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POTUS on Teen Pregnancy

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- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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Tee Prey
Potus Statement

Background on the Clinton Administration's Approach to Sex Education

- The Administration believes that the content and structure of education programs dealing with sex, family planning, and other controversial topics must be determined by individual communities--in light of their values and beliefs.
- Today young people face many serious problems such as violence, drug abuse, sexually transmitted diseases including HIV infection, unintended pregnancy, school dropout, low literacy, and disrupted family and home situations. These require innovative solutions supported by all segments of society, including our health and education systems.
- Schools are the only public institution that can reach nearly all youth; therefore schools are in a unique position to improve not only the educational status but also the health status of young people throughout the nation.
- The federal government can play an important role in supporting the development and evaluation of various types of sexuality education programs, abstinence education programs, and programs focused on the prevention of adolescent pregnancy and sexually transmitted diseases.
- The federal government can support local efforts to find the right approaches for their own communities by making information on promising approaches available to them.

Examples of such support are:

Adolescent Family Life Program: Last year, 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 encourage the involvement of parents in these discussions with their children.

Family Planning: Family Planning funds clinics that provide contraceptive counseling, birth control, health services, information and education, which many tailor to adolescents' needs. We strongly supported this program and fought to preserve its funding in this year's budget.

School Health Program: Through the Centers for Disease Control and Prevention, the federal government provides approximately \$20 million to state education agencies in every state and to school districts in 18 of the largest cities to promote healthy behavior. These agencies use the money from CDC for a range of services, such as: to work on HIV prevention activities; to train teachers; to provide schools with guidance about curriculum development and implementation; and to monitor risk behaviors of youth. It is unclear how much of CDC's funding directly goes towards sex education, but it is estimated to be a small a portion.

In addition to funding, the School Health Program collects information and provides data and guidance to state agencies so that they can make effective programming decisions.

January 19, 1996



CDC

Centers for Disease Control and Prevention

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FACSIMILE TRANSMISSION

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FROM: Kay Sessions Golan
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Major NCCDPHP Activities, FY 1995, cont.

■ Comprehensive school health program

Building infrastructure for comprehensive school health programs; strengthening comprehensive school health education to prevent important health problems; youth risk behavior surveillance system; guidelines for tobacco use prevention, nutrition education, physical activity, and comprehensive school health education

■ Collaboration with managed care organizations

Bringing organized health care systems together with the public health community to develop methods for improving health status, supporting research that explores data and intervention opportunities available in health maintenance organizations and managed care providers

■ Preventive Health and Health Services Block Grant and Prevention Research Centers

Intervention programs to reduce incidence of chronic diseases; detection of hypertension and elevated cholesterol; education and risk reduction targeting smoking, exercise, and diet; university-based centers for prevention research and demonstration projects

**CDC PRESS OFFICE**

404-639-3286

October 26, 1995

Embargued until 4pm EST

Findings of the Centers for Disease Control and Prevention's (CDC) 1994 School Health Policies and Programs Study (SHPPS) were published in the October issue of the *Journal of School Health* and will be presented at the American School Health Association conference in Milwaukee on October 28, 1995, and at the American Public Health Association annual meeting in San Diego on October 30, 1995.

BACKGROUND

The School Health Policies and Programs Study (SHPPS) provides the first in-depth description of policies and programs related to multiple components of the school health program at the state, district, school, and classroom levels. Specifically, this 1994 study assessed health education, physical education, health services, food service, and health policies related to tobacco, alcohol, and other drug use and violence among all 50 state education agencies and the District of Columbia and nationally representative samples of school districts and schools.

SUMMARY OF FINDINGS

- o Support for school health programs at the state level is strong, as evidenced by the large numbers of states that employ directors of health education, physical education, health services, and food service.
- o In-service training is a critical state-level activity because many persons responsible for implementing the school health program at the school level lack formal training in their field.
- o School health policies and programs, particularly at the school level, may not adequately address several of the most serious public health problems that afflict young people today--i.e., violence, unintentional injuries such as motor vehicle crashes, and unintended pregnancies.
- o At the state, district, school, and classroom levels, a solid foundation from which to build more effective school health programs clearly has been established.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES/Public Health Service

FINDINGS BY COMPONENT

Health Education:

- o Every state and 55.1% of all districts have a person responsible for directing school health education.
- o 90.2% of all states and 90.8% of all districts require schools to offer health education.
- o 73.1% of all middle/junior high schools and 83.9% of all senior high schools require at least one health education course. 5.4% of all middle/junior and senior high school health education teachers majored in health education. 48.2% are state certified to teach health education.
- o Alcohol and other drug use prevention and HIV prevention are the only health education topics taught in more than 75% of all middle/junior high and senior high school health education classes.
- o Required health education is provided as a separate course in 46.9% of all middle/junior high and senior high schools and infused into other courses that do not focus predominantly on health topics (e.g., biology or home economics) in 53.1% of all middle/junior high and senior high schools.
- o Fewer health education topics are covered for fewer class periods in infused health education courses than in separate health education courses.

Physical Education:

- o 76.5% of all states and 51.4% of all districts have a person responsible for directing physical education.
- o 94.1% of all states and 95.0% of all districts require schools to offer physical education.
- o Many states, districts, and schools provide students with less exposure to physical education than called for in the national health objectives for the year 2000 or the National Physical Education Standards.
- o The activities most commonly included in physical education courses are more likely to be competitive team sports than lifetime activities.

Health Services:

- o 75.5% of all states and 74.1% of all districts have a person responsible for directing school health nurse services.
- o 52.9% of all states require schools to offer school health nurse services.
- o Health aides are employed in 76.0% of all states, but only 7.9% of these states require prior technical training.
- o 57.3% of all schools have the services of a registered nurse on at least a part-time basis.
- o 59.2% of all states fund school-based or school-linked clinics. At least one school-based or school-linked clinic exists in 11.6% of all districts.
- o A variety of school staff including teachers, secretaries, and nurses administer prescription medication and first aid to students.
- o 58.8% of all states require and 74.7% of all districts have a policy on HIV infection.
- o During the past two years, more states offered inservice training on HIV prevention and alcohol and other drug use prevention than on any other health services topic.
- o Condoms are made available to students in or through 4.7% of all middle/junior high and 8.4% of all senior high schools.

