REMARKS BY: KEVIN **THURM**, DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
PLACE: NATIONAL **HISPANIC** MEDICAL ASSOCIATION, 2ND ANNUAL CONFERENCE, WASHINGTO
DATE: March 22, 1998

FEDERAL LEADERSHIP AND HISPANIC HEALTH CARE

I'm honored to join each of you this afternoon as you bring to a close this important conference on the future of **Hispanic** health care. I promise to follow FDR's proven secret of a successful speaker: Be sincere...Be brief...Be seated.

I can't think of a better way to begin than by commemorating one of Major League Baseball's greatest players and one of this country's greatest Latino-Americans -- Roberto Clemente. We've just marked the 25th anniversary of the day Roberto died tragically just one mile from his hometown in Carolina, Puerto Rico. He was on his way to help victims of earthquake-stricken Nicaragua, when his plane, loaded with relief supplies, crashed into the ocean. And while his on-the-field play was considered by many to be "absolute perfection," we must remember that he was so much more.

He was a wonderful father and husband, a cultural icon who took great pride in his Latino heritage and who always insisted on using his prestige to help those less fortunate than himself. Roberto Clemente was truly a citizen of the world, and a shining example of what is right about our country, not only for Latinos, but for all Americans.

America is, without question, a nation of many cultures coming from many directions, struggling to carve out our common destiny. And to succeed as a nation, the fundamental promises that we, as Americans, all cherish, must be available to all.

The promise of equality and opportunity, the promise of health and hope.

I myself come from a family of immigrants. Both of my grandfathers traveled from Eastern Europe to New York City. I've always felt very fortunate to have known them, to have been given their gift of culture and heritage, to have heard their stories - sometimes over and over and over again. They and their families came to this country the way that many immigrants come now, poor in material things, rich in spirit and possibility. They came eager to work, hungry for a better life for themselves and for their children.

That hunger and desire was, in turn, handed down to me, for I want nothing less than to give my two young sons the chance at a long and rewarding life. And that hunger and desire is no less important for Latino parents.

It doesn't matter whether they are recent immigrants, or whether they have called the U.S. home for generations; it doesn't matter whether their first language is English or Spanish. What matters is that they want what every American wants; they deserve what every American deserves: Health, hope and opportunity for their families - especially their children.

Creating the strategies and strengthening the partnerships necessary to accomplish this is what this conference has been all about. Like you, I take this very seriously.

And, frankly, it's why I -someone who is obviously not a Latino or a person of color - thought there was nothing more important than to address this gathering--to talk about some of the progress we have made together in improving the health of Latinos and other minorities, including the **Hispanic** Agenda for Action, and about what steps we must take together to ensure success far into the next century.

It is fitting that this conference coincides with the official beginning of spring, a time of looking forward with optimism. I, for one, look forward to another baseball season. I sometimes look at my job like baseball. There are lots of bases to cover. Batting .500 is considered phenomenal. And, like Yogi Berra once said about baseball: "Ninety percent of it's mental, the other half physical."

But most important, of course, spring is a season of rebirth and renewal, a time of promise and hope and good news. In fact, this nation has experienced something of a springtime when it comes to the overall health of our country.

I am proud to serve in an Administration that has committed itself to improving the health of all Americans. And that commitment is paying off.

Today, childhood immunizations rates are at an all-time high, infant mortality is at an all-time low, HIV and AIDS rates are falling for the first time in the history of the endemic. Just last week, the National Cancer Institute reported that overall incidence -- and death rates - for all cancers combined declined between 1990 and 1995. That reverses a 20-year trend. And more women than ever are having regular mammograms and clinical breast exams - and Medicare will now pay for mammograms for women 40 and over.

These trends tend to be true for all groups - even Latinos - which means we as a nation are living longer, healthier lives. But not every American shares equally in the good news about health.

There remains a distinct and persistent gap of health and disease rates between whites and non-whites. Simply put: Our nation suffers from unacceptable racial and ethnic health disparities.

I want to be clear: These health gaps should not be classified as a "Latino problem" or an "African American problem." It is not an "Asian American problem" or an "American Indian problem." It is an American problem.

It's an American problem when 30 % of all Latino children have no health insurance. It's an American problem when Latinos with mental health or substance abuse problems are less likely to have access to the services they need, in the language that they need, in the culturally competent setting they need.

It's an American problem when Latinos suffer stomach cancer 2 to 3 times the rate of whites, or when Latinas are more likely to die from cervical cancer than other women. And it's an American problem when Latinos, African Americans, Native Americans, and other minorities, are more likely to suffer and die from diabetes than the population at large.

We do not know all the reasons for these and other minority health disparities, although poverty is certainly a contributor. Inadequate education, lack of access to - or discrimination in - the delivery of health services, diet and cultural and linguistic differences may also be important factors.

But we do know we must act. We do know that we cannot treat the problem of health disparities as an unavoidable fact of life - a problem with no solution. We cannot -- as we have at times in the past -- set different national health goals for whites and minority groups.

The time has come to stop accepting racial health disparities with resignation - and to start fighting them with determination. Not only because it is morally right and just. But because eliminating the health disparities among different racial and ethnic groups will lead to better health for all Americans.

With the help of front-line leaders like you, that's exactly what this Administration is doing. Not only with words to spotlight the problem, but with action to solve the problem.

To help us get the word out, we've called on one of this nation's most respected physicians and public health leaders. I'm talking, of course, about Dr. David Satcher, our newly appointed Surgeon General. From raising public awareness about devastating diseases to helping free our children from the deadly grip of tobacco, Dr. Satcher is continuing to be an important voice of the department, an advocate for public health, who is reaching out not only to minority and underserved populations, but also to every American.

But as I said, we will need action too. From day one, both President Clinton and Secretary Shalala have committed themselves to doing just that, by standing up and holding themselves accountable for results, demanding real progress, and making changes that are systemic and cultural.

Just last month they unveiled the Administration's Race and Health Initiative - which addresses six critical health disparities among minority groups that must be eliminated by the year 2010. Now, for the first time in history, the federal government will establish universal national health goals, without setting separate, lower goals for minority communities.

Think about it: That's one set of goals for the entire country - for critical health areas like infant mortality, adult immunization, cancer screening and management, cardiovascular disease, diabetes, and HIV-AIDS infection rates.

As President Clinton said during the announcement, "America has the best health care system in the world. But we can't take full pride in that system until we know that every American has the best health care in the world."

We are also committed to making changes within the Department, changes that will help us reach out to minorities, including over 27 million of our Latino customers. I'm not talking about adding a program here or there. I'm talking about a top to bottom change in the way we do business.

At HHS, we knew from the start that we had to strengthen our service delivery to Latinos, as well as address the severe underrepresentation of Latino employees in the HHS workforce.

Over two years ago, Secretary Shalala called upon two of our senior officials, Dr. Jo Ivey Boufford, and Dr. Fernando Torres-Gil, to head up a working group made up of leaders throughout the Department. Their mandate was to come up with practical recommendations to help our Department better serve our Latino customers.

One year later, they delivered. They issued a comprehensive report that would become the **Hispanic** Agenda for Action. Since taking over the Steering Committee charged with implementing the Action plan, I've had the pleasure and honor of working closely with other dedicated public health leaders.

I'm talking about the HHS leaders some of you have met today, and many of you know well. Leaders like Dr. Nelba Chavez, Dr. Jose Cordero, Dr. Jo Ivey Boufford, Dr. Ruth Kirschtein, Dr. Clay Simpson, and

many others, including the distinguished NHMA president, Dr. Elena Rios.

And as you have already heard earlier today, under their watch, the **Hispanic** Agenda for Action is well underway and preparing HHS to better serve our Latino customers, not only for today and tomorrow, but also well into the next century.

How? By expanding our outreach to Latinos by using radio, television, and the information superhighway - and eliminating the language barriers that keep us from fully serving all of our customers. By improving our data about Latinos and increasing their involvement in every facet of research and clinical trials. By improving our support of **Hispanic** Serving Institutions and improving educational outcomes for Latinos.

I visited one of those institutions last summer - the University of Medicine and Dentistry of New Jersey - home of a model program called the **Hispanic** Center for Excellence. This program has been instrumental in recruiting many Latino high school students who have expressed an interest in pursuing a career in medicine.

Vigorous support for these and other model programs -- along with more internships and fellowships for Latinos within our Department - is especially important if we are to continue opening up pipelines of opportunity for future Latino doctors, scientists and researchers.

The fact is, the quality of tomorrow's decision makers will depend upon the decisions we make today - and our future institute and agency directors will come from the young scientists we nurture today. We can have both brilliant science and diversity. Both Nobel Prizes and diversity. And both excellence and diversity. They can - and should -- go hand in hand. They must go hand in hand. And, under our watch, they will go hand in hand.

In short, our **Hispanic** Agenda for Action has meant looking at everything we do, everything we fund, every public health campaign we develop, and asking ourselves: Are we ensuring that the best research, treatment and prevention in the world reaches all Americans?

So, are we headed in the right direction? Absolutely. But have we done enough? No, not by a long shot. Because if there's one thing we've learned over the last several years, it is that we can't reach the health outcomes we want without simultaneously addressing other socioeconomic factors that contribute to these pockets of need within our nation.

From poverty to geography, from education to access to care, we know that we need to address all the road blocks that stand between our Latino citizens and their ability to live long and healthy lives.

That's why improving the lives and the health of Latinos and Latino families is a part of everything that we do. And it happens in our Department and our Administration everyday. It happens when we balance the budget, when we raise the minimum wage, when we fight for working adults, for family friendly legislation - and especially, when we fight for children.

The balanced budget passed just last year, for example, included some special victories for Latino health. It contained an unprecedented $ 2 billion dollar commitment to fighting diabetes, a disease that, as you know, disproportionately affects Latinos and other people of color. And, it contained a $24 billion dollar commitment for our new Children's Health Initiative, the largest single investment in children's health in thirty years.

This is especially important for Latinos. We know that Latinos make up a disproportionate number of the

working poor in our country. They are the youngest population as a whole. And, they are the group most likely to be without insurance during the critical years of childhood.

Because of this new commitment, we will be able to fund individual state efforts to provide health care to as many as half of the 10 million uninsured children in our nation. Children whose families work hard, but are too poor to afford private insurance, not poor enough to be eligible for Medicaid, and, just poor enough to fall through the cracks.

To reach Latino children, in particular, we will enlist the help of everyone who comes into contact with them and their families: teachers and school nurses; Head Start centers and community health centers; churches, businesses and the media - both in English and Spanish - using approaches that are culturally sensitive and culturally relevant. And we're even encouraging states to use new and innovative ways to reach everyone, including putting the message about health insurance on everything from billboards to pizza boxes.

After all, as we all know, government will never meet the challenge of Latino health disparities - or any other challenge - alone. We know that we as a nation won't get to where we need to be without continued commitment and energy of leaders just like you.

That's why last year, HHS sponsored the first-ever National **Hispanic** Health Symposium in Los Angeles, bringing together Departmental officials and Latino leaders from across the nation to help us develop and refine our future plans for improving Latino health.

And that is why we will continue to work together to make sure children and adults are immunized, and find children who are eligible for Medicaid and the Children's Health Insurance Program; to encourage health screenings like mammograms and monitoring blood pressure; to spread the word that putting babies on their backs greatly reduces the risk of Sudden Infant Death Syndrome; to perform top quality data collection and research, while ensuring that minorities are fully represented in clinical trials; and perhaps most important, to recognize that this is not just a battle for our nation's health - it is a battle for our nation's future.

Because we must be - as the President has said many times - One America, a goal that we cannot reach unless millions of Latinos, African Americans, Native Americans, Asian Americans have the chance to bask in the springtime of a long and healthy life.

I want to be clear: Like you, I am personally committed to fostering and strengthening partnerships among government agencies and the private sector. To making sure that front-line leaders like you have the support and tools you need to create effective strategies that are culturally and linguistically appropriate.

When I walk away from this gathering today and return to my office, I will continue to devote myself to working with you - and holding myself accountable to you -- as we move together toward achieving success.

I'd like to conclude, as I began, with a story about Roberto Clemente. During his long career with the Pittsburgh Pirates, Roberto's talents were often overlooked outside of Pittsburgh and the Latino community. That changed in the 1971 World Series, when he finally got his chance to show the nation the level of excellence that he demanded from himself game after game. Over the course of the series, Roberto's thrilling hits, impossible catches, and astonishing throws almost single-handedly assured the Pittsburgh Pirates victory over the heavily favored Baltimore Orioles.

In accepting the Most Valuable Player Award, Roberto looked straight at the television camera and said: "I want everyone in the world to know that this is the way I play all the time. All season, every season."

That same passion and commitment to excellence must be present - in both government and the private sector -- if we are to reach the day when every American receives the health care they want and deserve. So as you conclude the conference later today, I urge you to continue to stand up and speak out with a strong voice that like America, is many, yet one.

A strong voice that demands both excellence and results. Every day, all year long. Because you are being heard. By me. By the Secretary. By our Senior Colleagues in the Department who are here today. And by the President.

Keep our feet to the fire. Hold us accountable. For the progress we make in HHS. And the progress the department makes for Latinos and their families and communities throughout the country.

Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Donna E. Shalala

U.S. Secretary of Health and Human Services

Announcement of the Initiative

"Hispanic Agenda for Action:

Improving Services to Hispanic Americans"

Hispanic Heritage Month Celebration

Rockville, Maryland

September 19, 1996

(Note: The text is the basis of the Secretary's oral remarks and should be used with the understanding that some materials may be added or omitted during presentation.)

Every year during Hispanic Heritage Month, we celebrate the great contributions that Latinos have made to our country. We celebrate the legacy and courage of Cesar Chavez and his United Farmerworkers Union. We celebrate Willie Velasquez and his politics of justice, passion, and commitment. And, we celebrate the spirit of family and faith found in the works of Rudolfo Anaya.

We celebrate the great names, the great legacies and the great battles fought -- and won -- for all of us.

Hispanic Heritage Month is a time for remembering a heroic past, but it is also a time for greeting the new sunrise, getting on with a new day, and building a new tomorrow. That's why today, I have a challenge. It is a challenge worthy of Hispanic history, and critical for the future of Hispanic children. I challenge you to think of Latino heroes, not just as people who live within our memories, but people who live within our midst.

I am talking about leaders like Secretary Cisneros and Antonia Pantoja. But, I'm also talking about the people whose names we do not know. I am talking about Latino doctors and social workers. I am talking about Latino field workers and small business owners. I am talking about hardworking mothers and fathers who fight every day to make a decent living, to keep their families together, and to find -- and live -- the American dream.

