives of these teenagers -- exposure to poverty, violence, drug use, HIV/AIDS, and so many other negative outcomes.

Because children born to teen parents are more likely to be poor,

... more likely to have serious health problems, ...

... more likely to drop out of school, ...

... and more likely to become teen parents themselves.

And because there is nothing more in the national self-interest than the protection and nurturing of children and our future leaders.

That's why I launched the "I Have a Future" program in Nashville, Tennessee back in 1986 -- and there's a lot we can learn from this effort to promote abstinence and reduce teen pregnancy.

The fact is, too many children today believe that their only hope is having babies.

We've got to replace that with a dream of hope and unlimited achievement.

That's the philosophy behind the "I Have a Future" program.

Our program is anchored in Nashville's public housing developments. The program emphasizes abstinence and involves all family members and the entire community.

Everybody from parents to politicians and from the clergy to business leaders has a role to play.

There are three parts to the program:

First, we equip young women and young men with the basic information they need about health, human sexuality, and drug and alcohol use so they understand the benefits of abstinence and the consequences of early sexual activity and other risky behaviors.

Second, we provide a comprehensive array of adolescent health services, with a focus on abstinence and academic achievement.

And third, and most important, we help young people enhance their life options through activities that improve their job skills, self-reliance, values and self-esteem.

For example, the youth entrepreneurial component of our program helps teenagers learn more about themselves and about the world of work by empowering them to start businesses in their communities.

We also take the time to understand the unique aspects of young peoples' lives, and to help them build up their self-esteem.

And the program is working.

This year, of the 24 program participants who are graduating from high school, 16 are going on to college, and four are joining the armed services. Eight of these college-bound students are African-American males.

It's a difficult process that takes time and requires lots of people -- but it does work.

This shows you what one community can do when it comes together and makes teenage well-being a real priority -- and I believe this kind of success is possible in every community.

But let me be clear: What works in Nashville may not work in Chicago or Charlotte.

It will be up to local communities to decide what's best for them.

I will continue to work with communities across the United States to help them develop their own successful programs that help young people avoid the pitfalls and instead achieve their greatest potential.

And make no mistake, as President Clinton has said, "We've got to ask our community leaders and all kinds of organizations to help us stop

our most serious social problem: the epidemic of teen pregnancies and births where there is no marriage."

There are no easy answers to this national tragedy.

... but we must have the courage to take on this tough battle

-- and the commitment to demand results.

Let's not forget, we have made some progress. The most recent figures show teen pregnancy and birth rates declining.

According to the Centers for Disease Control and Prevention, the birth rate for teens aged 15-19 declined 4 percent from 1991 to 1993.

The birth rate for teens aged 15-17 declined 2 percent from 1991 to 1992, and remained stable in 1993.

And teen pregnancy rates declined from 1991 to 1992 in 30 of the 41 reporting states.

But we still have a long way to go.

We must send a clear and consistent message to teenage boys and girls that they should abstain from sex.

But most important, we must give them reasons to want to postpone early sexual activity.

And we must expect them to succeed.

We've all must to come together to solve this problem. This hearing is the right step in the right direction.

Thank you.

THE CLINTON ADMINISTRATION RECORD ON REDUCING TEEN PREGNANCY

A Summary Report

President Clinton has called teen pregnancy one of the nation's most serious social problems, and reducing its incidence has been a key goal of this administration's policy for young people. All over the country Americans are beginning to address this and other issues by reasserting responsibility for themselves, their families and their communities, and they are starting to make a difference -- the teen pregnancy rate has come down two years in a row.

Although there has been progress, teenage pregnancy remains a profound problem, and we need to do more. Real solutions lie at the grassroots level, with families, communities and young people themselves. The federal government can help focus resources in support of work at the local level, and most important, it can help ensure that our policies support our national values. The Clinton Administration's policy on teen pregnancy, and on youth generally, have been built on two fundamental values:

> *Responsible Behavior*: Personal responsibility has been a central part of the President's message to young people, as he has urged them not to become parents before they are adults, have finished school, and are ready to support their children. He has supported policies that embody this principle, including abstinence-based curricula, welfare reforms that discourage early parenting and require young mothers to live at home and stay in school, and tough new child support enforcement provisions that drive home the responsibility of parenthood to young men.
>
> *Opportunities for Youth:* Teen pregnancy cannot be addressed in isolation from the wide range of other problems confronting youth, their families, their communities and their schools. Much of the Administration's social and economic agenda, ranging from education to crime prevention to empowerment zones, is designed to provide increased opportunities for young people and to give them something to say 'yes' to. If our youth do not have access to education, health services, jobs, or safe places to go after school and on weekends, they will not have a chance to make the right choices.