Food Service:

- o All states have a school food service director.
- o 15.7% of all states require districts to have a school food service director. 92.1% of all districts have one.
- o At the state level, support for implementation of food preparation techniques that support the DGAs is strong.
- o Meal preparation techniques reported by districts and schools demonstrate that many nutrition enhancing techniques are not practiced consistently.
- o Little coordination exists between the school cafeteria and classroom nutrition education.

Health Policies Prohibiting Tobacco, Alcohol, Other Drug Use, and Violence:

- o 64.0% of all states require districts and schools to have policies prohibiting tobacco use among students. 97.6% of all districts and 97.3% of all schools have written policies prohibiting tobacco use.
- o 90.2% of all states require districts and schools to have policies prohibiting alcohol and other drug use among students. 96.7% of all districts and 97.2% of all schools have written policies prohibiting alcohol and other drug use.
- o 40.0% of all states require districts and schools to have policies prohibiting violence among students. 91.0% of all districts and 90.7% of all schools have written policies prohibiting violence.
- o 54.7% of all middle/junior high and 77.0% of all senior high schools reported at least one incident during the past year in which a student was using tobacco.
- o 29.6% of all middle/junior high and 42.1% of all senior high schools reported at least one incident during the past year in which a student was in possession of alcohol and other drugs.
- o 51.5% of all middle/junior high and 49.0% of all senior high schools reported at least one incident during the past year in which a student was in possession of a weapon.
- o Most tobacco use, alcohol and other drug possession, and weapon possession incidents involved students who were firsttime offenders.

For more information: Contact Laura Kann, Ph.D., Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, (770) 488-5336. To set up an interview with Dr. Kann between October 26 and November 2, contact Kay Golan, CDC press Office, (404-639-3286.



FAX TRANSMISSION

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Office of the Secretary

DATE: January 19, 1996

TO: Ms. Debbie Fine

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1-19-96 1:41PM

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202 680 6247;# 2/ 2

To: Barbara Reynolds, CDC Press Office

From: Susan Woolley, DASH/NCCDPHP

Date: Jan. 18, 1996

Re: Funding sex education in schools

DASH provides approximately \$20 million to state education agencies (in every state) and to local education agencies (school districts) in 18 of the largest cities. We provide no funds directly to schools. The agencies that we fund use the money to work on HIV prevention activities to work on policy issues; to train teachers and other school staff; to provide schools with guidance about curriculum development, selection, and implementation; to monitor risk behaviors of youth; to determine what schools in the state are providing to students; to assess program activities; and to provide consultation to schools in their jurisdiction. Some agencies might use some of their funding to provide minigrants to schools on a competitive basis -- school would apply for those to strengthen their programs in some way. We do not know exactly how much of the money we provide directly funds sex education in schools, but it is a small portion. Local school programs are the responsibility of the schools. We (through those we fund) provide resources for schools that want technical or training assistance.

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Foreword

X The Centers for Disease Control and Prevention (CDC) is pleased to present the first report of the 1994 School Health Policies and Programs Study (SHPPS). This is the first study to examine multiple components of the school health program at the state, district, and school levels. Specifically, SHPPS assesses the current nationwide status of policies and programs for school-based health education, physical education, health services, food service, and health policies prohibiting tobacco use, alcohol and other drug use, and violence.

Today, our youth face many public health, educational, and social challenges not experienced at such epidemic levels by previous generations of young people. These challenges include violence, drug abuse, sexually transmitted diseases including HIV infection, unintended pregnancy, school dropout, low literacy, and disrupted family and home situations. These are serious challenges to our health and education systems and require innovative solutions supported by all segments of society.

Schools are the only public institution that can reach nearly all youth; therefore, schools are in a unique position to improve not only the educational status but also the health status of young people throughout the nation. The school health program can play a critical role in promoting healthy behaviors and enhancing academic performance.

National health objectives set forth by the Public Health Service in *Healthy People 2000* call for increasing the quantity and quality of various school health programs and their components. By identifying gaps that must be addressed to meet these objectives, this report furthers our understanding of opportunities to facilitate and barriers to the delivery of quality school health programs. Also, it reinforces the urgent need for the active support and involvement of public health officials, educators, communities, and families to strengthen existing, productive programs and create new ones that are innovative and effective. Supporting school health programs to improve the health status of our nation's youth has never been more important, and we all must be involved.

David Satcher, MD, PhD
Director

Centers for Disease Control and Prevention

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The School Health Policies and Programs Study (SHPPS): Rationale for a Nationwide Status Report on School Health Programs

Laura Kann, Janet L. Collins, Beth Collins Pateman, Meg Leavy Small, James G. Ross, Lloyd J. Kolbe

Only by knowing where we are can we determine where to go and how best to get there. This simple philosophy motivated the Centers for Disease Control and Prevention (CDC) to develop and implement the School Health Policies and Programs Study (SHPPS). This article describes the purpose and rationale for SHPPS in terms of the health status of youth and the role that schools and school health programs play in addressing the health-related needs of students.

HEALTH STATUS OF YOUTH

The leading causes of mortality, morbidity, and social problems among young people in the United States are caused largely by a relatively small number of preventable health problems. Among persons ages 5-24, almost three-quarters of all deaths are from motor vehicle crashes (30% of all deaths), other unintentional injuries (12%), homicide (19%), and suicide (11%).¹ Significant morbidity and social problems also result from these four causes, from the approximately 1 million pregnancies that occur annually among adolescents,² and from the more than 10 million cases of sexually transmitted diseases (STD) that occur each year among persons ages 15-29.³ Alcohol and other drug use are associated with much of the mortality and morbidity among youth. Alcohol use is a factor in about one-half of deaths associated with motor vehicle crashes, homicide, and suicide⁴ and it is associated with early initiation of sexual intercourse and with unintended pregnancy.⁵ Among adults ages 25 and older, two-thirds of all deaths and significant morbidity are from only three causes: heart disease (35%), cancer (25%), and stroke (7%).¹

Six categories of behaviors make a major contribution to the leading causes of mortality and morbidity that affect the nation:

- Behaviors, such as failure to use safety belts and weapon-carrying, that contribute to unintentional and intentional injuries,
- Tobacco use,
- Alcohol and other drug use,
- Sexual behaviors that contribute to unintended pregnancy and STD, including human immunodeficiency virus (HIV) infection,
- Unhealthy dietary behaviors, and
- Physical inactivity.