These are my Latino heroes. And, they are our future. Where are these heroes? We serve them in this Department every day. And we work with many of them every day.

When the President came to office, he promised us an administration that looked like America -- and he

has delivered. We have the most diverse Administration in history.

At HHS, we have been fortunate enough to fill our top posts with extraordinary Latino Appointees. You all know who they are: leaders like Dr. Sumaya, Dr. Chavez, and Dr. Torres-Gil (who served us well at HHS before returning to UCLA). In fact, at the end of the last fiscal year, eight percent of our non-career, executive level appointees at HHS were Latino.

That's a good track record, and I am proud of it. But clearly it is not enough.

We can not rest until Latinos are well represented throughout our Department and at every decision making table. But our commitment -- and your commitment -- is about more than just the appointments we make or the jobs that we fill. It's about how we confront the issues that affect Latinos through out our nation.

I am proud to serve with a President who "gets it" when it comes to fundamental issues of equal justice and opportunity. When people were lining up to trash affirmative action, this President stood up and said "Yes", we must mend the system, but we should not end our commitment of equal opportunity for women and minorities. We should not do it.

When people were climbing on the bandwagon to close the door of public education for undocumented children, the President said No that's wrong, we should not do it.

And, let me be clear: this President and this Secretary, with your help will come back to fix what is wrong with the Welfare Bill, to overturn the wrong-headed provisions on food stamps and legal immigrants that have nothing to do with Welfare Reform.

For our Department and our future, there is nothing we can do that's more important right now than protecting Latino children. We know that Latino children are now the largest group of minority children in this country. We know that Latino families are this Department's fastest growing customer base. And, we know that the greatest gifts that we can give Latino families -- indeed all families -- are the tools and opportunities they need to succeed at work and at home.

And, that's exactly what we are doing.

Because when we fight for better, stronger Head Start, when we fight for Migrant Head Start, when we fight for Early Head Start, we are fighting for Latino families. When we fight for an historic tobacco initiative to kick Joe Camel out of the lives of our children, we are fighting for Latino families. When we fight to maintain vital funding for refugee resettlement and for immigration policies that reunite families, protect refugees andvalue the critical role that immigrants play in the multicultural tapestry of America, we are fighting for Latino families.

Under the leadership of Dr. Sumaya, when we fight to link health profession schools with Latino students to give these young people the opportunities they need to succeed as health care professionals, we are fighting for Latino families. When we fight for the most comprehensive immunization initiative in history to raise rates and keep them there, we are fighting for Latino families.

When we fight to ensure that health insurance is there for you when you change jobs or get sick, we are fighting for Latino families. When we fight -- and win -- our battle to raise the minimum wage and make it a living wage, we are fighting for Latino families.

These are very important accomplishments. But we need to do more.

That's why, today I am announcing an important new initiative. Last year, I called upon Jo Ivey Boufford and Fernando Torres-Gil to head up a Working Group made up of leaders from throughout the Department -- including the Hispanic Employees Organization. I asked them to come up with practical recommendations about how we can better serve our Hispanic customers.

And, they have done it.

They have now issued a comprehensive report -- a blueprint for action -- and they told it to us straight: They told us we need to expand our outreach to Latinos through every means available -- radio, television, the information superhighway --and to eliminate the language barriers that keep us from fully serving all of our customers.

They told us we need to increase our support for Hispanic Serving Institutions and help improve educational outcomes for Latinos.

They told us we need to improve our data collection on Latinos and increase their involvement in every facet of research and clinical trials.

They told us we need to focus on meeting the specific health needs of Latinos as outlined in the "**TODOS**" Surgeon General's report.

And they told us that to accomplish all of this -- to improve the service we offer to Latino customers -- we must notonly mentor and recruit new Latino employees, we must make sure that Latinos are a part of everything that we do.

Let me be clear: this is not a report that will sit around and collect dust. I fully accept all of the recommendations.

That's why I have already asked the leadership of each of our operating and staff divisions to develop by October 28, a plan to meet the goals layed out in the report. And, that's why today, I am appointing a new steering committee, headed by our new Deputy Secretary Kevin Thurm, that will be charged with the task of overseeing the implemention of these recommendations by the leadership of your op-divs and staff divs who have to make it happen.

And, there is no time to waste.

The problems that confront the federal government's service to Latinos are historic -- some are systemic -- but none are insurmountable. But we will never meet these challenges working alone. To meet the task at hand, this Steering Committee will need all of our support, all of our hands, all of our hearts.

In Spanish they often say that "What is promised, is owed."

Today, I have made a couple of promises to you, but let me remind you that all of us make up this Department, and all of us need to make a promise to do our part and make it stronger. I can think of no more fitting way to commemorate Hispanic Heritage Month or Hispanic heroes.

And, I can think of no more fitting way to not only celebrate our past, but also to prepare for our collective future -- a future we are starting here today.

Let's get to it.

Thank you.

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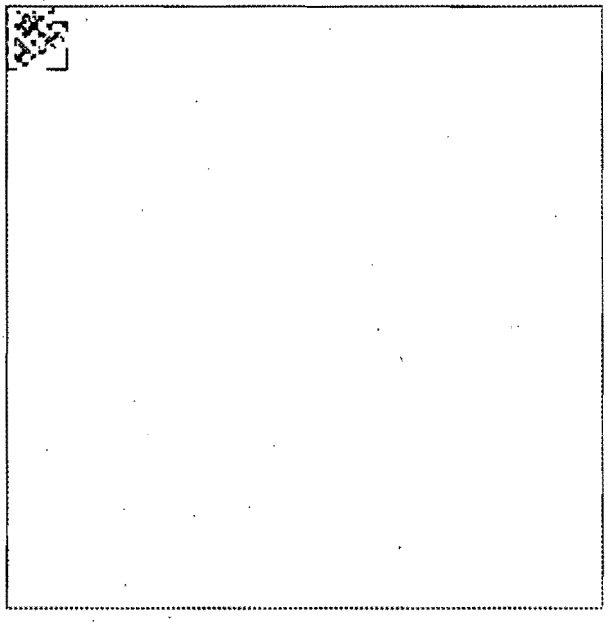
Last revised Monday, April 26, 1999
Comments/Suggestions to WebJefe Carl Montoya

DEPARTMENT OF HEALTH & HUMAN SERVICES

"Hispanic Agenda For Action: Improving Services To Hispanic Americans"

A One Year Progress Report



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Executive Summary

In the Fall of 1996, Secretary Shalala launched the "The Department of Health and Human Services' Hispanic Agenda for Action: Improving Services to Hispanic Americans." This initiative was based on the recommendations made by the Departmental Working Group on Hispanic Issues to strengthen the Department's efforts to improve service delivery to over 27 million Hispanic customers, and address the severe underrepresentation of Hispanic employees in the HHS workforce. The HHS Hispanic Agenda for Action Initiative (HAA) focuses on a broad range of issues relating to employment, customer services, educational support, health status and access, data and research, and procurement.

Annual Progress Report

During the past year, under the leadership of the Deputy Secretary, the Department has made significant strides in implementing the various components of the HAA. A Departmental Steering Committee was established to guide implementation of the HAA. Chaired by the Deputy Secretary, the Steering Committee convened four times and provided important guidance to facilitate the implementation of the HAA. Additionally, a Departmental Minority Initiatives Coordinating Committee was established to further coordinate HAA implementation activities. Initially, all the OPDIVs and STAFFDIVs were tasked to develop their own implementation plan based on the overall HAA conceptual framework. Upon the submission of these agency plans, HAA Steering Committee members reviewed and critiqued the documents for quality assurance and to identify areas of intra-Departmental collaboration and coordination. All the OPDIV and STAFFDIV implementation plans were officially approved by the HAA Steel ring Committee.

This progress report is based on the submissions made by the various OPDIVs and STAFFDIVs since the launching of the initiative. Some of the significant accomplishments and common themes include the following:

- Collectively sponsored the National Hispanic Health Symposium that was attended by over 550 Hispanic community organization representatives and leaders;
- Conducted a number of Hispanic activities to support Hispanic Heritage Month;
- Hired a number of Hispanic Association of Colleges and Universities student interns;
- Published and translated various departmental health and human media materials into Spanish;
- Initiated Spanish language instructional sessions for staff;
- Developed a Department Hispanic Website;
- Funded various Hispanic conferences for health promotion and prevention, and outreach

purposes;
- Established work groups to address common health and human service issues affecting the United States and Mexico;
- Completed annual plans to comply with Executive Order 12900 Educational Excellence for Hispanic Americans;
- Adopted a departmental policy for improving the collection of race and ethnicity data;
- Appointed key staff to the Departmental Minority Initiatives Coordinating Committee to participate on crosscutting issues relevant to the HAA.

This progress report also provides a snapshot where improvement is needed in some of the HAA components. As the Department prepares for the new millennium, the HAA serves as a blueprint for enhancing the delivery of health and human services to Hispanic American customers.

Conclusion

This annual progress report gives an indication of some of the major accomplishments made thus far in implementing the HAA. A number of agencies reported accomplishments in all the areas of the initiative and should be commended for their efforts. Those agencies whose accomplishments are not as evident are encouraged to make a greater effort. While agencies have demonstrated progress, more still needs to be done. As we enter the second year of this initiative, continued collaboration and commitment among agencies, especially on crosscutting themes, is crucial to the success of this endeavor. Once this is accomplished, the initiative will help fulfill the Secretary's charge to make the Department more reflective of the health and human service needs of Hispanic Americans.

HISPANIC AGENDA FOR ACTION ANNUAL PROGRESS REPORT

I.

Enhancing the HHS Capacity to Serve Hispanic Americans
(A. The HHS Workforce B. Involving Hispanic Customers)

Agency	Accomplishments
ACF	• Hired a Hispanic employee in its new Division of Consumer Services to develop strategies to enhance Office of Child Support Enforcement services to Hispanic families. • Translated into Spanish specific OCSE materials and press releases, which are available in print and on the agency Web-site. • Sponsored a Region X Hispanic Initiative Conference.

AHCPR	• Developed a matrix of Hispanic recruitment sources for the distribution of vacancies to increase the Hispanic applicant pool for the agency. • Designated two Senior Executive Service (SES) positions as Federal Equal Opportunity Recruitment Program (FEORP) recruits. • Successfully recruited a Hispanic Robert Wood Johnson Health Policy Post-Doctoral Fellow to its Center for Organization and Delivery Studies. • Established a formal policy requiring management officials to review recommendations and nominations for Hispanic representation in the pool of persons considered for appointments and nominations. • Distributed over 1.3 million copies of the agency's Spanish-language consumer guides through Spanish-language media and direct mail. • Published in Spanish its first non-consumer booklet on urinary incontinence for nurses' aides. • Provided financial support to the National Hispanic Symposium. • Collaborated with other OPDIVs in organizing a Hispanic Heritage Program at the Parklawn Complex featuring Maria Echeveste, Director, Public Liaison at the White House. • Remodeled its home page to include a link entitled "Informacion en Espanol" which allows individuals to access various information regarding AHCPR in the Spanish language.
AOA	• Developed a Hispanic mailing list to target special announcements for vacancies and notices on special events and activities. • Vacancy announcements were sent to Hispanic organizations for recruitment purposes. • AoA's newsletter was written and distributed in English and Spanish. • AoA was added to the Department's Website. • An AoA Fact Sheet on information and assistance was prepared in English and Spanish. It was released to the general public and aging network. • Conducted an educational forum on culturally sensitive training and on Hispanic aging issues. The Executive Director of the National Hispanic Council on Aging was the presenter.
ASL	• None reported.
ASMB	• Provided funding to support the planned Hispanic Customers Services Conference.
ASPA	• Publicized the Hispanic Agenda for Action through a number of media channels. • Provided advance press releases for the National Hispanic Health Symposium.

ASPE	• Provided funding to support the planned Hispanic Customers Services Conference.
CDC	• Established an internal Hispanic Recruitment and Retention Working Group to develop strategies for increasing the participation of Hispanics at all levels of the CDC workforce. • Drafted a report entitled "Enhancing Hispanic Representation in the CDC/ATSDR" to be used as a blueprint for improving the hiring and retention of Hispanics. • Provided grant funding support in collaboration with other HHS agencies for the development of Spanish-speaking health promotion commercial television programs to target the Hispanic community. • Provided financial support to conduct the National Hispanic Health Symposium. • Used the Symposium as a vehicle to recruit Hispanics, to disseminate Spanish-language health promotion and disease prevention materials, and to increase CDC's understanding of health needs of Hispanics. • Provided funding support for the development of Spanish-language health promotion commercial television programs. These programs will be broadcast through Univision, a major Spanish-language television company.
FDA	• Provided financial support to conduct the National Hispanic Health Symposium. • Collaborated with other OPDIVs in organizing a Hispanic Heritage Program at the Parklawn Complex featuring Maria Echeveste, Director, Public Liaison at the White House.
HCFA	• Initiated an awareness session for key management staff on specific HAA components. • Initiated a series of 12 hour seminars that targeted Hispanics, discussed Medicare and Medicaid issues and options to conduct outreach.
HRSA	• Provided financial support to conduct the National Hispanic Health Symposium. • Offered 12-week beginner and intermediate level Spanish language classes to HRSA employees. • Funded a project through a cooperative agreement with a national Hispanic organization to establish a National Prenatal Hotline. • Included the HHS Applicant Background Survey Form as part of the HRSA vacancy announcement application process. • Conducted recruitment activities for the Worker/Trainer Grade 1 positions in Dallas, Texas. • Amended HRSA's Executive Resources Management Plan to promote increased Hispanic representation among applications for SES vacancies. • Issued a 62 page publication entitled "Office of Rural Health Policy Outreach Profiles on Latino-Hispanic Rural Health".