This summary report provides some facts about teen pregnancy in the United States and highlights some of the key components of Administration's teen pregnancy and youth agenda, including: (1) Research and Evaluation to learn more about the causes of teen pregnancy, (2) Community demonstrations to help communities try different approaches to learn what works, (3) Policies that promote responsible behavior among young people, and (4) Policies that provide young people with greater opportunities.

Recognizing that government cannot solve this problem alone, the President has called for a national private sector campaign to prevent teen pregnancy, and the administration has been working to catalyze such an effort. This report is not intended to address the status of private sector initiatives, nor does it provide a comprehensive description of all federal efforts directed at teens.

January 27, 1996

The Facts About Teen Pregnancy

A NATIONAL EPIDEMIC

- Every year, about 1 million American teenagers become pregnant -- that's approximately 11% of women ages 15-19.

- From the 1950s through the early 1980s, the rate of births to teens decreased steadily. However, in 1986, that trend reversed, and over the period 1986-91, the rate grew by 24%. Recent news has been somewhat positive: From 1991 to 1993, the national rate declined by 4%.

- As the teenage population grows, teen births are expected to increase. Even if the teen birth rate remains constant, the number of births is expected to jump 30% by the year 2010.

TREND TOWARDS OUT-OF-WEDLOCK CHILDBEARING

- In 1960, only 15% of teenage mothers were unmarried. As of 1993, 71% were unmarried.

INTERNATIONAL COMPARISONS

- The rate of births to teens in the United States is now twice as high as in the United Kingdom and six times as high as in France, Italy, and Denmark.

ROLE OF ADULT MALES

- A recent survey indicates that at least half the babies born to teenage women ages 15-17 are fathered by adult men ages 20 or older.

COSTS TO THE CHILDREN

- Children born to teens are more likely to die in their first year of life, to have lower cognitive achievement, to repeat a grade in school, to be victims of abuse and neglect, and to become teen parents themselves.

- 80% of children born to unwed teenage mothers who have not completed high school live in poverty. In contrast, of those children born to 20 year-old married parents who are high school graduates, only 8% live in poverty.

COSTS TO SOCIETY

- In 1990, slightly more than half of all mothers receiving Aid to Families and Dependent Children (AFDC) first had children as teenagers. And 43% of the long-term welfare recipients are women who gave birth at or before age 17.

- More than three-fourths of all unmarried teen mothers receive welfare (AFDC) at some point during the 5 years following the birth of their child.

Research and Evaluation:
Learning What Works to Prevent Teen Pregnancy

The Clinton Administration supports comprehensive approaches to research and evaluation with an emphasis on prevention of both first and repeat pregnancies. Working to understand teen populations and the many forces that influence behavior both in and outside of the home, monitoring and targeting new data, and evaluating old and new programs to learn more about what approaches may be most effective in lowering teen pregnancy rates in the United States are priority elements of our approach to research and evaluation. Following are some examples:

- Comprehensive Study: In June of 1995, the Department of Health and Human Services issued, "**Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood**," a two volume report containing a comprehensive and exhaustive review of the most recent research literature on teenage sexual behavior, pregnancy and parenthood and on effectiveness of teenage pregnancy prevention programs. This report was produced by Child Trends, Inc. with funding from the Department of Health and Human Services, and is now available on the Internet at http://aspe.os.dhhs.gov/hsp/cyphome.htm.

- State Data: In September 1995, HHS reported **state-level teenage pregnancy data** for 1991 and 1992. This marks the first time that HHS is able to report state-level teen pregnancy data. Updating trends on a state-by-state basis regularly provides more information for making effective policy decisions and enables us to see where we need to target our resources.

- Family Planning and Adolescent Family Life : HHS funds, as part of Family Planning and Adolescent Family Life programs, research projects and studies that focus on **adolescent sexual behavior.** Goals of these studies range from developing strategies to improve services to sexually active adolescents who are at-risk for contraceptive non-compliance and young women who visit family planning clinics, to learning more about: precursors and results of pregnancy and birth among adolescent males, the factors that influence teen attitudes toward sexual behavior, and the consequences for teen mothers who decide to parent as compared to those who place their children for adoption.