These behaviors often are established during youth, extend into adulthood, and are interrelated. They can have a

significant impact not only on health status, but on educational achievement and economic productivity. Results from the Youth Risk Behavior Surveillance System indicate that many high school students engage in these behaviors at unacceptably high levels.⁶ For example, in 1993, among high school students nationwide, 35% rode in the past 30 days with a driver who had been drinking alcohol, 22% carried a weapon during the past 30 days, 8% attempted suicide during the past year, 70% ever tried cigarettes, 81% ever drank alcohol, 33% ever used marijuana, 53% ever had sexual intercourse, 34% considered themselves overweight, and 34% did not participate in any vigorous physical activity during the past week.⁷

REACHING YOUTH THROUGH SCHOOLS

Schools have more influence on the lives of youth than any other social institution except the family. In the United States, for approximately 180 days per year, 48 million youth attend the almost 110,000 elementary and secondary schools for about six hours of classroom time per day. More than 95% of all those ages 5-17 are enrolled in school. Daily attendance averages 90%. During high school, national dropout rates average 12%; however, prior to high school, dropout is almost non-existent.^{8,10}

The goals of schools are consistent with the goals of health promotion. Because healthy children learn better than children with health problems, to achieve their education mission, schools must help address the health needs of students. Furthermore, the underlying responsibility of schools to prepare youth to lead productive lives makes health promotion a central facet of the education mission. While schools alone cannot be expected to address the health and related social problems of youth, they can provide, through their climate and curriculum, a focal point for efforts to reduce health risk behaviors and improve the health status of youth.

ROLE OF THE SCHOOL HEALTH PROGRAM

School health programs can be an efficient means to prevent health risk behaviors and the problems they cause. Many national organizations, federal agencies and communities, and individuals have indicated support for all or part of the school health program.¹¹⁻¹³

Traditionally, three components (health education, health services, and the health environment) have comprised the school health program. An expanded concept and commonly used description of a comprehensive school health program includes eight interactive components: health education, physical education and other physical activities, health services, food services, school counseling and social services, integrated school and community efforts, faculty and staff health promotion, and the school environment.¹⁴ Recently, the Institute of Medicine, Committee on Comprehensive School Health Programs

Laura Kann, PhD, Chief, Beth Collins Pateman, MPH, HSD, Health Educator; and Meg Leavy Small, PhD, Behavioral Scientist, Surveillance Research Section; and Janet L. Collins, PhD, Chief, Surveillance and Evaluation Research Branch; and Lloyd J. Kolbe, PhD, FASHA, Director, Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, MS-E33, Atlanta, GA 30341-3724; and James G. Ross, MS, Vice President, Macro International, 11783 Beltsville Drive, Calverton, MD 20705.

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adopted this provisional definition of a comprehensive school health program:²³

A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness.

The success of the school health program or any of its components in building health-related skills and reducing health-risk behaviors among students is dependent on numerous factors such as teacher and staff training, fidelity to the curriculum and program parameters, time allotted for instruction, quality of instructional materials, involvement of family members, administrative and community support, collaboration among program components, the overall comprehensiveness of the curriculum and program, and constructive evaluation activities.²⁴

Several federal programs have provided ongoing support for various components of the school health program. Congress authorized the National School Lunch Program in 1946²⁵ and the School Breakfast Program in 1975.²⁶ In 1977, the Child Nutrition Amendments to the School Lunch Act established the Nutrition Education and Training (NET) Program. The NET Program was designed "to teach children, through a positive daily lunchroom experience and appropriate classroom reinforcement, the value of a nutritionally balanced diet and to develop curricula and materials and train teachers and school food service personnel to carry out this task."²⁷ In 1994, the U.S. Dept. of Agriculture initiated the School Meals Initiative for Healthy Children, which called for children to "select and enjoy meals consistent with the Dietary Guidelines for Americans supported by an integrated approach, including partnerships with agriculture, food, media, education, and health communities."²⁸

Congress authorized the U.S. Dept. of Education to administer the Drug Free Schools and Community Act in 1986 to help schools develop, implement, disseminate, and evaluate educational strategies and programs for tobacco, alcohol, and other drug use.²⁹ In 1994, the program authority was extended to address school-related violence.³⁰

Since 1988, CDC has provided fiscal and technical assistance to state and local education agencies and national health and education organizations to improve HIV education in schools.³¹ In addition, since 1992, CDC has assisted 10 state education agencies to plan, implement, and evaluate effective school health programs to prevent tobacco use, dietary patterns that contribute to disease, sedentary lifestyle, and sexual behaviors that result in HIV infection and other STDs. Important activities at the state level have included coordination of state education agencies and state health agency programs, policies, and personnel related to the school health program, as well as improvement of school health education curricula and teacher training programs with special emphasis on nutrition, tobacco use, physical activity, and HIV and other STD prevention. To facilitate state and local implementation of school health

programs, CDC has developed, or is developing, guidelines for HIV education, tobacco prevention education, nutrition education, promotion of physical activity, and school health education.^{32,33}

Other evidence of federal support for school health programs was provided by the April 1994 publication of a Joint Statement on School Health by the Secretaries of Education and Health and Human Services.³⁴ This statement demonstrated unprecedented coordination between the two departments in support of school health programs and called upon the fields of health and education to work together on strengthening these programs nationwide.

The U.S. Depts. of Health and Human Services, Education, and Agriculture jointly have established a Federal Interagency Committee on School Health, which includes representatives of more than 30 federal agencies, and a National Coordinating Committee on School Health, which includes representatives from approximately 25 national nongovernmental organizations.³⁵ These groups meet regularly to coordinate school health activities and policies.