IGA	• Hired two Hispanics. • Actively participated in organizing and conducting the National Hispanic Symposium.
IHS	• None reported.
NIH	• Developed targeted recruitment initiatives for Hispanics that are tied to specific areas of underrepresentation as identified by Equal Employment Opportunity analysis and incorporated into OPDIV FEORP program plans. • Projected 342 vacancies for the institutes/centers/divisions, with a goal of 61 targeted for Hispanics. • Conducted recruitment activities at over 15 Hispanic conferences (Hispanic Association of Colleges and Universities, Interamerican College of Physicians and Surgeons, Society for the Advancement of Chicanos and Native Americans in Science). • Hired 72 Hispanics for the NIH Summer Internship Program. • Obtained a net increase of 33 Hispanics in the NIH permanent workforce, making up 2.2% of the workforce. • Began three pilot efforts at reaching Hispanic audiences through Hispanic radio programming. • Provided a three day orientation to NIH activities for the Society for Advancement of Chicanos and Native Americans in Science. • Prepared baseline data for FY 1996 on participation of Hispanics on NIH Advisory Committees, on the NIH consultant file, as principal investigators on grants, and as recipients of underrepresented minority supplement awards for research. • NIH communication officers participated in a U.S. Latino Awareness Conference (Nuestra Gente), as a means of being introduced to the Latino consumer market, culture, and social issues important in developing NIH's capacity to serve its Hispanic customers. • The National Heart, Lung and Blood Institute (NHLBI) program "Salud Para Su Carazon, Community Alliance Working for Heart Health" was presented as a model program for involving Hispanic customers in the design and implementation of a culturally appropriate intervention program. • Provided funding to support the National Hispanic Health Symposium.
OCR	• Region X hired a Hispanic Student Intern during the spring quarter. • Provided technical assistance to the Administration for Children and Families (ACF) with their Hispanic Initiative Companeros en Accion-Partners in Action. • An Equal Opportunity Specialist conducted a one-hour Spanish-language radio interview in Dallas, Texas to discuss civil rights issues affecting Latinos. • Published a bilingual article regarding civil rights and functions of OCR in several Hispanic community newspapers.

OGC	• None reported.
OIG	• Assisted in developing the Department's Hispanic Home Page. • Began dialogue with the OIG's Office of Evaluation and Inspections to ensure future surveys of beneficiaries and providers reflect the needs of Hispanics.
OPHS	• Provided a long distance learning practicum for a Latino physician participating in a fellowship at the Harvard School of Public Health. • Hired a senior level Latina manager for the OMH's Division of Policy and Data. • Developed a nationwide resume= database of prominent Hispanic women with expertise in health related areas. • Employed one Hispanic from UCLA through an IPA arrangement. • Completed phase I of an evaluation design of a customers survey for the Office of Minority Health Resource Center. The study will target Hispanic and other racial/ethnic minority customers. • Developed high-blood pressure Spanish-language information packets and publicized their availability in minority newspapers across the country. • Awarded a contract to Hispanic Radio Network to develop radio programming for Spanish-speaking audiences on managed care. • Funded various Hispanic conferences, including the National Hispanic Symposium, the National Latina Institute for Reproductive Heath, Mid-Atlantic Regional Latina Health Forum, the U.S. Mexico Border Conference on Children's Health, and ACF's Hispanic Initiative Conference. • Exhibited at the various Hispanic conferences, National Council of La Raza, Hispanic Nurses Association, National Hispanic Medical Association, and the National Hispanic Health Symposium. • Conducted five work groups on the following topics: Migrant Health, Women's Health, Tobacco Use Prevention with an Emphasis on Adolescents, Immunization, and the Aging Group, of the U.S. Mexico Binational Commission.
PSC	• Played a significant role in planning and coordinating Hispanic Heritage Month activities for HHS. • Assisted in preparing a calendar of events for Hispanic Heritage Month for HHS.
SAMHSA	• Hired and recruited 3 senior level Hispanics within the agency. • Convened an agency-wide recruitment and personnel work group to assist the agency in providing outreach to Hispanic/Latino communities regarding employment opportunities within SAMHSA.

	• Initiated a grant cycle to award 4 grants of approximately $200,000 each to the U.S./Mexico border states to provide an array of cultural and linguistic competence prevention and early intervention activities on substance abuse targeted to youth and families. • Developed a multi-cultural webpage, which includes a Hispanic/Latino area on Prevline. Prevline is a community focused substance abuse prevention and treatment electronic communication network. • Offered two introductory level Spanish language classes for 6 weeks to its employees. • Provided funding to support the National Hispanic Health Symposium. • Sponsored a "Hispanic Mental Health Symposium: Models That Work" which highlighted outreach to the homeless, children and family services.

II.

Implementing Executive Order 12900: Educational Excellence for Hispanic Americans

Agency	Accomplishments
ACF	• Completed annual executive order plan.
AHCPR	• Contributed funding for the fifth consecutive year of the National Hispanic Youth Initiative, sponsored by the Interamerican College of Physicians and Surgeons. • Apportioned 28% of the funding to the University of California, San Francisco Medical Treatment Effectiveness Program (MEDTEP) Research Center to support a Hispanic co-principal investigator. • Supported the participation of two Hispanic students from the University of Puerto Rico in AHCPR's Minority Access to Research Careers Health Policy Summer Program at Harvard University.
AOA	• Completed annual executive order plan.
ASL	• Completed annual executive order plan.
ASMB	• None reported.
ASPA	• None reported.

ASPE	• Completed annual executive order plan. • Hired two Hispanic Association of Colleges and Universities (HACU) interns to work on immigration issues and a needs/impact assessment of services to Hispanics. • Facilitated the recruitment and hiring of HACU interns into other HHS offices.
CDC	• Completed annual executive order plan. • Supported the annual recruitment of Hispanic summer student interns through a collaborative program with other federal agencies and the Interamerican College of Physicians and Surgeons. • Recruited Hispanic students to participate in the CDC's summer internship programs with the Public Health Institute of Morehouse College and the Minority Health Professions Foundation.
FDA	• Completed annual executive order plan. • Hosted two HACU interns and provided funding support to the Interamerican College of Physicians and Surgeons Hispanic Youth Initiative. • Created a video showcasing HACU intern students through the HHS which was shown continuously through Hispanic Heritage Month.
HCFA	• Completed annual executive order plan.
HRSA	• Completed annual executive order plan. • Provided funding to support the development of the National Association of Hispanic-Serving Health Professions Schools to improve the education, supply, and quality of the Nation's Hispanic health personnel. • Provided summer internships for 6 HACU students. • Provided two long-term internships for HACU students (4 months). • Provided funding to the National Hispanic Youth Initiative sponsored by the Interamerican College of Physicians and Surgeons. • Completed the initial phase in the development of a management information tracking system to generate outcome/impact data to evaluate the effectiveness of health profession programs that serve Hispanics.
IGA	• Completed annual executive order plan.
IHS	• Completed annual executive order plan.

NIH	• Completed annual executive order plan. • Provided funding to the National Hispanic Youth Initiative sponsored by the Interamerican College of Physicians and Surgeons. • Signed a Memorandum of Understanding with the Hispanic Association of Colleges and Universities and provided internships for 8 HACU interns in the summer and 5 interns in the Fall of 1997.
OCR	• Completed annual executive order plan.
OIG	• Completed annual executive order plan.
OPHS	• Completed annual executive order plan. • Provided funding to support the development of the National Association of Hispanic-Serving Health Professions Schools to improve the education, supply, and quality of the Nation's Hispanic health personnel. • Employed an HACU intern during the summer.
PSC	• Donated surplus computer systems and office equipment to two schools with high percentages of Hispanic students located within empowerment zones in the District of Columbia.
SAMHSA	• Completed annual executive order plan. • Funded the UCLA School of Medicine Faculty Development Program to train approximately 200 student fellows and resident students to become experts in the field of substance abuse prevention. Thirty percent of the trainees are Latino/Hispanic. • Placed 10 HACU summer interns within the agency. • Contributed funding for the National Hispanic Youth Initiative sponsored by the Interamerican College of Physicians and Surgeons.

III.

Hispanic Data

Agency	Accomplishments
ACF	• None reported.

AHCPR	• To encourage Hispanic/Latino participation, recruitment materials for the Medical Expenditure Panel Survey (MEPS) are available in Spanish. In addition, interviews are now conducted in Spanish as needed.
AOA	• Completed an analysis of the number of low income minorities that have received services over the last five years, including Hispanic elderly.
ASL	• N/A
ASMB	• N/A
ASPA	• N/A
ASPE	• None reported
CDC	• Initiated a process of expanding the availability and tabulation of morbidity and mortality data for Hispanic subpopulations, and to increase the use of electronic systems, e.g., the Internet as a mechanism for data dissemination.
FDA	• None reported.
HCFA	• Updated HCFA's enrollment database to include Hispanic identifiers.
HRSA	• Compiled a profile summary list of existing rual health projects funded by the Office of Rual Health Policy serving the Latino community. • Initiated the collection of an annotated bibliography on Latinos and rural health and a variety of other information resources on minority and Latino rural health.
IGA	• None reported.
IHS	• None reported.
NIH	• Obtained first reports from a tracking system for the inclusion of women and minorities in clinical research; NIH studies involved approximately 7.9% Hispanic participants.
OCR	• None reported.
OGC	• N/A

OIG	• N/A
OPHS	• Provided staff support to the HHS Data Council which developed the HHS Policy for Improving Race and Ethnicity Data. The policy reaffirms the HHS commitment to the appropriate inclusion of data on minority groups in research, services and related activities.
PSC	• N/A
SAMHSA	• Served on the HHS Data Council which developed the HHS Policy for Improving Race Ethnic Data. • Operationalized HHS policy on including race and ethnicity on all data-collection efforts, including contracts, and both discretionary and block grants.

IV.

Hispanic Health Agenda

Agency	Accomplishments
ACF	• None reported.
AHCPR	• Five Hispanic investigators served on study sections to review grant applications. • To encourage Hispanic/Latino participation, made it a practice to use Spanish recruitment materials for the Medical Expenditure Panel Surveys. Additionally, interviews are now conducted in Spanish as needed.
AOA	• None reported.
ASL	• None reported.

ASMB	• N/A
ASPA	• None reported.
ASPE	• None reported.
CDC	• Initiated efforts to review the Together Organized Diligently Offering Solidarity (**TODOS**) to develop an internal inventory of the **TODOS** recommendations to facilitate monitoring of progress and ensure those **TODOS** elements are addressed in the HAA.
FDA	• None reported.
HCFA	• Launched the development of a Hispanic Services Research Initiative which will address some of the recommendations of the "**TODOS**" Report--Hispanic Health Agenda. This initiative consists of four components: (1) Hispanic Data Users Conferences to develop ties between Hispanic researchers and HCFA staff; (2) Design and implement a grant program to encourage new health services researchers to pursue research issues that effect Medicare and Medicaid programs, and help Hispanic researchers in academic institutions that serve Hispanic populations by supporting outside research in the health services arena; (3) Create a Hispanic Health Services Research network to identify resources and research needs; and (4) Implement a Hispanic Technical Assistance Program, assisting access to and use of HCFA's Medicare and Medicaid data to enhance the capacity of Hispanic researcher to participate in HCFA's program activities.
HRSA	• Funded three Hispanic-focused cooperative agreements under a program titled "Partnerships for Health Professions Education (PHPE)". • Organized a rural minority health workshop panel with a Latino physician. • Staff participated in the National Rural Minority Health Conference which addressed special access and bilingual and bicultural issues.
IGA	• None reported.
IHS	• None reported.
NIH	• Posted the **TODOS** Report on the HHS Hispanic Homepage for internal and external use. • National Institute of Child Health and Human Development conducted a two-day grantee workshop on Hispanic Maternal and Child Health to evaluate progress and plan for future directions.

	• Conducted a workshop on Prostate Disorders and Minorities. The conference focused on initiative-development to determine how to address the issue of prostate disease in minorities, including African and Hispanic Americans, Asian American and Pacific Islanders, Native Americans and Alaska Natives.
OCR	• None reported.
OGC	• None reported.
OIG	• None reported.
OPHS	• An initial analysis of the **TODOS** Report was completed to determine appropriate agency leads for the cited recommendations. • Successfully conducted the second progress review of Healthy People 2000 for Hispanic Americans.
PSC	• None reported.
SAMHSA	• Initiated efforts to conduct internal inventory of **TODOS** recommendations and to monitor progress and to ensure **TODOS** elements are addressed in the HAA.

V.

Research

Agency	Accomplishments
ACF	• Previously reported under Item I.
AHCPR	• 5 Hispanics investigators served on study sections to review grant applications. • Completed an analysis of the distribution of hospital cases in public and private hospitals by race and ethnicity, in which Hispanics are represented, to the Capital Subgroup of the Secretary's Academic Health Center Policy Review Team. The results of the study were published in the AHCPR Provider Studies Research Note 26.
AOA	• None reported.

ASL	• None reported.
ASMB	• None reported.
ASPA	• None reported.
ASPE	• Launched a review of the HHS health and social services research, demonstration, and evaluation agendas/portfolios that are targeted to Hispanic Americans. Review will include clinical research agendas/portfolios that address disorders that have a disproportionately large effect on Hispanic Americans. The reviews will assist in developing a baseline on what is known of HHS supported health and social services to Hispanics and to identify gaps that should be addressed in the future. • Organized an HHS work group to advise ASPE in compiling the information on relevant service research, demonstrations, and evaluation projects.
CDC	• Several Border states activities to improve health and quality of life are ongoing, and include the establishment of a Center of Excellence for Birth Defects Research and Prevention in Texas to study causes and prevention of birth defects, including Neural Tube Defects; community health education programs in Texas colonias, and a BiNational Agreement with Mexico to exchange information and coordinate efforts to improve health. • Increased Hispanic immunization coverage through the use of toll-free hotlines and public service announcements targeted to the Hispanic/Latino community. • Developed action plans to strengthen current program efforts targeted to Hispanics in the areas of diabetes control, cancer, HIV, STD, injuries, emerging and reemerging infectious diseases, infant health and tobacco. • Supporting and actively participating in efforts to increase Hispanic participation in the National Diabetes Education Program. • Using lay health providers, increased the provision of low-cost breast and cervical cancer screening services to medically underserved Hispanic women. • Supported the National Center for Farmworker Health, Inc., Migrant Streams Forums to address special health concerns of migrant agricultural workers and their families. • Implemented occupational health and safety education and awareness training programs for Hispanic health professionals, business owners and workers. • Developed emergency department guidelines that facilitate the collection of injury data on Hispanics. • Investigated cases of malaria in the US/Mexico border areas with study of practices and knowledge regarding domestic water quality and cholera prevention.
FDA	• None reported.