- New Mothers' Study: HHS funds The New Mothers' Study and has expanded its original scope to provide support for a 5-year follow-up to look at longer term outcomes, including employment and welfare dependency. *The Study focuses on research and analysis of a study in Memphis, Tennessee, where a sample of first-time, low-income, pregnant women received weekly visits from a nurse. Approximately 65% of the research sample were 18 or younger at enrollment. Early findings indicate that there were* ***significantly fewer repeat pregnancies*** *within two years following the birth of the child for those women who received home visits. It was originally started in 1988, and is also supported by other government agencies and private foundations.*

- Teenage Parent Demonstration: In order to gain further insight into the occurrence of repeat pregnancies, in 1993, HHS funded a 5-year follow-up evaluation of the Teenage Parent Demonstration, initially conducted from 1986 to 1991. This program targeted the high-risk population of teenage mothers on welfare, providing case management and support services such as education, training and child care. The follow-up evaluation continues to monitor these mothers and focuses on the occurrence of repeat pregnancies.

Reaching Into Our Communities And Promoting Partnerships to Prevent Teen Pregnancy

"I'm trying to do things that I believe will help our country meet the challenges we face today so that young people will have a better future. And it's obvious to me that.... unless young people have good, healthy, constructive lives at the grass-roots level, the things that I do will not succeed in getting you the future you deserve." **President Clinton; August 9, 1995**

The Clinton Administration encourages local governments and communities to pilot new and innovative demonstration efforts to prevent teenage pregnancy, and works with them to help make these programs a reality. The Administration has sponsored a range of approaches from abstinence-based education to service-oriented community collaborations. If a program proves effective, one goal of collaboration is to foster sustainability so that it can eventually operate without government assistance. Following are some examples of programs funded under the Clinton Administration:

- Adolescent Family Life Program: In September of 1995, HHS's Adolescent Family Life Program awarded 15 grants totaling $4.2 million dollars for comprehensive demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies. These programs feature innovative ways to **emphasize abstinence as the best way to prevent adolescent pregnancy** and to encourage the involvement of parents in these discussions with their children.

- Community Coalition Partnership Programs for Prevention of Teen Pregnancy: In September of 1995, Centers for Disease Control and Prevention launched the new Community Coalition Partnership Programs for Prevention of Teen Pregnancy by awarding 13 grants totalling $6.5 million over two years. These grants enable communities to develop plans for implementing and evaluating **community-wide interventions** that are innovative, comprehensive and sustainable. In addition, these demonstrations include an evaluation component.

- Healthy Schools/Healthy Communities: In 1994, the Administration started the new Healthy Schools/Healthy Communities program -- funding 27 **new school-based health centers** in 20 states and the District of Columbia. These centers provide for the health services and education needs of children and teenagers at high risk for poor health, teenage pregnancy, and other problems. A comprehensive evaluation of this program is currently being conducted.

- The Corporation for National Service: Created under the Clinton Administration in 1993, the Corporation for National Service supports over 50 teen pregnancy programs in 20 states across the country -- working both to **prevent teen pregnancy and to assist teen parents**. National service participants provide case management, mentor pregnant teens, sponsor health fairs, teach parenting skills to teen parents, make presentations on teen pregnancy prevention to school-age youth, help youth access health care, provide referrals to health care providers, and develop social supports for teen parents. *National service programs are operated with members of AmeriCorps, Learn and Serve America, and the National Senior Service Corps, who work collaboratively with school districts, universities, churches, health departments, national non-profits, and community-based organizations.*

- Healthy Start Program: HHS continues to support the Healthy Start Program, which has demonstration projects underway in 22 communities nationwide to **reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants and their families.** Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for them that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem. A comprehensive evaluation is ongoing and results are expected in 1997.

- The Home Visiting Services Demonstration: In September 1994, HHS launched this new grant program that is currently operating in three sites. Under the demonstration, paraprofessional home visitors provide first-time teenage parents on welfare with instruction and supportive guidance related to family planning, parenting skills, health care for themselves and their children, and child support. The visitors also facilitate the teenagers' participation in the required education and employment-related activities.

Promoting Personal Responsibility Among Young People

President Clinton has made personal responsibility a central part of his message to young people, urging young people not to get pregnant or father a child. Estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child. To prevent welfare dependency in the first place, teenagers must get the message that staying in school, postponing sexual activity, and preparing to work are the right things to do.

By supporting welfare reform that promotes work, demands responsibility, and toughens child support enforcement activities, President Clinton has sent a message that, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

Welfare Reform: The President supports welfare reform that sends a clear message to minor parents seeking assistance: to get help, you have to live with a responsible adult, you have to stay in school, and you have to prepare for work. Congress has endorsed the President's proposal requiring unmarried teen mothers to live at home and stay in school in order to qualify for assistance. Congress also supports the Administration's efforts to establish "Second Chance" homes, or adult-supervised group homes, as alternative living situations to help teen parents break the cycle of welfare dependency.