CURRENT DATA ON THE STATUS OF SCHOOL HEALTH PROGRAMS

Prior to SHPPS, information about the status of school health programs nationwide had been available from a variety of sources. For example, since 1974 the American School Health Association periodically has described state policies that support school health programs.³⁶ The National Children and Youth Fitness studies conducted from 1982 to 1987 described the status of physical education in grades 1-12 nationwide.³⁷ Since 1989, the National Association of State Boards of Education and the Council of Chief State School Officers have monitored policies for HIV education.³⁸ In 1990, the National School Boards Association and the American Association of School Administrators examined policies associated with health education and HIV education.³⁹ The 1992 School Nutrition Dietary Assessment provided extensive information about the food and nutrients provided in the National School Lunch Program and the School Breakfast Program.⁴⁰ While each study has been extremely informative, neither alone nor together do they provide a comprehensive assessment of school health programs nationwide.

PURPOSE OF SHPPS

SHPPS was designed to measure policies and programs at the state, district, school, and classroom levels across multiple components of the school health program. Specifically, SHPPS was designed to answer the following questions:

1. What is the current status of five components of the school health program (health education, physical education, health services, food service, and health policies prohibiting tobacco use, alcohol and other drug use, and violence) at the state, district, school, and classroom levels nationwide?
2. Who is responsible for delivering each component of the school health program? What collaboration occurs among components?
3. What is the relationship between state and district policies and school programs and services?

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4. What facilitates and prevents the delivery of quality school health programs?

The *Goals 2000 — Educate America Act*⁸ outlined an agenda for setting education priorities and activities throughout the 1990s. National Education Goal 7 states that "By the year 2000, every school in the United States will be free of drugs, violence, and the unauthorized presence of firearms and alcohol and will offer a disciplined environment conducive to learning." *Healthy People 2000*⁹ set a

similar agenda for public health priorities and activities via 300 measurable objectives. Of the 111 objectives that address adolescents, 14 can be attained directly by schools (Figure 1). SHPPS was designed to contribute to the assessment of National Education Goal 7 and to provide data relevant to 14 national health objectives. Prior to SHPPS, adequate data were not available to monitor some of these objectives.

LIMITATIONS

Although SHPPS provides a broad and relatively detailed view of school health programs, it is not exhaustive in either scope or depth. SHPPS provides limited information on counseling and social services, integrated school and community efforts, faculty and staff health promotion, and physical aspects of the school environment. SHPPS was not designed to explore the link between school health programs and students' health-related knowledge, beliefs, and behaviors; evaluate the impact or effectiveness of specific interventions or services; or assess students' perceptions of the programs and services available to them. Although the state and district levels of SHPPS measured policies and programs in grades K-12, the school and classroom levels of SHPPS focused only on middle/junior high schools and senior high schools. These decisions reflected resources available for the study and recognition of the infused nature of health education and physical education at the elementary school level, which would have required a significantly different sample design, methodology, and questionnaire approach.

CONCLUSION

Ultimately, the success of SHPPS will be determined by the degree to which it stimulates positive changes in school health programs nationwide. Hopefully, SHPPS also will stimulate research regarding how to foster the adoption and maintenance of school health programs that can have a positive impact on the health status of youth. ■

References

1. Kochanek KD, Hudson BL. Advance report of final mortality statistics, 1992. *Morbidity and Mortality Weekly Report*. 1995;43(5-8):1-74.
2. Hoffman SL. Teenage pregnancy and its resolution. In: Hofferth SL, Hayes CD, eds. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. Washington, DC: National Academy Press; 1987:174-206.
3. CDC. *Division of STD/HIV Prevention Annual Report, 1990*. Atlanta, GA: US Dept of Health and Human Services, Public Health Service; 1991.
4. Perrine M, Pack R, Bell I. Epidemiologic perspectives on drunk driving. In: *Surgeon General's Workshop on Drunk Driving: Background Papers*. Washington, DC: US Dept of Health and Human Services, Office of the Surgeon General; 1988:35-76.
5. Pullum KB, Pullum MT, Bowser BP, Cross SA. Risk of sexually transmitted disease among black adolescent crack users in Oakland and San Francisco, California. *JAMA*. 1990;263:831-835.
6. Kann L, Kolbe LJ, Collins JL, eds. Measuring the health behavior of adolescents: The Youth Risk Behavior Surveillance System and recent reports on high-risk adolescents. *Public Health Rep*. 1993;108(suppl 1):1-47.
7. Kann L, Warren CW, Harris WA, Collins JL, Douglas KA, et al. Youth risk behavior surveillance — United States, 1993. *MMWR*. 1995;44(SS-1):1-36.
8. National Center for Education Statistics. *Digest of Education Statistics, 1993*. Washington, DC: US Dept of Education, Office of Educational Research and Improvement; 1993.

Figure 1
Relevant National Health Objectives,
School Health Policies and Programs Study,
1994

- | | |
|--------|--|
| 1.8: | Increase to at least 80% the proportion of children and adolescents in grades 1-12 who participate in daily school physical education. |
| 1.9: | Increase to at least 60% the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities. |
| 2.17: | Increase to at least 90% the proportion of school lunch and breakfast programs and child care food services that are consistent with the nutrition principles in the Dietary Guidelines for Americans. |
| 3.18: | Increase to at least 75% the proportion of the nation's schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education. |
| 3.10: | Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education. |
| 4.18: | Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs (AOD), preferably as part of quality school health education. |
| 5.2: | Increase to at least 80% the proportion of people ages 10-18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs. |
| 7.18: | Increase to at least 60% the proportion of elementary and secondary schools that teach resolvable conflict resolution skills, preferably as a part of quality school health education. |
| 8.4: | Increase to at least 75% the proportion of the nation's elementary and secondary schools that provide planned and sequential K-12 quality school health education. |
| 9.18: | Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 90% of public school systems (K-12). |
| 13.12: | Increase to at least 80% the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow-up for necessary diagnosis, preventive, and treatment services. |
| 18.10: | Increase to at least 85% the proportion of schools that have age-appropriate HIV education curricula for students in grades 4-12, preferably as part of quality school health education. |
| 19.12: | Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education. |
| 20.11: | Increase immunization levels as follows: Basic immunization series among children in licensed child care facilities and kindergartens through post-secondary education institutions: at least 90%. |

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School Health Education

Janet L. Collins, Meg Leavy Small, Laura Kann,
Beth Collins Pateman, Robert S. Gold, Lloyd J. Kolbe

Health promotion has been included as one of the desired outcomes of formal education in the United States at least since 1918 when the Commission on the Reorganization of Secondary Schools/Education named health as the first of seven Cardinal Principles of Education.¹ Since that time, leading educational groups have called attention to the role of school health education in assuring the full and productive lives of citizens as well as contributing to attainment of other education goals.² In 1981, one of the most important policy statements supporting school health education was issued by an education task force representing the education commissions of the 50 states.³ According to the Education Commission of the States, school health education should be planned by both school and community; demonstrate scope, sequence, progression, and continuity; be planned for grades K-12; be taught by teachers trained and prepared in health education; be designed to develop critical thinking and individual responsibility for one's health; be structured to incorporate current and emerging health problems; be focused on the dynamic relationship between physical, mental, emotional, and social well-being; and be strengthened by integrating available community resources into classroom teaching.