HCFA	• None reported.
HRSA	• None reported.
IGA	• None reported.
IHS	• None reported.
NIH	• Completed the first report on the Inclusion of Women and Minorities in Clinical Research. Hispanics are estimated at 7.9% of enrolled subjects. • NHLBI is supporting observational studies in 10 groups that are either entirely Hispanic or that contain substantial numbers of Hispanics (e.g., National Longitudinal Mortality Study, a longidinal study of Cardiovascular Disease and its risk factors, Insulin Resistance Atherosclerosis Study). • NHLBI supported 8 grants that focus on intervention studies in Hispanic adults or children. • Provided support to the University of Texas which designed, implemented, and evaluated an intervention program for Hispanic children with asthma. • National Eye Institute supported an epidemiological research project to determine the prevalence and cause of blindness and visual impairment of 4,500 Mexican American persons age 40 and older who reside in Arizona. • National Institute on Drug Abuse funded seven ongoing clinical sites that evaluate new medications to decrease drug addiction, four of which have recruited high percentages of Hispanics in clinical trials. • National Institute on Aging, in collaboration with NIH Office of Research on Minority Health, developed an RFA to support several Exploratory Centers for Research on Health Promotion in Older Minority Populations. Specific centers were selected to focus specifically on Hispanic populations. • National Institute of Arthritis and Musculoskeletal and Skin Disease initiated an asthma study to target segments of the Hispanic population. This study proposes to determine whether reduction of exposure to cockroach and dust mite allergens will reduce the incidence of asthma among individuals who are genetically predisposed to asthma. • National Institute of Environmental Health Sciences undertook a pesticide study of migrant farm workers in Florida to evaluate whether farm workers who worked as pesticide applicators suffer neurological damage. • Approved funding for 10 Hispanic candidates for the Minority Investigator Research Supplement Program at NHLBI. • The National Institute of Diabetes amd Digestive and Kidney Diseases awarded a new Clinical Trial Unit at Drew University in Los Angeles, which serves a diverse population including 65% Hispanics.

OCR	• N/A
OGC	• N/A
OIG	• N/A
OPHS	• Provided continued funding for 6 bilingual/bicultural service demonstration grants which focused on the Hispanic/Latino community. • Awarded 8 bilingual/bicultural demonstration grants to Hispanic/Latino organizations to focus on managed care service delivery issues.
PSC	• N/A
SAMHSA	• N/A

VI.

Promoting Cross-cutting Collaboration within HHS

Agency	Accomplishments
ACF	• Appointed a senior staff person to the Departmental Minority Initiatives Coordinating Committee (DMICC) who participates on those crosscutting issues relevant to the HAA.
AHCPR	• Same as above.
AOA	• Same as above.
ASMB	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA. • Established a committee to address personnel issues for the HAA .

ASPA	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA.
ASPE	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA. • Established a committee to address research, demonstration, and evaluation issues for the HAA .
CDC	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA.
FDA	• Same as above. • Appointed a staff person to serve on a committee to address cultural competence service delivery issues. • Established a committee to develop a department wide mentoring program for Hispanic Americans.
HCFA	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA.
HRSA	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA. • Obtained funding from the CDC as part of a collaborative effort to support the HRSA-sponsored East Coast, Midwest, and Western Migrant Stream Forum meetings.
IGA	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA.
IHS	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA. • Appointed a staff person to serve on a committee to address cultural competence service delivery issues.
NIH	• Appointed a senior staff person to the DMICC and participates on those crosscutting issues relevant to the HAA.
OCR	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA. • Appointed a staff person to serve on a committee to address cultural competence service delivery issues.

OGC	• Same as above.
OIG	• Appointed a senior staff person to the DMICC who participates on those crosscutting issues relevant to the HAA.
OPHS	• Established committees to address the coordination of various databases and data issues pertaining to the HAA.
PSC	• Appointed a senior staff person to the DMICC. • Co-established a committee to determine and report on "best practices" that may be used by OPDIVs and STAFFDIVs to recruit, hire, and retain Hispanics.
SAMHSA	• Appointed a senior staff person to the DMICC and participates on those crosscutting issues relevant to the HAA. • Established a committee to address cultural competence service delivery issues.

VII.

Procurement

Agency	Accomplishments
ACF	• Contracted with a Hispanic 8(a) firm to adopt Child Support Enforcement Handbook into a culturally appropriate format for Hispanic populations.
AHCPR	• None reported.
AOA	• None reported.
ASMB	• None reported.
ASPA	• None reported.

ASPE	• Hired a consultant to work on the social services research, demonstration, and evaluation crosscutting issue of the HAA.
CDC	• None reported.
FDA	• None reported.
HCFA	• None reported.
HRSA	• Created a database of Hispanic 8(a) firms for inclusion in the Agency's Source List receiving solicitations. • Conducted a technical assistance workshop targeted to Hispanic/Latino firms. • Provided insight to representatives of Hispanic/Latino-owned businesses on how to participate in HRSA procurement activities. • Awarded $5 million to Hispanic 8(a) firms.
IGA	• None reported.
IHS	• None reported.
NIH	• Contracted with two Hispanic owned firms for software development and meeting support. • Contracted with a Hispanic Serving Health Professions Schools for clinical trails.
OCR	• None reported.
OGC	• None reported.
OPHS	• Awarded 10 contracts to Hispanic organizations to perform various professional services. • Two contracts were awarded to purchase Spanish-language publications for distribution to the Hispanic community.
PSC	• None reported.

SAMHSA	• None reported.

VIII.

Language Barriers to Access Departmental Services

Agency	Accomplishments
ACF	• Previously reported under Item I.
AHCPR	• Previously reported under Item I.
AOA	• Previously reported under Item I.
ASMB	• None reported.
ASPA	• None reported.
ASPE	• None reported.
CDC	• Previously reported under Item I.
FDA	• Through the Seafood Hotline, made available copies of the Spanish version of the "Vibrio Vulnificus Oyster Warning" brochure. • Revised and translated into Spanish a brochure on "Keep Your Baby Safe: Eat Hard Cheese Instead of Soft Cheeses During Pregnancy." • Translated into Spanish the "Iron Poisoning Prevention Poster."
HCFA	• Launched Spanish lessons during Hispanic Heritage Month program for employees.
HRSA	• None reported.
IGA	• Regional Director in Atlanta encouraged Spanish language classes be made available for staff.

IHS	• None reported.
NIH	• The Alzheimer's Disease Centers program developed culturally appropriate educational materials and clinical tools and translated them into Spanish for staff, as well as broader distribution. • To improve access to medical literature, the National Library of Medicine (NLM) translated the medical subject literature into Spanish, which is now on electronic databases, making it more accessible to the Hispanic community. • The NLM prepared a 10 minute video to welcome Spanish-speaking visiting groups to the NLM.
OCR	• Drafted a policy guidance on Title VI Prohibition Against National Origin Discrimination--Persons with Limited-English Proficiency. • Initiated compliance reviews on five cases surrounding Title VI complaints affecting Limited-English proficient Spanish-speaking persons.
OGC	• None reported.
OPHS	• None reported.
PSC	• The PSC Supply Center at Perry Point, Delaware, translated and printed pharmaceutical labels in Spanish and shipped medical supplies and equipment to hospitals and clinics within the Commonwealth of Puerto Rico.
SAMHSA	• Offered two introductory level Spanish language classes for six weeks to its employees.

IX.

Hispanic Steering Committees

Agency	Accomplishments
ACF	• Established a Customer Service Steering Committee to oversee and monitor the implementation of the HAA.
AHCPR	• The Agency's Minority Health Coordinating Committee is charged with implementation and monitoring of the Hispanic Agenda for Action.

AOA	• Established a Minority Steering Committee to oversee and monitor the implementation of the HAA.
ASMB	• None reported.
ASPA	• None reported.
ASPE	• None reported.
CDC	• Established a Hispanic Steering Committee to implement the HAA.
FDA	• Established a Committee on Hispanic Issues to provide guidance in implementing the HAA.
HCFA	• Established a Minority Beneficiaries Work group to assist in implementing the HAA.
HRSA	• Established a Minority Health Advisory Committee to oversee the implementation of the HAA.
IGA	• None reported.
IHS	• None reported.
NIH	• Established a Hispanic Task Force to oversee the implementation of the HAA.
OCR	• Established a Hispanic Steering Committee to implement the HAA.
OGC	• None reported.
OPHS	• Uses the DMICC to monitor HAA implementation progress.
PSC	• Established an Initiatives Coordinating Council to oversee the implementation of the HAA.
SAMHSA	• Established a Hispanic Steering Committee to implement the HAA.

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Last revised Monday, June 28, 1999
Comments/Suggestions to WebJefe Carl Montoya

HHS FACT SHEET
October 28, 1998
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CLINTON ADMINISTRATION INITIATIVE TO ADDRESS HIV/AIDS AMONG RACIAL AND ETHNIC MINORITY POPULATIONS

Overview: Since the AIDS epidemic began in 1981, more than 640,000 Americans have been diagnosed with the disease and more than 385,000 men, women and children have lost their lives to it. An estimated 650,000 to 900,000 Americans are believed to be living with HIV, the virus that causes AIDS.

The Clinton Administration has made an unprecedented commitment to battle this epidemic by responding aggressively to the growing threat, enhancing research, treatment and prevention initiatives. Innovative policies and aggressive new strategies are making a difference. The National Center for Health Statistics announced October 8 that the age-adjusted death rate from HIV infection in the U.S. declined by an unprecedented 47 percent from 1996 to 1997, and HIV infection fell from 8th to 14th place among leading causes of death for the same period.

But while the news on the HIV/AIDS front is encouraging overall, recent data indicate that the face of this disease is changing. While overall AIDS deaths are down, it remains a severe and ongoing crisis in African-American and other racial and ethnic minority communities, and is the leading killer of African-American men age 25-44 and the second leading killer of African-American women in the same age group. The largest percentage increases for HIV/AIDS are now among women and youth, racial and ethnic minorities, injecting drug users and their sexual partners.

Part of the Clinton Administration's response to the disproportionate burden of AIDS in racial and ethnic minorities is outreach to those communities most heavily affected. Most recently, the Department held discussions with the Congressional Black Caucus about ways to enhance the fight against HIV/AIDS - especially in African-American communities.

As a result of those discussions, the Department has announced a special package of initiatives aimed at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities. Based on discussions with the Congressional Black Caucus and final FY 1999 appropriations action, HHS will spend an additional $156 million on initiatives to address HIV/AIDS among racial and ethnic minorities.

THE INITIATIVE: RESPONDING TO HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES

For fiscal year 1999, the U.S. Department of Health and Human Services will spend an additional $156 million to enhance the federal response to HIV/AIDS in racial and ethnic minority communities. This funding is spread across three broad categories: technical assistance and infrastructure support; increasing access to prevention and care, and building stronger linkages to address the needs of specific populations.

Initiative activities include:

- **Centers for Disease Control and Prevention (CDC).** To fund grants to minority community-based organizations to create new service programs in African-American communities heavily impacted by HIV/AIDS; technical assistance for grantees; and for a faith-based program to develop HIV and substance abuse prevention training grants at the schools of divinity on the campuses of Historically Black Colleges and Universities (HBCUs). CDC also plans to strengthen the requirement that state allocation decisions about HIV/AIDS grants reflect the changing face of the epidemic.

- **Health Resources and Services Administration.** Ryan White CARE Act Title I supplemental funding for eligible metropolitan areas that have at least 30 percent African- American HIV/AIDS cases, for the improvement of quality of care and health outcomes for those persons; Title III funding for targeted planning grants to broaden the reach of organizations that serve African-American and **Hispanic** areas highly impacted by HIV/AIDS; Title IV to address the prevalence of HIV/AIDS among African-American children; and for AIDS Education Training Centers at Historically Black Colleges and Universities to work with the National Medical Association and the National Black Nurses Association to educate health care providers serving African-American communities on the new HIV/AIDS treatment guidelines. HRSA will also broaden its technical assistance programs.

- **Substance Abuse and Mental Health Services Administration.** To stem the rise of African-American and **Hispanic** HIV/AIDS cases related to injection drug use, the agency will provide funding for comprehensive substance abuse treatment programs for African- American and **Hispanic** women with or at risk for HIV/AIDS and their children as well as for high-risk men; and funding targeted to African-American youth and women of color prevention programs and activities. SAMHSA plans to earmark funding for HIV and substance abuse treatment for communities of color as part of its Targeted Capacity Expansion Program which helps address treatment needs for emerging substance abuse problems specific to a city, county, state or region.

- **National Institutes of Health.** Will support activities to increase the number of African- American principal investigators conducting HIV/AIDS research targeting the links between substance abuse and HIV/AIDS through the Office of Minority Health Research. Special emphasis will be on behavioral and clinical research targeting the links between substance abuse, sexual behavior, and the HIV infection rates in African-Americans; outreach education programs; and population-based research.

- **Crisis Response Teams.** In recognition that the HIV epidemic has become highly concentrated in some areas, HHS is prepared to make available Crisis Response Teams to a number of highly affected municipalities. These teams would focus on providing technical help in addressing HIV/AIDS within minority populations. Upon a formal request, and with the participation and coordination of local government and community leaders, HHS will make a team of experts available to provide special skills and support over a period of several weeks. The goal is to assess existing prevention and treatment services for racial and ethnic minorities and to support development of strategies for enhancement.

- **Office of Minority Health,** will continue to work closely with HHS agencies and offices as a catalyst, advocate, coordinator and policy development office on activities related to HIV and AIDS in minority communities.

CURRENT HHS HIV/AIDS INITIATIVES TARGETED TO RACIAL AND ETHNIC MINORITIES

Today's announcement builds on a variety of current initiatives at the Department to address HIV/AIDS in racial and ethnic minority communities. In fact, a substantial portion of federal dollars are now serving racial and ethnic minorities: 63 percent of participants in NIH-sponsored AIDS clinical trials are minorities, of whom 40 percent are African-American. Some 42 percent of clients served by Title I of the Ryan White CARE Act are African-Americans and 24 percent are **Hispanic**, and some 80 percent of Title IV Ryan White clients are racial and ethnic minorities.

Earlier this year, the Clinton Administration unveiled a major, new federal initiative to bolster these efforts - a strategy to eliminate racial and ethnic disparities in HIV/AIDS and five other key areas of health. Congress appropriated $65 million to begin these activities in fiscal year 1999.

In addition, to address HIV/AIDS specifically, HHS announced competitive grant programs and cooperative agreements last summer as a first step toward addressing the infrastructure needs in affected communities. As part of these efforts, HHS invested in community-based organizations, provided new grants to directly address HIV/AIDS in underserved areas and racial and ethnic minority communities, and redirected additional funds to address HIV/AIDS in these communities.

Below are examples of key ongoing programs at HHS to address HIV/AIDS in racial and ethnic minority communities.

Centers for Disease Control and Prevention (CDC)

- **Community Prevention.** CDC funds state and local health departments for HIV Prevention Community Planning programs. Under this process, health departments establish prevention and intervention priorities by working through a local planning group of a cross-section of community representatives involved in the HIV/AIDS fight. Funding is targeted to racial and ethnic minorities.