Strengthening Child Support Enforcement: In 1995, the Administration collected a record $11 billion in child support from non-custodial parents, an increase of 40% since 1992. From 1992 to 1995, paternity establishments have also risen by over 40%, to an estimated 735,000. This increase includes, for the first time, paternities established as part of the Clinton Administration's in-hospital paternity establishment program.

President Clinton proposed a comprehensive child support enforcement plan as part of his welfare reform legislation. The plan would streamline paternity establishment; require new hire reporting; make child support laws uniform across state lines; computerize state-wide collections to speed up payments; and require states to revoke drivers' and professional licenses to parents who refuse to pay child support. Both House and Senate have adopted these provisions--changes that should increase child support collections by $24 billion over the next 10 years. In addition, in 1995 President Clinton signed an Executive Order to crack down on Federal employees who owe child support.

State Welfare Reform Demonstrations: The Administration has approved state welfare reform demonstrations to a record 35 states that include various provisions affecting minor parents. Nineteen states have authority to implement provisions linking AFDC benefits to the school attendance of minor parents. Seven states have received waiver authority to require minor parents to live with their parents or guardians or in an adult-supervised setting. A comprehensive evaluation will be conducted for each of these demonstrations.

Teen Pregnancy Prevention As Part Of A Comprehensive Approach to Youth Policy

The Clinton Administration has worked to address the high rate of teen pregnancy by confronting the complex economic and social factors often behind these high rates. We have stressed the importance of investing in young people and in the communities where they live in order to offer them positive alternatives to early parenting and sexual behavior. Critical to this effort are Administration initiatives to invest in early childhood and adolescent development, to provide equal educational opportunities for our children and youth, to invest in distressed urban and rural communities, and to create more jobs.

Researchers have documented correlations between poor academic skills and early childbearing; high dropout rates, illiteracy, a history of physical and/or sexual abuse, and poor employment prospects are all risk factors for early childbearing. Research has also shown that the risk factors for teen pregnancy, violent behavior, delinquency, and drug use are similar and that comprehensive programs focused on changing behaviors related to alcohol, drugs and teen pregnancy -- such as focusing on raising self-esteem -- have an impact.

Following are examples of programs and initiatives in this area that the Administration supports:

LEARNING MORE ABOUT YOUTH AT-RISK

- National Adolescent Health Survey: Teens have been a significantly understudied sector of the population. In 1994, the National Institutes of Health began funding a new 5-year study known as Add Health, the first comprehensive study of the determinants of adolescent health. Using a national sample of 7th through 12th graders, Add Health examines the personal, familial, peer-related and community related influences on health behavior, taking a more **comprehensive look at the health of our nation's teenagers** in order to provide a better understanding of the complex forces that promote good health for our young people and those factors that put youth at risk.

- Preventing Youth Violence in Public Housing: This year, HUD and CDC have awarded a $550,000 grant to collect and develop information on youth violence prevention research. The intent is to disseminate existing information on successful programs to Indian and Public Housing authorities so that they can make more informed choices about prevention programs, which offer alternative services and activities for youth that can play a major role in preventing teen pregnancy as well.

- Comprehensive Strategy and Guide for Implementation: In December of 1993, the Department of Justice published a *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders,* following up with a *Guide* to implementing the *Comprehensive Strategy* in June of 1995. Studies on the causes and correlates of delinquency, which used large random samples of inner-city, high-risk youth in three sites, provided the research underpinnings for these publications. All three studies showed that **chronic violent delinquent offenders have higher rates of dropping out of school, gun ownership for protection, gun use, gang membership, teenage sexual activity, teenage parenthood, and early independence from their family**.

  Comprehensive Strategy and its *Guide* for implementation provide an alternative to increasing reliance on the criminal justice system by calling for the establishment of a **coordinated system of prevention** and graduated sanctions programs that provide a continuum of care for each child.

- Review for Practitioners: *Family Life, Delinquency, and Crime: A Policymaker's Guide--Research Summary*, was completed in May of 1994 by the Department of Justice. Its findings indicate that **family is one of the most powerful socializing forces for young people**, and can therefore seriously impact children's behavior.

- Parenting Initiative: The Department of Justice completed research work in 1993 under a grant to the University of Utah and the Pacific Institute for Research and Evaluation. This four-year major parenting initiative resulted in a document entitled *Effective Parenting Strategies for Families of High-Risk Youth (December 1993),* which identified a representative group of 25 programs as potentially the most promising. The research findings underscore the **importance of a family-focused approach to prevention and intervention of youthful problem behavior.**

EXPANDING OPPORTUNITIES FOR YOUTH AT-RISK

- SafeFutures: In September 1995, the Department of Justice created the SafeFutures Program, a five-year program which will provide approximately $8 million per year to six jurisdictions for a comprehensive and coordinated **delinquency prevention and intervention program for at-risk and delinquent youth.** Several programmatic components allow the four cities, one rural jurisdiction and one tribal government, to address teen pregnancy and receive support for specific counseling and education services. These include support for family strengthening activities, mentoring, specific services to at-risk and delinquent females, and general delinquency prevention activities.