In 1984, the National Professional School Health Education Organizations defined the following as some of the criteria for school health education: instruction intended to motivate health maintenance and promote wellness and not merely the prevention of disease or disability; activities designed to develop decision-making competencies related to health and health behavior; a planned, sequential pre-K to 12 curriculum based on students' needs and current and emerging health concepts and societal issues; opportunities for all students to develop and demonstrate health-related knowledge, attitudes, and practices; and integration of the physical, mental, emotional, and social dimensions of health as the basis for study of 10 topic areas — community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse.⁴

In 1990, the Centers for Disease Control and Prevention (CDC) prepared an interim operational definition which represented another step in the evolving process of defining school health education.⁵ According to this definition, elements of a school health education program include: 1) a documented, planned, and sequential program of health education for students in grades K-12, 2) a curriculum that

addresses and integrates education about a range of categorical health problems and issues, 3) activities to help young people develop the skills they will need to avoid behaviors that result in unintentional and intentional injuries; alcohol and other drug (AOD) use; tobacco use; sexual behaviors that result in human immunodeficiency virus (HIV) infection, other sexually transmitted diseases (STD), and unintended pregnancies; imprudent dietary patterns; and inadequate physical activity, 4) instruction provided for a prescribed amount of time at each grade level, 5) management and coordination in each school by an education professional trained to implement the program, 6) instruction from teachers who have been trained to teach the subject, 7) involvement of parents, health professionals, and other concerned community members, and 8) periodic evaluation, updating, and improvement.

In 1995, the Joint Committee on National Health Education Standards published seven standards detailing what students should know and be able to do in health education.⁶ The Standards are intended to serve as a framework for organizing health knowledge and skills into curricula at the state and local levels. In addition, performance indicators for grades four, eight, and 11 were provided for each Standard to help educators focus on the skills most essential to the development of health-literate students.

The importance of school health education in promoting the health of young people and contributing to the overall public health mission also is articulated in *Healthy People 2000* by nine national health objectives to be attained by the year 2000.⁷ Objective 8.4 calls for increasing to at least 75% the proportion of the nation's elementary and secondary schools that provide planned and sequential K-12 grade quality school health education. Eight additional objectives call for the delivery of specific categorical health education content through the schools:

- 2.19: Increase to at least 75% the proportion of the nation's schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education.
- 3.10: Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education.
- 4.13: Provide to children in all school districts and private schools primary and secondary school educational programs AOD, preferably as part of school health education.
- 5.8: Increase to at least 85% the proportion of people ages 10-18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs.

Meg Leavy Small, PhD, Behavioral Scientist; Beth Collins Pateman, MPH, MSD, Health Educator; and Laura Kann, PhD, Chief, Surveillance Research Section; and Janet L. Collins, PhD, Chief, Surveillance and Evaluation Research Branch; and Lloyd J. Kolbe, PhD, FASPA, Director, Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, NE, MS-K31, Atlanta, GA 30341-3724; and Robert S. Gold, DrPH, PhD, Vice-President, Macro International, 11785 Belleville Drive, Calverton, MD 20705.

- 7.16: Increase to at least 50% the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education.
- 9.18: Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50% of public school systems (K-12).
- 18.10: Increase to at least 95% the proportion of schools that have age-appropriate HIV education curricula for students in grades 4-12, preferably as part of quality school health education.
- 19.12: Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education.

SELECTED FEDERAL SUPPORT AND RELATED RESEARCH

Congress authorized the U.S. Dept. of Education to administer the Drug-Free Schools and Communities Act in 1986 to help schools develop, implement, disseminate, and evaluate educational strategies and programs for reducing AOD use.⁸ In 1994, the legislative authority was extended to address school-related violence.⁹ From 1989-1994, the U.S. Dept. of Education also funded demonstration projects in state and local education agencies, universities, national organizations, and other institutions to improve the training of elementary teachers and other school staff in school health education and to strengthen and expand school health education curricula for elementary school students.¹⁰

Since 1988, CDC has provided fiscal and technical assistance to state and local education agencies and national health and education organizations to improve HIV education in schools.¹¹ In addition, since 1992, CDC has assisted 10 state education agencies to plan, implement, and evaluate effective school health education to prevent tobacco use, dietary patterns that contribute to disease, sedentary

lifestyle, and sexual behaviors that result in HIV infection and other STD. To facilitate state and local implementation of school health programs, CDC has developed, or is developing, guidelines for HIV education,¹² tobacco prevention education,¹³ nutrition education, promotion of physical activity, and school health education.

Previous studies described the status of health education nationwide. *School Health in America: An Assessment of State Policies to Protect and Improve the Health of Students*, fifth edition, conducted most recently in 1989 by the American School Health Association, provided information about state-level support for school health education.¹⁴ State directors of health education provided information about health education requirements, organization and coordination of health education, teacher certification, and curriculum requirements.