- **Community-Based Organizations.** In fiscal year 1998, CDC directly funded 94 CBOs to design and implement HIV prevention programs targeted to high-risk persons of racial and ethnic minority populations. A total of 71 - 76 percent - of these organizations direct their services to African-Americans.

- **Capacity Building.** CDC provides grants to national and regional minority organizations to enhance their capacity to deliver HIV prevention programs and services to their communities. Included are such organizations as the National Organization of Black County Officials, the National Minority AIDS Council, the Association of Black Psychologists, and the National Council of Negro Women.

- **Behavioral Research Projects.** CDC conducts numerous research projects designed to reduce HIV infection in the African-American community. This includes a study of women and infants with HIV targeting women age 15-34, a study to prevent HIV/AIDS in young African-American men, and research projects on such behavioral issues as injection drug use, people with high rates of STDs, and gay and bisexual men of racial and ethnic minorities.

Health Resources and Services Administration (HRSA)

Activities under the Ryan White CARE Act:

- **AIDS Drug Assistance Program (ADAP).** This program, authorized under Title II of the Ryan

White CARE Act, provides medications to low-income persons with HIV disease and who have limited or no private insurance or Medicaid coverage. In 1996, more than 52 percent of persons served by ADAP were African-American or **Hispanic**.

- **Training and Technical Assistance.** Through a three-year cooperative agreement with the National Minority AIDS Council, HRSA's HIV/AIDS Bureau funds a variety of activities related to the development and dissemination of minority-related HIV/AIDS programs.

- **Special Projects of National Significance (SPNS).** This program funds innovative models of HIV/AIDS care that can be replicated across the country, with the main focus to improve HIV/AIDS services to hard-to-reach populations, including racial and ethnic communities. Among SPNS projects focusing on the African-American community are a youth-oriented HIV prevention partnership in Chicago; a Washington, D.C. project to reduce linguistic and organizational barriers to care for women with HIV; an HIV Primary Care Center at Chicago's Cook County Hospital, and a special care center in St. Louis for women living with HIV.

National Institutes of Health (NIH)

- **Women's HIV Studies.** Racial and ethnic minorities are more than 80 percent of the participants in two major natural history and epidemiological studies on mother-to-infant transmission and on the clinical manifestations of HIV infection among women.

- **Perinatal Intervention Trials.** Most of the women involved in trials to determine the effectiveness of AZT therapy in preventing mother-to-infant transmissions as well as the ongoing follow-up studies are racial and ethnic minorities.

- **Support for AIDS Clinical Trials Research at Minority Institutions.** NIH supports efforts to enhance HIV clinical trials research at minority institutions, through improved training, increasing the number of minority investigators conducting research as well as the number of racial and ethnic minority participants involved in clinical studies.

- **Outreach to Historically Black Colleges and Universities.** NIH outreach programs help train health professionals associated with HBCUs to use electronic information resources to make HIV information readily available for people working closely with HIV-affected communities.

- **Clinical Trials.** The clinical trials networks continue to recruit participants to reflect the changing demographics of the epidemic. Sixty-three percent of the participants in NIH- sponsored AIDS clinical trials are minorities, including 40 percent African-American and 22 percent **Hispanic**.

- **Population-Specific Behavioral Interventions.** NIH supports a broad array of behavioral intervention studies with specific focus on African American populations.

- **HIV and Drug Use.** NIH supports research on characterization of the disease process in drug users, including factors influencing disease progression, consequences of multiple co- infections, effectiveness of therapeutic regimens, and the impact of health care access and adherence to therapeutic regimens on disease outcomes. Most of the participants of these studies are African-American.

- **Topical Microbicides.** The development of topical microbicides, chemical and physical barriers that can be used by women to inactivate HIV and other sexually transmitted diseases, will continue

to be one of the highest priorities of the NIH intervention research agenda. NIH is supporting Phase I, Phase II and Phase III trials of various agents. Increased funds are included in the fiscal year 1999 budget for this research.

Substance Abuse and Mental Health Services Administration (SAMHSA)

- **Substance Abuse Prevention/HIV Prevention Initiative for Youth and Women of Color.** This activity is designed to combat the dual risks of HIV and substance abuse, which together form a deadly pathway to HIV/AIDS for women of color. The purpose of this initiative is to examine the psychosocial and economic factors associated with substance abuse in order to help women make more appropriate sexual choices.

- **AIDS Outreach Program.** This program targets injection drug users, their sex partners and other high-risk substance abusers to encourage them into treatment for substance use as well as provide medical diagnostic services for HIV/AIDS and related illnesses. The program also aims to change behaviors that could increase the risk of acquiring HIV.

- **HIV Set-Aside Activities.** SAMHSA's Substance Abuse Block Grant requires states with a high incidence of HIV/AIDS to use a portion of the block grant funds for counseling and testing and early intervention in order to reduce the spread of HIV infection among substance abusers and their sex partners as well as persons with whom they share needles. These funds are partially targeted to communities of color, targeting in particular at-risk persons receiving substance abuse treatment.

- **Addressing Mental Health Needs.** SAMHSA's Center for Mental Health Services (CMHS) has awarded grants to evaluate different approaches to providing a range of high quality mental health services to people affected by or living with HIV/AIDS.

- **Targeted Treatment Capacity Expansion Program.** This program awards grants to states, cities and/or government entities to create and expand comprehensive substance abuse treatment services. Pending the availability of funds in fiscal year 1999, the program will involve an earmark for HIV and substance abuse treatment for communities of color.

###

2. Characteristics of the Latino Population

The Latino population is the fastest growing minority in the United States. Growth rates among the Latino population not only exceed other minority groups, but also exceed the growth rate of the U.S. population as a whole.[1] If the projected growth trends continue, the Latino population will be the largest minority group in the United States, reaching a projected 96.5 million people—24.5% of the total population—by the year 2005.[2]

Several factors contribute to the fast growth rate of the Latino population:

- the abatement of immigration policies that had previously made it difficult for Latinos to enter the United States,
- high fertility rates among Latinos, and
- the large proportion of young people in the Latino population.

Changes in immigration policies since the 1960s have had a dramatic impact on the growth rate of the Latino population.[3] In the Immigration Act of 1965, restrictive quotas based on national origins for immigrants from non-European countries were abolished, opening the door for Caribbean, Mexican, and Central and South American immigrants. The 1986 Immigration Reform and Control Act contributed to an additional increase in documented Latino

immigrants by allowing a large number of immigrants to be legalized. By 1997, Latinos who were foreign born accounted for 38% of the Latino population residing in the United States.[4]

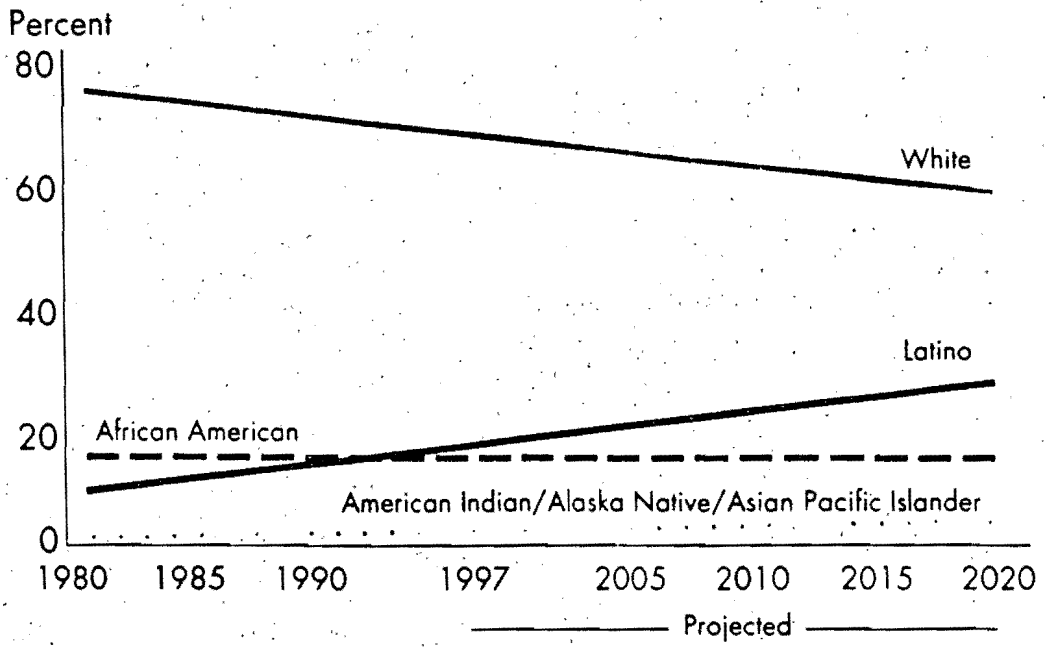
Birth rates among Latinos play another important role in the increases in the population. Latinas age 15-44 have higher numbers of children than other racial and ethnic groups and are more likely to carry a birth to term. Foreign-born Latina women from all subgroups are much more likely to have a fourth or higher order birth. Additionally, surveys reveal that Latina women both desire and have larger numbers of children than African American or white women.[5]

Compared to whites and African Americans, Latinos are a young population. Approximately 35% of Latinos are under the age of 18, while only 24% of whites and 30% of African Americans are under the age of 18.[6] The number of Latino children in the United States has already surpassed that of other minority groups. Latinos have increased more rapidly than any other racial and ethnic group, growing from 9% of the child population in 1980 to 15% in 1997. In 1998, the number of Latino children was estimated to be 10.5 million—35,000 more than the number of African American children.[7] By the year 2020, an estimated 1 in 5 children living in the United States will be Latino.[8] The growth rates only further emphasize the need for organizations that serve youth to be more responsive and better prepared to meet the needs of the diverse Latino youth population in the coming century. (See Figure 1.)

Demographics

The growth rates in the Latino population will have a greater impact on some states than on others. In 1997, more than half of the Latinos in the United States lived in either California or Texas. Six states had Latino populations of more than 1 million: California, 9.9

Figure 1. Percentage Distribution of U.S. Children Under Age 18 by Race and Latino Origin, 1980-97, and Projected 1998-2020



Source: U.S. Bureau of the Census, Population Estimates and Projects.

million; Texas, 5.7 million; New York, 2.6 million; Florida, 2.1 million; Illinois, 1.2 million; and Arizona, 1.0 million. California in particular has four of the ten counties in the country with the highest Latino populations: Los Angeles, Orange, San Diego, and San Bernadino. By 2025, it is estimated that the Latino population in California will grow to 43% of the total population of the state, making it the largest ethnic or racial group in California.[9] These demographic changes and fertility rates among Latino adolescents and Latina women, when coupled with the steady immigration rates, will have a profound effect on service providers and policymakers in the 21st century as they work to meet the needs of the expanding Latino community.

Racial and Ethnic Diversity

The Latino population in the United States is ethnically and racially diverse. The term *Latino* is often used in the research to include people of Mexican, Puerto Rican, Central or South American, Cuban, or other Spanish descent. In 1997, the U.S. Latino population was 63% Mexican American, 11% Puerto Rican, 4% Cuban, 14% Central and South American, and 7% other Latino origin.[10] Differences among subgroups may be more dramatic than differences between other racial groups; however, the subgroups also share many similarities. Each country's immigrants and additionally, each generation of immigrants, have come from a different level of education and economic conditions, have a different level of English proficiency, have different cultural values and traditions, and have different reasons for migration, whether political, social, or economic. Patterns of relocation in the United States, whether urban to rural, southwest to northeast, may also account for some differences in subgroups' experiences with the U.S. culture. Because of this diversity, information in this report is presented according to subgroup wherever possible. Statistical information is not often available in subgroups for Latinos, however.

Latino Culture

Latino subgroups experience a wide variety of social, political, and economic conditions that make their culture unique. Though the Latino culture is rich and distinct among the different groups, there appear to be several overarching cultural attitudes and beliefs that influence Latinos' experiences in the United States, as well as Latino adolescent development. It is important to note, however, that culture acts as an influence on behavior, not as a determinant of behavior: "Each person interacts with his or her culture in a unique

way and is a complex blend of individual and cultural characteristics."[11] Although the cultural context of Latino adolescent development is crucial in understanding the conflicts and decisions that a teen may make, the cultural values discussed in this report should not be used to generalize or stereotype the Latino population as a whole.

One of the major cultural values is *familism*, which places strong emphasis on the family and children and values the traditional role of women as caretakers and mothers. Familism is commonly cited as a critical influence on Latino families and adolescent sexuality and early childbearing. Familism, however, even with the importance of the role of the woman in the family, has been shown to be a protective factor against the early initiation of sexual intercourse: "Daughters who are less acculturated are more compliant with parental traditional value systems, which act as a strong deterrent to premarital sexual behavior."[12] In addition, Flores et al. found that, among Mexican American female adolescents, those who are second generation and more acculturated engage in sexual activity early and have more sexual partners than those who are less acculturated.[13] Latinas who remain closely tied to traditional values, such as familism, may be less likely to engage in risk-taking behavior, including early or unsafe sexual activity.[14]

Another Latino cultural value that has an impact on Latino adolescent sexual relationships is the emphasis on *respeto* (respect): revering the traditional gender roles, deferring to elders (including parents and community members), and behaving in a manner that will not bring shame to the family. Marcell found that, among three generations of Mexican American males, those adolescents who adhered to traditional cultural values were more insulated from delinquent or risk-taking behavior.[15]

Latino males may also be influenced by the cultural value of *machismo*, emphasizing the traditional male role of being the family breadwinner and the traditional female role of being submissive to men.

The acculturation process is a powerful influence on the Latino population. As each individual comes into contact with the mainstream American culture, it impacts in different degrees on his or her customs, values, identity, and patterns of living: "Acculturation is a process by which people of one culture learn to adjust their behavior to accommodate the rules and expectations of another culture. The individual does not give up his or her culture in the process, but retains the identity, custom, and most everyday behaviors of his or her culture of origin."[16] Culture is dynamic and for Latino communities, cultural changes between generations can be quite extensive.[17] Latino youth are expected to learn and accept the prevailing norms from their parents, as well as the norms of the larger community that surrounds them. Many Latino youth experience the mainstream American culture more so than their parents as they progress in school. This can create a clash as they experience one culture and value set at school and a very different one at home.