- High Risk Youth Demonstration: HHS supports the High Risk Youth Demonstration program, which funds **innovative and effective model programs for preventing alcohol and drug use among high-risk youth**. One component of the program targets the specific needs of females from 12 to 20 whose use of substances often occurs with special factors (e.g. sexual abuse and domestic violence) that underlie or contribute to women's addictive problems. Every component of the program is evaluated.

- School Health Programs: The CDC has established a national framework to support school health programs that are locally determined and consistent with community values. Programs in all 50 states and 18 major cities are designed to help young people avoid those risk behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies. CDC's Youth Risk Surveillance System provides information about the prevalence of behaviors practiced by youth that put their health at risk, and states, cities, and CDC use this information to more effectively target and evaluate school health programs.

- Youth Development Initiative: Started in 1994 under the Departments of Veterans Affairs and Housing and Urban Development, the purpose of this initiative is to address the problem of violence in low-income communities by providing young people aged 13 to 25, with access to education and employment opportunities and supportive services. Offering these positive alternatives and services to youth to reduce violence are shown to be effective for affecting other teen behavior as well, such as sexual behavior that could lead to teen pregnancy.

- Youth Fair Chance: In July 1994, the Department of Labor implemented the Youth Fair Chance program, funding seventeen sites. Youth Fair Chance is a community-based program that targets money directly into **high poverty areas where youth problems are greatest**. Working in cooperation with local service providers, these sites use in- and out-of-school components to provide a variety of services that focus on youth problems, like teen pregnancy, unemployment, drug and gang involvement, and dropping out of school. Some of the sites utilize AmeriCorps volunteers.

- The Community Schools Youth Services and Supervision Grant: Through this new program established in 1994 under the Crime Bill, HHS provides matching grants to communities with significant poverty and juvenile delinquency for **after-school, weekend and summer recreation and education programs**. The program includes an evaluation component.

- Family Planning: In the face of strong opposition, the President has proposed budget increases for the federal Family Planning Program each year and successfully maintained the program. Among other reproductive health and education services, this program makes family planning information and contraception available to millions of women who might not otherwise get reproductive health care.

- 4-H Youth Development Program and Children, Youth and Families at Risk Initiative: The Department of Agriculture, through the Cooperative Extension System, funds these important initiatives serving young people. These programs work with communities to implement effective research-based programs which address a broad range of issues and needs, including teen pregnancy, child abuse, infant mortality, community crime and violence, and child care.

- Safe and Drug-Free School Act: Passed in 1994, this act responds to the continuing crisis of violence and drugs in our schools by **supporting comprehensive school-and community-based drug abuse and violence prevention programs**. Local school districts in high need areas are coordinating violence and drug prevention programs with comprehensive school health education programs.

- Comprehensive Services for Teenage Parents on Welfare: In 1994, HHS funded these grants, which supported development of programs providing **comprehensive services to meet the personal, physical and social needs of teenage parents**, as well as aiding the cognitive, physical and emotional development of their children. They were implemented in conjunction with mandatory participation requirements for education and employment-related activities.

LIFELONG LEARNING: INVESTING IN OUR YOUNG PEOPLE

> *"We can do all these things -- put our economic house in order, expand world trade, target the jobs of the future, guarantee equal opportunity -- but if we're honest, we'll admit that this strategy still cannot work unless we also give our people the education, training, and skills they need to seize the opportunities of tomorrow."* **President Clinton; January 25, 1994**

Under the Clinton Administration, the Department of Education has launched a number of initiatives that address teen pregnancy prevention through improved schooling for disadvantaged students, coordination of health and social services, and school-to-work opportunities to increase economic self-sufficiency. Drop-out prevention and drug-free schools and communities programs address risk factors that are the same or related to those leading to teen pregnancy.

Specific initiatives started or expanded include: **The Goals 2000: Educate America Act, Improving America's Schools Act, Title I Program**; **1994 School-To-Work Opportunities Act;** and **Head Start**.

EMPOWERING COMMUNITIES TO SOLVE PROBLEMS

The Clinton Administration has worked hard to encourage investment in distressed communities, to create jobs and to help these communities rebuild themselves by designing initiatives like the **Empowerment Zones and Enterprise Communities** and The **Community Development Banking and Financial Institutions Act.**