Several other studies have focused on HIV education at the state, district, or local levels. Since 1987, the National Association of State Boards of Education and the Council of Chief State School Officers periodically have surveyed state-level efforts to provide HIV education in schools.¹⁵ In 1988, the Alan Guttmacher Institute conducted surveys among 4,200 secondary public school teachers, 162 of the nation's largest school districts, and all 51 state education agencies on education for the prevention of unplanned pregnancy and sexually transmitted diseases, including HIV infection.¹⁶ Special emphasis was placed on the content of instruction, the professional preparation of teachers, and perceived barriers to quality instruction. In 1990, the National School Boards Association and the American Association of School Administrators conducted a survey among a nationally representative sample of school districts to determine the nature and extent of HIV education and policies and practices that support HIV education.¹⁷ In addition, the study explored the extent to which school health education is required by school districts. In 1992, the Sex Information and Education Council of the U.S. surveyed all 51 state education agencies to assess the status of HIV education and analyzed 34 state-level HIV education curricula and guidelines.¹⁸ The School Health Policies and

Table 1
Percentage of All States and Districts Specifying How Health Education Must Be Offered,
by Type of Delivery and Grade Level,
School Health Policies and Programs Study, 1994

Type of delivery	% of all states specifying at each level			% of all districts specifying at each level		
	Elementary school	Middle or junior high school	Senior high school	Elementary school	Middle or junior high school	Senior high school
As a separate course devoted almost entirely to health topics	9.8	27.4	54.8	18.7	43.9	65.9
As a course split equally between health education and physical education	2.8	15.7	17.8	9.1	28.3	10.7
As lessons taught as part of the school curriculum	36.9	11.8	7.8	44.8	13.8	12.4
Not specified	68.7	47.1	17.8	18.8	10.6	1.4

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- inform and educate parents about healthy infant care practices. To elicit more data regarding the practice of healthy infant care, NCCDPHP has modified its Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaires to collect information regarding infant sleeping practices. The data from this survey will provide state- and race-specific information on infant sleep position in the United States for the 13 PRAMS states and the District of Columbia.

Preventing Teenage Pregnancy

NCCDPHP has applied public health methods to address the problem of teen pregnancy.

- In 1995, NCCDPHP awarded cooperative agreements to 13 communitywide coalition partnership programs in support of their work with youth to delay pregnancy and childbearing. The purpose of this program is to demonstrate that community coalitions can mobilize and organize community resources to support comprehensive, risk-specific, effective, and sustainable programs for the prevention of initial and repeat teen pregnancies. The programs aim to provide youth with significantly stronger incentives to remain abstinent and delay pregnancies and childbearing. For sexually active youth, these programs promote the consistent and effective use of contraceptives, and will ensure access to family planning counseling and services.
- In September of 1995, NCCDPHP published a report entitled "State-Specific Pregnancy and Birth Rates Among Teenagers—United States, 1991-1992." This report presented state-by-state pregnancy rates for teens ages <15, 15-17, 18-19, and 15-19. The study found that pregnancy rates for teens age 15-19 decreased significantly in 31 of 42 reporting areas from 1991 to 1992. Among states with significant decreases, the relative decrease was generally greater for abortion rates than for birth rates. Pregnancy rates were generally higher for older teens than for younger teens, higher for black teens than for white teens, and higher for Hispanic teens than for non-Hispanic teens.

Assessing School Health Policies and Programs

X
In 1995, results from the School Health Policies and Programs Study (SHPPS) were published in eight articles in the Journal of School Health. This study provides the first in-depth description of policies and programs related to multiple components of school health programs at the state,

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district, school, and classroom levels. Specifically, SHPPS assessed health education, physical education, health services, food service, and health policies related to tobacco, alcohol, and other drug use and violence among all 50 state education agencies, the District of Columbia, and nationally representative samples of 502 (82%) school districts and 766 (79%) schools. The results provide a blueprint of school health programs nationwide and allow NCCDPHP to monitor progress in implementing school health programs.

The National Youth Summit on HIV Prevention and Education

The National Youth Summit on HIV Prevention and Education was held on May 6-9, 1995, in Washington, D.C. One hundred and sixty young people, aged 15-19 years, from across the nation met to discuss the HIV epidemic, to consider which HIV prevention and education programs work, and to agree on a series of recommendations for themselves and the nation. This national summit was a collaborative effort of young people working together with private and public organizations in the fields of education, health, youth services and AIDS services. Participants developed seven core concepts "necessary to the promotion of accurate and inclusive HIV/AIDS prevention and education." These core concepts provided the foundation for five recommendations, one each for community-based organization, families and homes, the spiritual community, educators and parents, and the media. The summit was supported by NCCDPHP, in partnership with INSURE, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Elton John AIDS Foundation.

Sex Education

Decisions regarding the content and implementation of human sexuality education curricula are largely the responsibility of States and local communities. The Department of Health and Human Services (primarily within the Office of Population Affairs and the Centers for Disease Control and Prevention), has been instrumental in providing support for the development and evaluation of various types of sexuality education programs, abstinence education programs, and programs focused on the prevention of adolescent pregnancy and sexually transmitted diseases.

There is every reason to believe that comprehensive health education -- including sexuality education and access to contraceptive information and services for adolescents who need them will reduce disturbingly high rates of adolescent pregnancy and sexually transmitted diseases. Through Federal support for development and testing of such efforts, more information becomes available to local communities on promising approaches to human sexuality education. Within the Office of Population Affairs, some examples include:

- o Development of a program archive that collects and disseminates information about promising pregnancy and STD prevention programs. Nicknamed, "Projects in a Box," this effort will provide local communities with a complete package of materials necessary to replicate promising programs in their own communities.
- o The Adolescent Family Life Program supports prevention projects that are largely educational/informational efforts focusing on abstinence from adolescent sexual activity.
- o Title X Family Planning clinics provide contraceptive counseling, birth control, gynecological exams and pregnancy testing. Many clinics tailor their clinical, information and education, and counseling services to adolescents' needs.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: Janet

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: X 1/12

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule 2: ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

Julie: Ticker 1/12

12/28/95

Dear Ms. Rasco,

I am writing because our country is bogged down in an old fashioned backwards attitude about sex & sexually transmitted diseases & pregnancies especially in our young people. I am sure you're well aware that many people are against even mentioning or speaking about these ideas.

It's not out of mind out of sight any more
 Here in NY.C. our School Board
 Except for Brooklyn (where we come from) voted against demonstrations of Condemn use in the Public School system, we feel a very short sighted decision. These demonstrations are not done indiscriminately but by organizations such as Planned Parenthood. We also need Family Planning & Sex Ed. clinics & a Surgeon General maybe. C E Koop.