The cultural norms for gender roles in Latino communities are often a powerful influence in a young person's educational attainment. Young Latinas must struggle with the pressure to fulfill the cultural expectation of becoming a mother and the desire to obtain an education. Many value the role of motherhood more than higher education, though this varies intergenerationally: "As a group, a larger percentage of foreign-born Latina teens reported their intention to be housewives and mothers as compared to U.S.-born teens."[18] Compared to African American and white adolescents,

pregnant Latina adolescents reported more often that they intended to become pregnant, or that they had not been concerned about whether or not they become pregnant.[19] Latina adolescents who value both being a mother and furthering their education often end up conflicted when they become pregnant: "The more acculturated teens did not want to give up school to be full time mothers."[20]

The pregnancy rate among second and third generation American Latino teens is higher than that of first generation teens. It is believed that "foreign-born Latinas, as compared to U.S.-born Latinas, were more likely to be sexually conservative regarding the number of sexual partners and age at first intercourse. They were also more likely to have planned their pregnancies and to be married or living with a partner."[21] Researchers agree that it is important to understand the intergenerational differences in adolescent pregnancy for intervention purposes: "Fertility studies regarding Latinos have shown that fertility decreases as women become more acculturated, that is, as they increase their levels of education and speak less Spanish."[22]

Early childbearing remains an impediment to women's educational, social, and economic status in all parts of the world. Motherhood at an early age entails a risk of maternal death much greater than average, and the children of young mothers have higher levels of morbidity and mortality. For Latina young women, early motherhood can severely curtail their educational and employment opportunities with long-term adverse impacts on their, and their children's, quality of life.

With the increasing growth rates for Latinos into the next century, there is a significant need for culturally appropriate services and programs that provide Latino youth with information to empower them to have safe and healthy relationships and to lead productive lives.

Notes

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3. Factors Contributing to Latino Adolescent Pregnancy

A number of factors have been documented in the research as antecedents to or risk factors associated with adolescent pregnancy and premature parenthood: poverty, family dysfunction, low educational achievement, and risk-taking behaviors. For the Latino population, however, many of these risk factors impact on Latino youth in unique ways often not addressed or perhaps not even recognized by prevention programs and policymakers. This chapter will explore socioeconomic status, health care accessibility, educational attainment, religiousness, and milestones of adolescent development as they impact on adolescent pregnancy in the Latino community.

Socioeconomic Status

Research shows a direct relationship between the poverty level, education level of parents, and adolescent pregnancy rates: young people who live in extreme poverty with parents who have low levels of education have higher rates of pregnancy than youth in middle- to high-income families.[1] In fact, 80% of young women who give birth are poor.[2] Therefore, information regarding the socioeconomic status of Latino families is critical in the discussion of adolescent childbearing.

Latinos have the highest poverty rate of any major racial or ethnic group in the United States.[3] Between 1995 and 1996, the pov-

erty rate for Latinos remained at 29.4%, higher than the poverty rate for either African Americans (28.4%) or whites (11.0%).[4] Median family income for Latinos was $26,179 in 1996, compared to $44,756 for white families, and $26,522 for African American families.[5] In 1995, 39.3% of Latino families with children under age 18 lived below the poverty level, and 57.3% of Latino families headed by a single mother with children under the age of 18 lived below the poverty level.[6] Latinos and whites have the largest numbers of children living in poverty. When the proportions are examined, however, 40% of Latino children and 40% of African American children were living in poverty, compared to only 10% of white children in 1996.[7] The decrease in socioeconomic status for the Latino population is attributed to the large numbers of Latino immigrants who often have less education and lower incomes than the Latino population as a whole.

Health Care

Latinos were more than twice as likely to lack health insurance as whites in 1995 (32% of Latinos were uninsured, compared to 13% of whites).[8] Overall, the Latino population is the most likely of all racial and ethnic groups to be uninsured or underinsured. Even though the percent of the population that is uninsured does decrease as income level increases, Latinos are most likely to have higher rates of being uninsured in all income levels when compared to whites and African Americans.[9]

As compared to white or African American children, Latino children under the age of 18 are the least likely to have health insurance.[10] For Latino adolescents, approximately 34% are uninsured, as compared to 13% of white adolescents. Subgroup data reveal that a larger percent of Mexican adolescents do not have health insur-

ance as compared to Puerto Rican adolescents (37% to 11%, respectively).[11] This issue is of particular concern to programs that provide adolescent pregnancy prevention efforts and prenatal services for pregnant adolescents.

Another group falling through the cracks in the nation's health care system are children in undocumented Latino families. Illegal immigrants face great medical risks, for they are most likely to be living in poverty, have little access to health care and family planning services, and are most likely to have health problems.[12] Efforts to provide health care for undocumented Latino families often prove difficult, as many undocumented Latinos are wary of coming into contact with figures of authority, for fear of being reported.

Education

Latino youth make up approximately 14% of the school-age population, and by the year 2020, the census estimates that Latino youth will make up 22% of the school-age population. However, according to administrative officials, Latino advocates, and academic experts, "Those children are falling behind in school in a manner that could have a serious economic effect on the whole nation."[13]

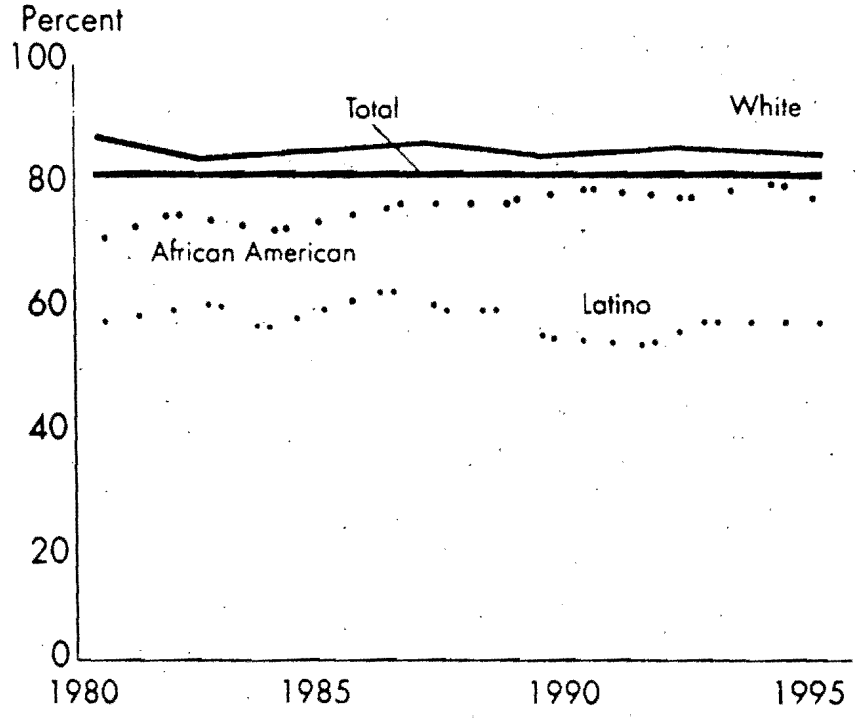
The proportion of high school dropouts in the Latino population is significantly higher than any other major ethnic group.[14] In 1994, the dropout rate for Latinos between the ages of 16 and 24 was between 30 and 35%, compared to 12.6% among African Americans and 10.5% among whites.[15] Latinos have lower high school completion rates than either African Americans and whites, fluctuating between a low of 57% in 1980 and a high of 67% in 1985 during the 1980-1996 period.[16] The Latino high school completion rate was approximately 62% in 1996.[17] Dropout rates and low educational achievement are closely associated with rates of adolescent preg-

nancy, making the high incidence of leaving high school among young Latinos a paramount concern.

Other troubling problems persist. Not only do Latino youth drop out of high school at twice the rate of other groups, they are also dropping out at a younger age. The percentage of Latino youth who drop out before finishing the tenth grade is 55%, compared to approximately 30% for white youth and 25% for African American youth.[18] In fact, one study from 1988 showed that, among Latino youth ages 16-24 who had not completed a high school education, at least half of the group had never even begun high school: 32% had ended their education at the sixth grade or earlier and another 34% had dropped out between the seventh and ninth grade.[19] An additional challenge for the education community is that Latino youth who drop out of high school are less likely to return to school or complete a GED.[20] (See Figure 2.)

Causes for high school dropout rates vary. Latino males frequently reported leaving school for economic reasons and the need to work. Discrimination and cultural and language barriers often precipitate Latino students leaving school, because they feel pushed out or alienated from the educational system. The majority of Latino youth attend segregated schools, with inadequate resources, fewer high-quality teachers, less rigorous classes, and lower teacher expectations for their performance than their white counterparts.[21] For Latina adolescents, low educational aspirations among peers was found to be particularly influential when reporting reasons for leaving school. Latinas were more likely than African Americans or whites to have left school before they were pregnant. Latinas are less likely to return to school after having a child, placing them at greater risk for future economic hardships. Further understanding the reasons that lead Latinas to leave school may be particularly useful in early pregnancy prevention efforts.

Figure 2. Percentage of Adults Ages 18 to 24 Who Have Completed High School by Race and Latino Origin, 1980-96



Note: Percentages are based only on those not currently enrolled in high school or below. Prior to 1992, this indicator was measured as completing four or more years of high school.
Source: U.S. Bureau of the Census, October Current Population Survey. Tabulated by the U.S. Department of Education, National Center for Education Statistics.

School connectedness, defined by adolescents in grades 7-12 as feeling close to people at school, feeling a part of the school, getting along with teachers and peers, and feeling that the teachers treat the students fairly, has been shown to be a protective factor in delaying initiation of sexual intercourse.[22] With Latino youth dropping out of school in large numbers prior to the ninth grade, the American school system is clearly failing to help Latino youth feel a sense of connectedness to their school, further placing them at greater risk for early sexual activity, unintended pregnancy, and limited life options.

Religion

Religion and spirituality play a strong role in the traditional Latino culture. Religious affiliations differ somewhat, depending on ethnicity. For instance, 96% of Mexicans are Roman Catholics, while the predominant religions among Puerto Ricans are Catholicism and Protestantism (Evangelical and Pentecostal). The folk religions of "santería and espiritismo are accepted, if not followed, by a substantial part of the [Puerto Rican] population."[23] Dominicans primarily affiliate with the Catholic church, though some Dominicans do adhere to some of the Protestant denominations. Among Dominicans, there are also some who follow and practice folk religions, such as santería and voodoo.

While there are some Protestant denominations that are popular in some areas, Roman Catholicism remains the predominant religion for most Latinos. The conservative positions of the Catholic church (i.e., abstinence until marriage, no contraceptives except for natural family planning, and the lack of openness about sexuality) have possibly contributed to the higher fertility rate among Latina women.

Religious identity, however, seems to serve as a protective factor against many risks during adolescence. Youth who feel connected to their religion and who make a vow of abstinence are more likely to delay the onset of sexual intercourse until their later adolescent years.[24] A number of studies found that adolescent females, 15-19 years of age, who felt religion was not of great significance in their lives and did not regularly attend church, were more likely to be sexually active.[25] Moreover, it does not appear that any particular denomination has any greater likelihood of predicting sexual activity.[26] The extent to which second, third, or fourth generation Latino youth embrace their religion and feel a strong religious identity is

an area that needs considerably more research to determine what steps could be taken to support Latino youth's religious identity in hopes of protecting them from adolescent pregnancy and sexually transmitted diseases.

Adolescent Development

Adolescence begins with a biological event, the onset of puberty, and ends with entrance into the adult world, an unspecified event that cannot be pinpointed in time but usually coincides with commitments to marriage, work, or career. The chronological benchmarks vary, although adolescence generally begins around age 12 and is generally recognized to end at age 20. The emphasis of adolescence is on sexual development, as well as the integration of societal and family values into the identity of the individual. This stage of development facilitates the adolescent's ability to plan for the future and move away from the need for immediate gratification.

During adolescence, youth must adjust to their changing bodies, form their identities, and develop adult thinking skills. All three are directly related to teen sexuality. The dramatic biological changes that occur during the adolescent growth spurt are usually spread over a two- or three-year period. There are obvious increases in height and weight and changes in body proportion, including the appearance of sexual characteristics and the capacity to reproduce. A critical aspect of adolescents' understanding of selfhood involves coming to terms with their changing bodies. Adolescents must adapt to their own body changes in appearance and function, as well as to the responses of other persons to those changes.

The dramatic physiological changes occur in tandem with a major psychological event: the adolescent quest for personal identity. In the Latino culture, children are taught at an early age that the

needs of the family are more important than the needs of the individual. This value may lead to increased stress upon Latino youth as they begin to become acculturated in the wider culture.

During adolescence, teens begin to switch from identification with their parents to increased identification with their peers. Research suggests that adolescents often seek out peers whose beliefs, values, and even behaviors are similar to those of their families. While peer and other social influences often reinforce familial values, some influences may expose the adolescent to values that differ significantly from the family's. Thus, the need to balance peer pressure and family expectations creates both new challenges and family tensions as adolescents begin to make independent decisions. These challenges are exacerbated for Latino teens who are placed in the position of accepting traditional family values *and* integrating into the wider society.

Adolescence is a time for trying out new behaviors. Although experimentation is essential for development, it may also lead to an increase in risky behaviors—and adolescents are likely to underestimate the potential for negative consequences.

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4. Sexual Activity, Contraceptive Use, and Sexually Transmitted Diseases

Latina adolescents are twice as likely as whites to give birth, were less likely to be informed about human sexuality and birth control, and were less likely to have used contraceptives during intercourse. This chapter offers an in-depth examination of these concerns.

Sexual Activity

Recent research compares the sexual activity of African American, Latino, and white adolescents by race. For example, according to the Urban Institute, the age of onset of sexual intercourse for Latino youth falls between that of African Americans and whites: by the age of 17, 50% of Latino teens report having intercourse, compared to age 16 for African Americans and age 18 for whites.[1] The age of initiation of sexual intercourse varies for Latino adolescent males and females. Males tend to initiate sex at 13.9 years of age, two years earlier than females, at 15.9 years of age. However, significant interethnic and intergroup differences exist that are not often addressed. Day[2] emphasizes that it is inaccurate to characterize *all* Latino males as being between African Americans and whites when comparing age at first intercourse. Day's research found that Mexican American men are not significantly different from white men for age of sexual debut.

The age of initiation of sexual intercourse for Latinas also varies with ethnicity. Latinas overall report an average age of 15 for initiating sexual intercourse, with Mexican American Latinas starting slightly older, at 16. Additionally, studies have looked at the impact of the acculturation process on Latinas' age of initiation of sexual intercourse and rates of sexual activity. Among Mexican American adolescent females, generational differences exist: Mexican-born adolescent females report having a later age of onset of sexual activity (between age 17-19), while U.S.-born Mexican American females report having initiated sexual intercourse between the ages of 15-17. Additionally, Mexican-born adolescent females report having fewer partners than U.S.-born adolescent females.[3]

A current study that examined the effectiveness of HIV/STD and pregnancy prevention programs for urban middle school students in Northern California found that, among different ethnicities, Latinos were most likely to report having a boyfriend or girlfriend who was older. The older the boyfriend or girlfriend, the more likely that the youth had had first intercourse by the sixth grade. The boys who were dating were more likely to report having had sexual intercourse than the boys without girlfriends. For the boys, the age difference of the partner was not found to be a significant factor. For the girls, however, the age of the boyfriend was found to be significant. Not only did girls who were dating report having had sexual intercourse significantly more than those girls without boyfriends, but also those girls with older boyfriends were significantly more likely to have had sexual intercourse than girls dating someone of the same age.