We need information BI-racially & BI-lingually. As our country is both
 There are many people in our country who can't

Speak AND READ ENGLISH well enough to
Receive This information + make informed
choices. We need TV to help out
much more often with Public Service

Announcements much earlier in the evening
when whole families are together not after

the 11 PM news when people are going to bed
+ are falling asleep. Teachers need to ask

questions of their parents + get information
+ they need it in school too. The announcements have to be
out with people of color + also white ⁱⁿ ASIAN
English + Spanish. A lot of people think

this disease ~~is~~ a gay white man's disease
+ ~~we're~~ ^{by not telling them the truth} ~~hiding~~ them. We know 2 families
a Jewish family (we're Jewish) and a black
family each had a child die from Aids.

It was very + is very terrible + sad -
These people will never recover their loss.

It's still very stigmatized. Sex education
isn't getting too far in this country either.

I've tried to speak to the schools in my
neighborhood about some more clinics + about
AIDS. They were not too interested about it.

We are drowning in these problems - Mr. Bennett
+ his group are trying to remove -

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. Letter	Helen Korchin to Carol Rasco [partial] (1 page)	12/28/1995	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11028

FOLDER TITLE:

POTUS on Teen Pregnancy

2010-1083-S

rc128

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

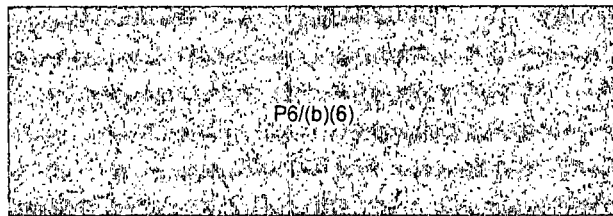
- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

new ideas from TV - and programs that
speak about these subjects. Our young people
need more programs & more people speaking out
not gagging our people & retreating into 50 yrs
ago. These days will never, never return
if they ever existed at all.

Please do something & get out
more information soon - in our mail or
TV or Radio, much more
frequently & in more various ways -
& not just once a week or less & only under
constant pressure & phone calls -

Sincerely, Yours -

Mrs Helen Rosch



[001a]

P.S.

We need, this age the electronic
age to get people closer together &
discuss all these problems - before
they get so far out of hand - we can't
do anything about it.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. envelope	envelope re: address [partial] (1 page)	12/28/1995	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11028

FOLDER TITLE:

POTUS on Teen Pregnancy

2010-1083-S

rc128

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

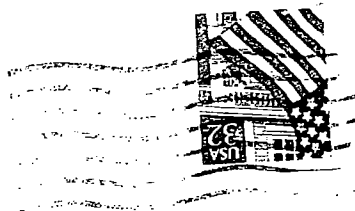
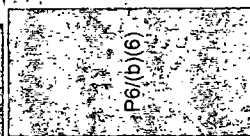
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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[9100]

4. Korchen



CAROL RASCO
ASST. Pres - DOMESTIC
Policy
The White House
WASH. DC
20500

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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002. letter	Carol Rasco to Helen Korchin [partial] (1 page)	02/13/1996	P6/b(6)
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Lyn Hogan
OA/Box Number: 11028

FOLDER TITLE:

POTUS on Teen Pregnancy

2010-1083-S

rc128

RESTRICTION CODES

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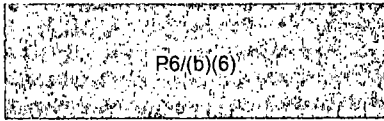
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February 13, 1996

Mrs. Helen Korchin



[002]

Dear Mrs. Korchin,

Thank you for your letter and for expressing your concerns on the importance of educating our children about all health issues, including the danger of sexually transmitted diseases and unintended pregnancy. Today young people face many serious problems and, as you mention, these require innovative solutions supported by all segments of society.

This Administration believes that the federal government can and must play an important role in supporting the development and evaluation of various types of sexuality education programs, abstinence education programs, and programs focused on the prevention of teen pregnancy and sexually transmitted diseases.

We can help, for example, by making information on promising approaches available to local communities so that they can make effective decisions. Some other examples of the kinds of support the federal government offers include: (1) grants for demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies; (2) Family Planning funds for clinics that provide contraceptive counseling, birth control, health services, and information; (3) a school health program for state education agencies that use federal funding for services that include work on HIV prevention activities and monitoring risk behaviors of youth; and (4) a new public service announcement campaign on AIDS prevention that specifically targets adolescents and young adults.

At the same time, I must underscore that we believe that the content and structure of education and other programs dealing with sex and family planning must be determined by individual communities--in light of their values and beliefs.

That is why I encourage you to continue being active on this issue. It is efforts and voices like yours that become critical for developing solutions that teach young people personal responsibility and that are right for your community.

Sincerely,

Carol Rasco
Assistant to the President for Domestic Policy

individuals at the community level. And we have tried to focus on that very sharply. So we've tried to bring down the size of the Federal bureaucracy but to increase the commitment of the Federal Government at the grassroots level so you could do what needs to be done.

You know, this is beginning to work. We know that for the first time in a long time, as I said, the crime rate is down. There is a greater responsibility ethic in the country. There's a stronger sense of family in the country. There's a stronger sense of community in the country.

In addition to the crime rate being down, you might be interested to know that over the last 3 years, the welfare rolls are down, the food stamp rolls are down, the teen pregnancy rate has come down 2 years in a row, and the poverty rate is down. Child support payments are up 40 percent, and the college and delinquency rate is down by 50 percent. There is a real sense that this country is coming back together around core values, and that's very important.

Having said that, we know that crime, welfare, poverty, violence, and drug abuse are still far too high. We know that random juvenile violence and casual juvenile drug use are both going up, even as the overall statistics seem to be getting better. There's still too many of our children out there raising themselves. There are too many kids out there who aren't a part of something

individuals at the community level. And we have tried to focus on that very sharply. So we've tried to bring down the size of the Federal bureaucracy but to increase the commitment of the Federal Government at the grassroots level so you could do what needs to be done.

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Public Papers of the Presidents

November 2, 1995

CITE: 31 Weekly Comp. Pres. Doc. 1972

LENGTH: 3050 words

HEADLINE: Remarks to the National Jewish Democratic Council

... back together as a people. In the last 3 years, compared with 3 years ago, the crime rate is down; the welfare rolls are down; the food stamp rolls are down; the poverty rate is down; the teen pregnancy rate is down; the infant mortality rate is at an all-time low; child support collections are up 40 percent; and the delinquency rate of young people on student loans has been cut in ...

Public Papers of the Presidents

October 30, 1995

CITE: 31 Weekly Comp. Pres. Doc. 1955

LENGTH: 4423 words

HEADLINE: Remarks to the White House Conference on Travel and Tourism

... living. In almost every State and significant community in America the crime rate is down, the murder rate is down, the welfare rolls are down, the food stamp rolls are down, the poverty rate is down, the teen pregnancy rate is down, and child support collections have increased 40 percent in the last 3 years. Our country is moving in the right direction and coming back together. That is a terribly important development.

Specifically with ...

Public Papers of the Presidents

October 20, 1995

CITE: 31 Weekly Comp. Pres. Doc. 1883

LENGTH: 3668 words

HEADLINE: Remarks at the Opening Session of the Midwest Economic Conference in Columbus, Ohio

... in the United States. We have -- a lot of people don't know this, but generally throughout the country, the crime rate is down, the welfare rolls are down, the food stamp rolls are down, the poverty rate is down, the teen pregnancy rate is down. Now, these problems are still very profound in our country, but the American people are reasserting responsibility for themselves, their families, their communities. They're moving this country in the right direction.

And I believe that the ...

businesses, the so-called misery index, the combination of unemployment and inflation, is at its lowest point in 25 years. We are moving in the right direction. And we see the American people coming back together and reasserting a sense of responsibility for themselves and their families and their communities, responsibility in a personal way. The welfare rolls are down; the food stamp rolls are down; the poverty rate is down; the crime rate is down; the teen pregnancy rate is down. And community service through things like AmeriCorps, the national service program, is up. This country is moving in the right direction.

We are facing a challenge today in Washington that is a very important one. We do need to balance the budget. When I became President, I was worried that the debt of this country was going to hang over your future like a dark cloud and make your future less than it ought to be. And in 3 years, we took the deficit from \$ 290 billion a year down to \$ 160 billion, the biggest drop in American history.

I want to balance the Federal budget. That is not the question. The question is, how shall we do it? What is the honorable way? What do we need to do? If you want the kind of future that I believe you do, we have to invest, as well as cut. We have to guarantee that we have enough to educate all of our people to the fullest of their abilities. We have to guarantee that we have enough to

And I believe our policies have played a role. I believe our welfare reform policies, I believe our crime bill, I believe a lot of the things we have done have played a role. But the American people are leading the way to bring the crime rate down. The welfare rolls are down. The food stamp rolls are down. The poverty rate is down. The teen pregnancy rate is down in America.

Now, they're all still too high, every one of them. But the point is that we are at least gaining on it for a change. And what we need to do is to keep gaining on it. There will be problems in this old world as long as people like you and me inhabit the planet because we're not perfect. But the issue is, are we gaining on it, are we getting closer every day to living by the values we believe in, to lifting up the potential of every person, to giving everybody the chance to be the kind of person that they ought to be? The answer is, we are. And what we ought to do is to continue that.

We still have some troubling problems. For example -- can you explain this -- drug use is down among young adults, but casual drug use is up among juveniles. The crime rate is down among young adults, but random crime is up among juveniles. Why? We're gaining on it, but there's still too many kids out there raising themselves. And we have to keep working on that.

Public Papers of the Presidents

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HEADLINE: Remarks to the Business Council in Williamsburg, Virginia

... all be somewhat hopeful there. The crime rate is down in almost every place in America. The murder rate is down. The welfare rolls are down. The food stamp rolls are down. The poverty rate is down. The teen pregnancy rate has gone down for 2 years in a row. Americans are reasserting their beliefs in old-fashioned personal, family, and community responsibility. And it is beginning to work.

Yes, we have some problems. We ...

You look at the teen pregnancy problem. People obviously have to make a decision not to do that. We can't make that decision for them. They have to make that decision and people have to be -- [applause] -- that's a matter of personal ethics and discipline and values. And we're just kidding ourselves if we pretend that there's some picture-pretty social program that will solve this.

On the other hand, when people do want to behave, they're entitled to a little help from their friends, from their Samaritans. If a young girl has a child and wants to get off welfare and wants to go to school or go to work, then there has to be some child care. So you need -- if you want to fight the crime problem, you've got to punish those who do wrong, but you also have to take these kids who are in severe, severely difficult circumstances, at great risk of doing wrong, and give them something to say yes to, something to be hopeful about.

You know, a couple of years ago when we passed the crime bill, which had the toughest punishments in history, we put more money into prevention programs than ever before. And the people who opposed us ridiculed us in the name of something called midnight basketball. As far as I know, nobody has ever been arrested playing midnight basketball for dealing dope on a basketball court with an adult supervisor there.

teen pregnancy in our country, for example, mean that an awful lot of kids who are born into poverty and never escape it, and an awful lot of parents who don't escape it because they don't have education and ...

... everybody in America knows what it is and knows how to take advantage of it.

Four, have tougher national standards for child support enforcement. Five, figure out who's been successful in preventing teen pregnancy and organize a national campaign to do the same thing in every community in the country. Six, build on what works to prevent drug abuse and drug use, and do it. Don't just talk about -- ...

... people need to know about it, not fewer. Not a single business has gone broke since we protected family and medical leave in 1993.

Tougher child support enforcement; prevent teen pregnancy; reduce drug abuse among young people; prevent teens from starting smoking; handgun and assault weapons, keep those bills in there on the Brady bill and the assault weapons bill, and pass the cop-killer bullet ban; raise the minimum wage; have a reform of the family ...

Public Papers of the Presidents

May 3, 1995

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HEADLINE: Remarks to the White House Conference on Aging

... on average, a longer work week.

We also have a new class of poor people, mostly unmarried, uneducated young women and their little children. We must do more to discourage the things that create poverty, especially teen pregnancy, and to require more education and efforts to enter the work force for those who are dependent upon welfare.

But the real problem facing this country is the problem of the middle class and stagnant earnings, and the insecurity of the American dream that ...