Among sexually active youth, those with an older partner were more likely to have sex more frequently, to have more partners in the last 12 months, to have used drugs or alcohol during the last

sexual encounter, and to have used a condom during the last sexual encounter than students with same-age partners. Girls who had an older partner, however, were no more likely to report greater condom use than girls with a same-age partner. This is a particularly important point to address when examining the cultural impact of communication among males and females around issues of contraception and sexual decisionmaking. Gender and relationship power issues within the Latino culture may prevent Latina youth with partners of any age from negotiating sexual and contraceptive choices, placing Latina female adolescents at risk for unintended pregnancy and STDs.

The number of Latino teenagers who have had sexual intercourse falls in between African Americans and whites. Between ages 15-19, the number of Latino teenagers who report having sex is 61%, significantly lower than the percentage of African American teenagers (80%), but higher than whites (50%).[4] When activity among females is compared, Latina adolescents report the lowest percentage of sexual activity: 45% of Latina adolescents have had sex, compared to 59% of African Americans, and 48% of whites.[5]

When measuring the number of partners and frequency of sex, of those Latino adolescent males who were sexually experienced, 49% had had more than one partner in the past year, compared to 53% of African Americans and 39% of whites. Mel Hovell et al. studied the sexual activity of Latino and white teens.[6] The study found that Latinas were the least sexually experienced of all gender/race groups, meaning they had fewer partners and had sex less frequently. In addition to this finding, the Latinas were less experienced than the Latino males, while there was no significant difference between white males and females. de Anda's study supports Hovell's findings.[7] For example, she reports that in a small survey

among Mexican American and white female adolescents, whites had had two to three partners, compared to one among the Mexican American teens. Again, the white teens reported a higher frequency of intercourse.

Contraceptive Use

Latina youth may be more at risk of unintended pregnancy due to religious and family beliefs against contraception and premarital sex. Efforts to study family influences on the sexual behavior of teens have provided mixed results, however.[8]

Two facts remain clear: Latina adolescents report lower levels of sexual involvement and they are less likely to use contraceptives early or at all. Family or religious values that may inhibit communication between parents and children, coupled with the lack of access to health care common among Latino youth, may pose barriers to acquiring information and contraceptives.

Research regarding contraception use suggests this as a significant area for intervention. Studies show that Latino individuals have less information available on human sexuality, pregnancy prevention, and STDs, and less access to contraceptives,[9] possibly accounting for the low level of contraceptive use among Latino teens.

One study analyzed condom use among 1,198 teenage males, ages 15 to 19, in 1988. Latino males were less likely to use condoms than African American or white teens.[10] Similarly, in a comparison of females, Latinas were less likely than either African American or white female teens to use a contraceptive.[11]

A comparison by the Urban Institute found that condom use in 1995 among Latino adolescents remained significantly less than African Americans or whites: 71% of sexually active adolescent Latino males reported using condoms *inconsistently or not at all*, com-

pared to 54% of whites and 53% of African Americans.[12] Among Latino youth, a sizable proportion reported that they were not using any contraceptives, and for those that were, a large number reported relying almost exclusively on withdrawal. This lack of contraception use among Latino adolescents magnifies their vulnerability for unintended pregnancy.

In addition, certain characteristics of teenage sex among all teens may leave Latino adolescents particularly at risk. The Alan Guttmacher Institute suggests characteristics of teenage sex that may leave youth on the whole more vulnerable to unintended pregnancy and STDs. These may have an even more significant impact on Latino youth:

- First, teenagers tend to have sexual intercourse sporadically, which can affect efforts to prevent STDs and unintended pregnancy by making them less likely to be prepared when they do have intercourse.[13] Latino adolescents report the lowest frequency of sex, thus the most sporadic. This may contribute to the lack of planning or contraceptive use.
- Second, the necessary communication and agreement regarding contraception may be more difficult for teens whose partners are significantly older. As de Anda reported, the presence of older partners is common among Mexican American female adolescents.[14] The age of their partners was significantly older—on average five years.

Research indicates a third and more troubling characteristic of adolescent sexual intercourse that could contribute to Latina teens' lack of contraceptive use and unplanned sexual activity. Flores et al. report that Mexican American adolescent females indicated a vulnerability for engaging in unwanted sex.[15] This finding is consistent with research reporting that many Latina women, similar to

white and African American women, experience some form of sexu coercion from their male partners.[16]

Sexually Transmitted Diseases (STDs)

Compared with older adults, adolescents (10- to 19-year-olds) ar at higher risk for acquiring STDs for a number of reasons: they ma be more likely to have multiple sexual partners rather than a single long-term relationship; they may be more likely to engage in unprotected intercourse; and they may select partners at higher risk. During the past two decades, the age of initiation of sexual activity has steadily decreased and age at first marriage has increased, resulting in increases in premarital sexual experience among adolescent women and in an enlarging pool of young women at risk. In addition, the higher prevalence of STDs among Latino adolescents reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for English-speaking adults, and concerns about confidentiality.[17]

According to the Centers for Disease Control and Prevention, every year approximately 3 million American teenagers acquire an STD. The most serious of these infections is HIV and the development of AIDS. Although Latinos comprise only 12% of the 13- to 19-year-old group, they account for 18% of the cases of AIDS reported for this age group.[18]

Latinos represent 17% of all cases of AIDS among men and 20% of the total number of cases reported among women. For Latino men, the current AIDS case rate (the number of cases relative to population size) is nearly three times that for white men (94.5 cases per 100,000, compared to 32.5 cases per 100,000). For women, the rate is six times higher (23 cases per 100,000, compared to 3.8 cases per 100,000).[19]

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Notes

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5. Marriage and Childbearing

Since 1991, teen pregnancy and birth rates have declined. After increasing sharply in the late 1980s, birth rates declined for American teenagers from 1991 through 1997.[1] Declines were reported for all race and ethnic origin groups, with the largest declines found for African American teenagers. Since 1991, the rate for Latino teenagers has declined by a total of 7.1%. Between 1996 and 1997, preliminary data revealed that birth rates for Latino teenagers fell 3%[2]; however, they continue to be substantially higher than those for other racial groups, except African American teens. This chapter presents information on rates among Latino adolescents for childbearing and marriage.

Perceptions of Marriage and Childbearing

In a study of girls enrolled in grades 6-8 at four public schools in southern California, it was reported that Latina girls want their first birth and marriage to be at an earlier age than their African American and white counterparts. Further, Latina girls reported the youngest best age of first birth (21.9 years), desired age at first birth (23.3), and desired age at marriage (22.1). Latino girls place the least importance on educational and career goals and were most pessimistic about achieving those goals. As respondents' age increased and

as their educational and career aspirations decreased, they became more likely to intend to have sexual intercourse in the near future. Latino respondents were similar to Southeast Asians in being influenced by their mothers' age at marriage and first birth; furthermore, as Latina girls' family incomes rose, they became less likely to intend to have sexual intercourse soon.[3]

Finally, the study examined school and job prospects. Among all respondents except Latina girls, positive educational and job aspirations were associated with a low perceived likelihood of a nonmarital birth. Latina girls from families with low incomes were more likely to expect that they would experience a nonmarital birth than were those from wealthier families; this perception was also found among those who were born in the United States and those who had been living in the United States for many years.[4]

Marriage

Many point out that early childbearing is more culturally acceptable in the Latino community and that many teenagers who give birth are married. Indeed, Latinos are more likely to marry during adolescence; in 1997, 14% of 18- to 19-year-old Latina women were married, compared to 6% of whites and 4% of African Americans in that age group.[5] It is equally important to note, however, that the rate of those who are married has declined. Some researchers believe that, as Latinos become acculturated, the rate of marriage among Latino teenagers will decrease.

A factor in the levels of nonmarital childbearing observed for Latina women is related to the relatively high incidence of cohabitation among Latino couples. Birth certificate data provide additional evidence of this. The birth certificate used in Puerto Rico distinguishes between unmarried women who are living with the

father of the child and unmarried women who are not living with the father. According to 1995 data, three-quarters of the unmarried women who gave birth were living with the father of the child.[6]

Childbearing

Latina teens are more likely to give birth when they become pregnant,[7] which contributes to the higher birthrates.[8] Latina adolescents may have adopted traditional Hispanic cultural values that make it acceptable to become an adolescent mother and have a family.[9] Although a positive, functional occurrence in an agrarian society, teenage marriage and childbearing becomes a negative one in light of the economic reality that immigrant Latino families are forced to accept in this society.

The Latino adolescent birth rate for 15- to 19-year-olds fell marginally from 101.8 births per 1,000 in 1996 to 99.1 per 1,000 in 1997.[10] Yet, even with the slight decrease, Latino teens still have the highest adolescent birthrate compared to African American teens (89.5 per 1,000 in 1997) and non-Hispanic whites (36.4 per 1,000 in 1997). Among births to all Latino women in 1997, births to Latino adolescents accounted for 17%, compared to 10% for whites and 23% for African Americans. There are significant subgroup differences in the Latino population, however. In 1996, the proportion of births to teenage mothers among Cuban women was only 8%; among Central and South American women, 11%; among Mexican and "other/unknown" Latino women, 18-20%; with the highest proportion among Puerto Rican women, at 23%.[11] Examining the proportion of births to teenagers may be useful in gauging the impact of adolescent childbearing on a population.

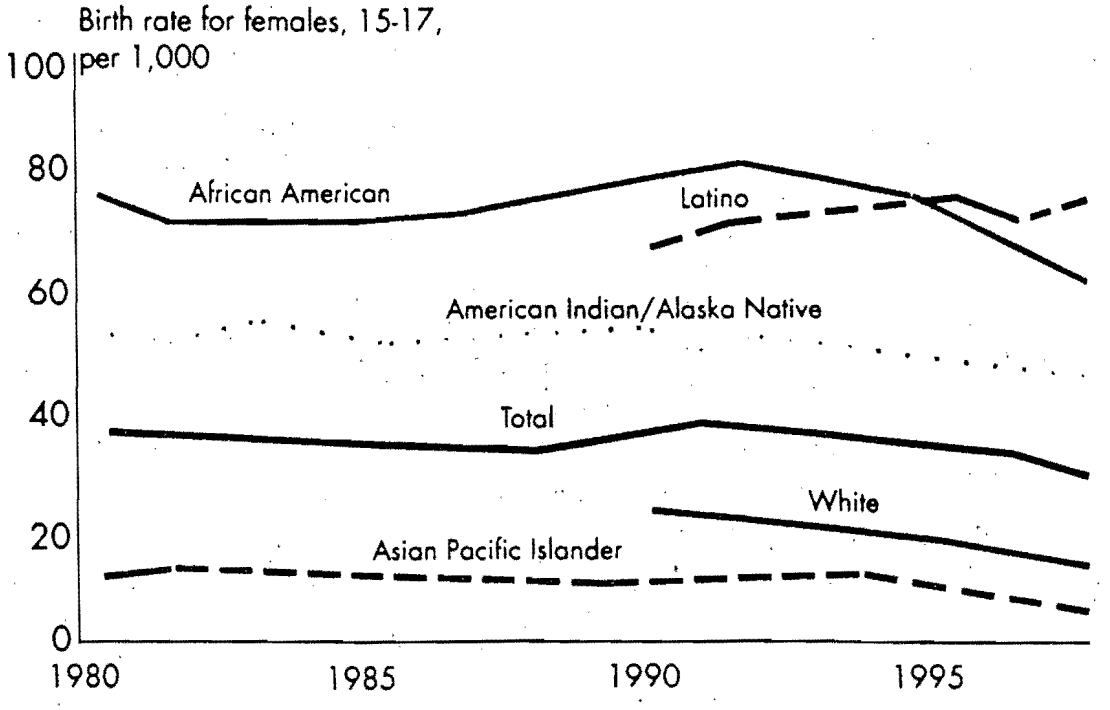
There is a distinctive pattern in the levels of age-specific birth rates by race and Latino origin and the rates vary substantially.

Among teenagers 15-19 years, rates are highest for Mexican teenagers (120.7 per 1,000 in 1996) followed by African American (94.2), Puerto Rican (82.3), and American Indian teenagers (73.9 per 1,000). The rates for non-Hispanic white (37.6), Cuban (34.0), and Asian Pacific Islander (24.6) teenage subgroups are considerably lower. Among teenage subgroups 15-17 and 18-19 years, the patterns were generally similar to those for all teenagers 15-19 years. Rates were highest for Mexican teenagers and lowest for Asian Pacific Islander teenagers. These relationships were observed in each year, 1994-1996. Prior to 1994, birth rates had been highest for African American teenagers. (See Figures 3 and 4.)

Between 1995 and 1996, teenage birth rates declined for all groups except Cuban teenagers, for whom the rate increased from 29.2 to 34.0 per 1,000. The declines were 3% and 4%, respectively, for Mexican and white teenagers. Other declines were 5% for African American teenagers, 8% for Puerto Rican, and 10% for other Latino teenagers. From 1991, when rates for teenagers generally were at a peak, to 1996, birth rates fell 20 to 21% for African American, Puerto Rican, and other Latino teens. Declines for white teens were less, at 13%.[12]

Prenatal care utilization, which provides opportunities for professional medical advice and detection and management of preexisting medical conditions, can promote healthier pregnancy outcomes. The proportion of Latino teens who began prenatal care in the first trimester improved. For Latina teens under 15 years of age, 50% began prenatal care in the first trimester and for 15- to 19-year-olds, 63% began in first trimester. A decrease was noted in the percent of Latina teens who had late or no prenatal care: 15% of under 15-year-olds and 9.2% of 15- to 19-year-olds had late or no care. By comparison, among African American teen mothers 15 to 19 years of age, 9% had late or no care, versus 5% for white teen mothers 15 to 19 years of age. (See Figure 5.)

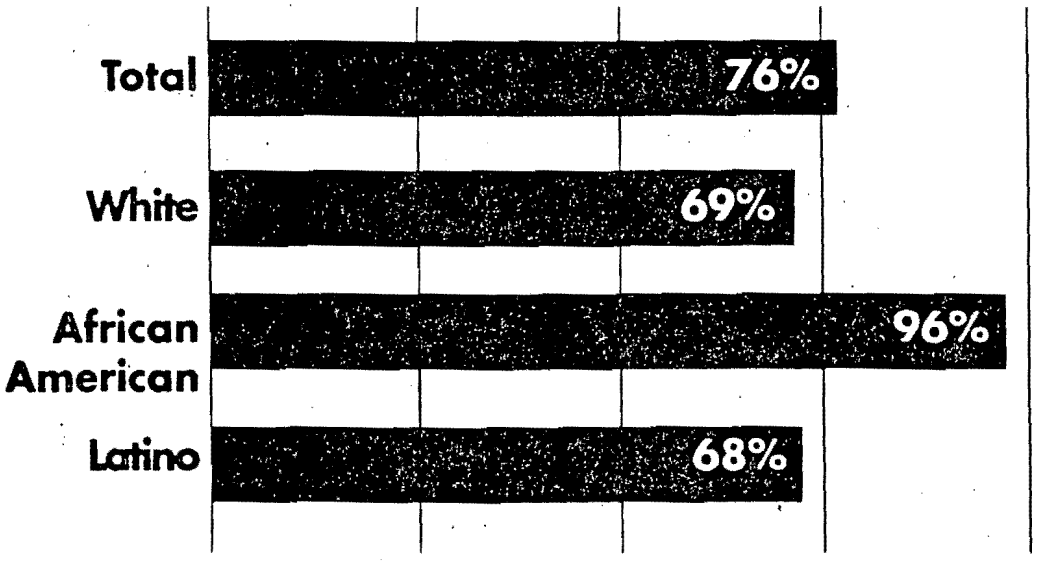
Figure 3. Birth Rate for Females Ages 15 to 17 by Race and Latino Origin, 1980-97



Note: Rates from 1981–1989 were not calculated for Hispanics or non-Hispanic whites, because estimates for populations were not available. 1997 data are preliminary.

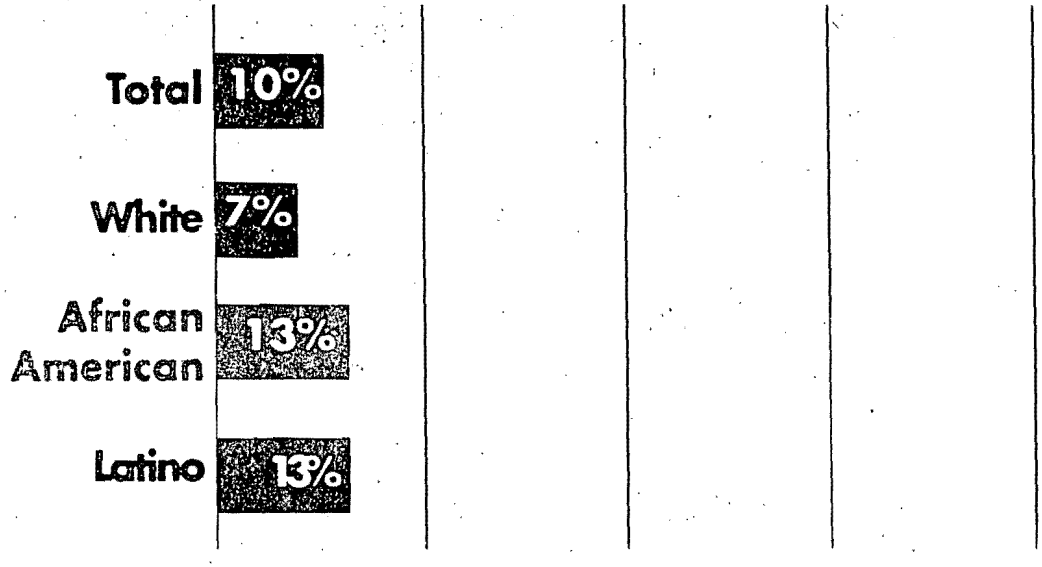
Tobacco use during pregnancy is associated with a variety of adverse outcomes, including low birthweight, intrauterine growth retardation, and infant mortality, as well as negative consequences for child health and development. Maternal smoking among teenagers increased about 2% overall, but among young teenagers aged 15 to 17 years, the rate rose 5% to 15.4%, with an even greater relative increase for African American teenagers, from 4.3 to 5%. Smoking rates rose as well in 1996 for Mexican and Puerto Rican teenagers aged 15 to 17 years. Despite these increases, smoking rates for non-Hispanic white teenagers are still four to six times the rates for Latino teenagers.

Figure 4. Percent of Teen Births That Occurred to Unmarried Teens by Race/Ethnicity, 1996



Source: The Annie B. Casey Foundation, from data compiled by the National Center for Health Statistics. (1998). *When teens have sex: Issues and trends.* Kids Count Special Report.

Figure 5. Percent of Births to Teens Receiving Inadequate Prenatal Care by Race/Ethnicity, 1996



Source: The Annie B. Casey Foundation, from data compiled by the National Center for Health Statistics. (1998). *When teens have sex: Issues and trends. Kids Count Special Report.*

Another important measure for the Latino population is the proportion of births to adolescents born in the United States, as compared to foreign-born Latino adolescents. Here the differences are very substantial, with twice as many teenage mothers among U.S.-born Latino adolescents as among foreign-born Latina adolescents (26.1% compared to 12.0%, respectively). Again, considerable differences exist among the subgroups. For Mexican teens, the percent of teenage mothers among U.S.-born adolescents is 27.2%, compared to 12.5% for foreign born; for Puerto Rican adolescents it is 25.3%, compared to 19.8%; for Cuban adolescents, 12.1% compared to 5.0%; for Central and South American adolescents, 23.5% compared to 9.6; and for adolescents of "other and unknown Latino" origin, the proportion of teenage mothers among U.S.-born Latino adolescents is 23.2% compared to 10.1%.[13] These last figures highlight the impact of the acculturation process for Latino adolescents in the United States.

Notes

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8.
Latino Adolescent Pregnancy Prevention

Central to the problem of early, unintended pregnancies among adolescents is the ability to make healthy decisions. Learning the values, skills, and goals for health decisionmaking is a lifelong task. It begins with healthy parents, and is reinforced by them throughout the child's life. But just as a child grows up in a family, parents and families exist in a larger world. We believe that families should have access to the support and the assistance of helpful community members and systems designed to their needs. These recommendations are ways that we can empower youth to be responsible about their sexuality and make healthy decisions about their sexual behavior, and how society can provide support to Latino families.

1. Adolescent pregnancy prevention programs must be aimed at primary prevention and address multiple factors.

Prevention requires a multipronged approach that addresses the capabilities, challenges, and potential of young people at each stage of life. No one program approach will be effective. Programs that address delaying sexual activity may be effective in reaching preadolescents and young adolescents. These programs should also include components to enhance communication about sexuality, relationships, and values between preadolescents and their parents or other significant adults, and opportunities to gain new skills. For middle adolescents, programs should promote assertiveness train-

ing and resistance skills, information on sexually transmitted diseases, encouragement of school achievement, and involvement in the community by participation in social, religious, cultural, volunteer, and recreational activities for teens ages 12 to 14. For older adolescents, programs should focus on setting goals, address sex role stereotyping as a potential limitation on their aspirations, provide strategies for avoiding unsafe sexual activity and skills for contraceptive access, and offer career planning and job exploration.

In addition, prevention initiatives should strengthen families, address other factors such as poverty and lack of opportunity, and provide educational enrichment and economic opportunities.

2. Develop programs that embrace the Latino culture and values. Programs should embrace family and cultural context of marriage, sexuality, and fertility.

The concept of culture is dynamic and ever changing. Many Latino adolescents participate in two cultures: the Latino culture of their parents and the culture of the wider community. Programs should build on Latino concepts of *familism* for adolescents to bring pride and honor to the family, *respeto* (respect), and *dignidad* (dignity).

Programs should be intergenerational and involve strategies that focus on groups of youth, neighborhoods, and families (rather than on individual behavior) and on parent sexuality education and parent-child communication.

Program components for effective programs should seek to reinforce clear cultural values and messages to strengthen group values and norms against unprotected sex.

Provide family counseling to address intergenerational conflict regarding changing gender role expectations within the context of family acculturation differences between parents and adolescents. Focus on helping the family to be flexible and to negotiate compromises and changes within the cultural value orientation. Reinforce

same-sex relationships between parent and adolescents for information and support.[1]

3. Male involvement programs must focus on the needs and concerns of young men in the community beyond child support enforcement issues.

Programs for Latino young men should seek to provide healthy, positive male role models to assist boys in their identity struggle. Boys need to hear from male staff who can explore and express their feelings and who show a caring, vulnerable side. Programs should provide information on sex and sexuality to boys, improve communication between father and son and other adult males in the community, help boys to understand that there are consequences to risk-taking behaviors and to accept equal rights and responsibilities for their sexual decisions. Information on gender-specific attitudes, beliefs, and behaviors regarding romantic relationships, sexuality, and contraception must be included. Male involvement in casual, impulsive sex, and drinking must be included in program strategies. Linkages to educational and occupational opportunities for males must be explored.

4. Before developing a program, involve the community. Program developers should seek to become knowledgeable about the needs and characteristics of the community.

For organizations that are initiating a program in a Latino community for the first time, work with organizations already serving the Latino community. Share resources to expand program services.

Begin with a community advisory board to guide the development of the program until it is possible to build Latino representation in the organization's own board and staff. Hire residents to participate in the program in a variety of roles, including peer educators, community organizers, and administrators.

5. Involve adolescents in the development of adolescent pregnancy prevention programs.

Have youth identify the sociocultural issues impacting adolescent sexuality and participate in designing the programs to reduce risky sexual behavior. Peer health educators and peer leaders are just two ways in which youths can be involved.

Components for effective programs should involve group counseling that involve youth in small group exercises, which can

- provide basic information about risks of unprotected intercourse,
- provide basic information about strategies for avoiding unsafe sexual activity,
- address social pressures to be sexual,
- reinforce clear and appropriate cultural values and messages to strengthen group values and norms against unprotected sex,
- provide modeling and practice of communication and negotiation skills, and
- provide guidance for developing healthy relationships.[2]

6. Programs that aim to prevent adolescent pregnancy should provide educational enrichment and tutoring, as well as opportunities to increase the number of Latino adolescents who graduate from high school and enter college.

Several strategies are needed to reach Latino youth to assist them to complete high school. Traditional adolescent pregnancy prevention programs will not be as effective as programs that aim to increase life options. Any program that serves Latino youth must work

to reduce the high incidence of early dropping out. Programs that emphasize career exploration and link job training and education have proven to be effective with African American youth. Similar programs must be developed and implemented in the Latino community.

7. Any Latino adolescent pregnancy prevention strategies must be family-centered and community-based with the goal to strengthen the family.

Programs aimed at reaching only Latino youth will not be as successful as family-centered programs. Programs must provide information and education to parents and community residents so that they have the skills, knowledge, and comfort level to discuss sexuality issues. Programs that include parents and community residents as the sexuality educators (who impart information and values within a Latino cultural context to their children) and that provide parents with opportunities for educational advancement are more effective in reaching Latino youth.

8. National and state adolescent pregnancy prevention organizations should be provided with information about Latino adolescent pregnancy prevention programs.

Programs may need to be retooled to address the cultural differences, influences, and impact on adolescent pregnancy prevention issues. Such programs should provide continuing education for professionals to give them skills to make assessments in culturally competent manner.

9. Funding communities need to increase their efforts to fund adolescent pregnancy prevention efforts in the Latino community. Model adolescent pregnancy prevention programs should be replicated across the Latino population and evaluated for effectiveness.

There is a lack of information of adolescent pregnancy prevention in the Latino community. Many adolescent pregnancy prevention programs have been evaluated for effectiveness and impact on the white and African American community; however, little information is available regarding impact on the Latino community. In addition, because of subgroup differences, programs must be replicated in the various subgroups.

10. Improve data collection, analysis, and dissemination by reviewing the current data and developing an action plan to address the unidentified gaps.

In developing this report, we were struck by the lack of data on the Latino population. Only since 1989 have the states reported Latino births to the National Center for Health Statistics. These data have been helpful in the development of this report. We are concerned, however, that there is some movement away from the collection of data based on ethnicity. We would oppose any changes that remove ethnic group delineation.

11. Develop aggressive outreach programs targeted towards adolescent Latino parents to ensure that they stay in school or return to school after the birth of the baby.

Provide intensive case management programs to link to services, provide information on community resources, and monitor school attendance and the school's response toward adolescent mothers. These programs should also include education on parenting, child development, and careers, as well as information about higher education.

12. Continue to have a dialogue with the Latino community to tease out the relationship between traditional values and adolescent reproductive health issues.

The Latino community is not a heterogeneous community. Latinos of different national origins—Mexican American, Cuban, Do-

minican, Puerto Rican, individuals from Latin or Central America and others—are grouped together. Although they share a common language and heritage, there are differences among the many nationalities in cultural influences and histories. Discussions with the different subgroups around these issues should continue.

13. Provide undocumented aliens with primary health care services that are specialized to meet their developmental needs.

Communities should undertake aggressive outreach to provide information about services and to educate undocumented noncitizens or immigrants as to their right and responsibility to obtain health care services. The services must be provided in locations that undocumented noncitizens perceive as safe havens.

14. Youths who are at high risk for pregnancy (out-of-home care, homeless, juvenile system) must be provided with human sexuality information, family planning services, and opportunities for educational and economic success.

Human service providers serving Latino communities should provide comprehensive services that support youth development. Such programs should include educational and job opportunities, health care (including contraceptives for sexually active youths), outreach to parents to facilitate connection to community resources, parenting education, and life skills planning.

Topics should include but not be limited to discussions with caregivers on communicating about sex for early adolescents; resistance skills for mid-teens; and life options, career planning skills, and responsible decision-making skills about contraceptive use for older teens. Child welfare agencies should recognize that a history of child sexual abuse may be common among youth in out-of-home care. Sexuality education must include information on child sexual abuse. Family planning services should include a variety of health,

educational, and counseling services related to birth control, including contraceptive services, pregnancy tests and counseling, and information and referral services. Life skills programs should include tutoring to improve school performance or provide employment training, role models, and mentors. These programs can assist youth in out-of-home care to understand the negative consequences of becoming parents and the impact of parenthood on their present and future plans.

States must develop and implement standards for comprehensive health services, including medical, nutritional, and psychological care for teens who are incarcerated or in out-of-home care.

Notes

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2 Flores et al. 1998.

Appendix C

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